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Committee on Ways and Means
Subcommittee on Health
Subcommittee on Oversight

Hearing:
Medicare Advantage: Past Lessons, Present Insights, Future Opportunities

July 22, 2025

Statement for the Record
American Academy of Dermatology Association

Chairman Buchanan, Chairman Schweikert, Ranking Members Doggett, and Ranking Member Sewell,

On behalf of the more than 17,000 U.S. members of the American Academy of Dermatology Association (AADA), we thank you for the opportunity to submit a statement for the record regarding your hearing, *Medicare Advantage: Past Lessons, Present Insights, Future Opportunities*.

Traditional Medicare and Medicare Advantage (MA) play a vital role in ensuring access to health care for America's seniors. Traditional Medicare influences Medicare Advantage payment rates via benchmarks which set the maximum amount the federal governments pays MA plans.[i] Unfortunately, adjusted for inflation in practice costs, Medicare physician reimbursement declined 33% from 2001 to 2025. Despite Congressional intervention in recent years, physician practices have continued to see cuts. Long-term reform is needed to fortify independent medical practice, combat consolidation and maintain access for patients in both traditional Medicare and MA.

Stabilizing Medicare Physician Payment

Stable and predictable Medicare reimbursement will help lead to more options for patients, greater flexibility in finding physicians in their communities that fit their needs, and higher patient utilization of preventative care. Medicare physician payment cuts threaten patient access as physician offices close or become consolidated within larger health systems with narrow networks to specialists and subspecialists. This results in reduced accessibility to affordable, high-quality dermatologic care and fewer options for patients to choose their own physician and health insurance that best meets their needs.

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To accomplish this goal, Congress must take action to advance Medicare physician payment reform by:

- Establishing a positive annual inflation adjustment; and
- Increasing the budget neutrality threshold.

In the 2025 Medicare Physician Fee Schedule (MPFS) Rule, the Centers for Medicare & Medicaid Services (CMS) finalized changes that resulted in a 2.8% cut to Medicare physician payment on January 1, 2025. *The AADA urges Congress to pass H.R. 879, the Medicare Patient Access and Practice Stabilization Act of 2025,* which would stop the 2.8% cut to Medicare physician payment, ensure that physicians are made whole for the cuts already in effect in 2025, and provide an overdue positive inflationary adjustment for physician practices for 2025. *The AADA also urges Congress to pass legislation like H.R.6371 – 118th Congress, Provider Reimbursement Stability Act of 2023* which would raise the outdated budget neutrality threshold in the MPFS.

The AADA is appreciative of the 2.5% plus-up to Medicare physician payment for calendar year 2026 in *H.R.1, One Big Beautiful Bill Act*; however, the 2025 cut remains and annual cuts to reimbursement needs to be replaced with predictable inflationary adjustments.

The failure of the MPFS to keep up with inflation is the greatest threat to access to care in physician offices. Stabilizing the MPFS is critical to fortify independent medical practice, combat consolidation and maintain access for patients. On January 16, 2025, the Medicare Payment Advisory Commission (MedPAC) voted to recommend tying Medicare physician payment for CY 2026 to the Medicare Economic Index (MEI) minus 1 percentage point. The MEI, which measures practice cost inflation, is projected to increase by 2.3% in 2026.

Since 2001, the cost of operating a medical practice has increased 59%. During this time, Medicare hospital and nursing facility updates resulted in a roughly 70% increase in payments to these entities, significantly outpacing physician reimbursement. Adjusted for inflation in practice costs, Medicare physician reimbursement declined 33% from 2001 to 2025. This out-of-balance payment structure disproportionately threatens the viability of medical practices, especially smaller, independent, physician-owned practices, as well as those serving low-income or historically marginalized patients. Dermatologists are seeing the real effect of cuts. In the past 8 years, private insurance patients for dermatologists have increased by 21% while Medicare patients are down 27%.

The current Medicare physician payment system has led to increased consolidation and hospital ownership of physician practices resulting in higher expenses and reduced competition to the health care system. In considering the failure of the MPFS to keep up with the rising costs of delivering medical care, it is important to remember that physicians rely on reimbursement to cover a multitude of practice expenses. These expenses include staff salaries, benefits, federal and state regulatory compliance costs, and expenses associated with insurance mandates, such as step therapy and prior authorization.

The impact of these burdens is unsustainable. Many physicians have already had to close their doors, leave their communities, retire early, or leave the practice of medicine. The inability to provide inflationary pay raises to practice employees is contributing to the current health care workforce crisis in which we are seeing increasing burnout rates and a mass exodus of our clinical, administrative, and clerical staff into other industries.

Fewer physicians in our communities means longer waiting times for patients to receive care. Currently, dermatology is only able to meet approximately 37.1% of patient demand in non-metro areas.[ii] When those patients do receive care, their only option may be non-physician providers of care with less training, or more expensive care in suboptimal settings including emergency departments and hospital-based practices. Medicare patients will suffer in the end with delayed and second-rate care at a higher cost. Declining reimbursement and increasing administrative burdens will exacerbate this shortage of physicians when offices close their doors.

In its latest report, MedPAC shared its concerns about whether beneficiaries will continue to have adequate access to care in the coming years as growth in physician practice operating costs is expected to exceed growth in Medicare payment rates by a greater amount than it did in the prior two decades. This larger gap could create incentives for physicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program.

Additionally, the AADA has called upon the Centers for Medicare & Medicaid Services (CMS) to require MA plans to explicitly provide detailed information on its provider payment arrangements and methodologies. All payers are urged to align their payment policies with current established coding conventions and guidelines. Payment policies that improperly reduce payment by failing to adhere to established coding principles, such as inappropriately bundling separately identifiable services and lowering the value of an appropriately documented claim (downcoding), should be avoided. The Academy has urged CMS to oppose reimbursement policies implemented by MA plans that reduce payment for separately valued services when appropriately reported by current coding guidelines. Additionally, we are aware of MA plans' requirements under CMS' Risk Adjustment Data Validation (RADV) program and are concerned that the MA plan record request in many cases, is not for purposes of validating diagnoses previously submitted to CMS, but for mining for additional diagnoses to submit to CMS in order to increase their risk adjustment scores and secure higher Medicare payments for their enrollees. CMS is urged to review MA plans "coding intensity" and the administrative burden placed on physician practices.

Medicare Advantage Network Adequacy

The AADA believes provider networks should serve patient needs, specifically by ensuring that patients have adequate and timely access to providers with appropriate training and specialty or subspecialty expertise.

In response to *CMS-4208-P Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly,* AADA supported a proposed change to conduct network adequacy reviews at the MA plan benefit package level rather than continuing its current practice of conducting the reviews at the contract level. This change would ensure that patients in each plan benefit package service area have meaningful access to robust provider networks. In the final rule, CMS deferred implementation and plans to address in future rulemaking.

AADA supports CMS strengthening network adequacy requirements by requiring plans to consider availability of subspecialty providers. Lack of accountability for including dermatologic subspecialties can result in significant access problems as each subspecialty within dermatology provides unique services to distinct patient populations with varying care needs. CMS should therefore establish network adequacy standards for dermatologic sub-specialties.

MA plans should be required to publicly notify CMS, plan members and its provider network, of its rationale for significant reductions or closures of their networks. Physician practices have reported MA plans increasingly reducing or closing their networks without clear explanation, thereby impacting patient access. AADA called upon CMS to implement guardrails for MA plans to provide a meaningful appeal process whenever a physician is terminated or denied application to the provider network. The appeal review should consider whether the removal of the physician from the network would result in network inadequacy, and this should be a basis for reinstatement. Additionally, plan members should be allowed to stay with a physician until the next open enrollment period if the provider is eliminated from a network mid-year.

AADA supports additional changes that would increase access to dermatologic care for MA enrollees. For example, we urge CMS to support the principle that any willing, qualified physician should be allowed to participate in MA plan managed care networks. The AADA also supports all patients having direct access to dermatologic care delivered by dermatologists. Direct access to dermatologists is the easiest and most cost-effective method of providing quality dermatologic services in managed care settings

Promoting Informed Choice & Reducing Burdens

In response to *CMS-4208-P Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly,* AADA commented on a CMS

proposal that would require MA organizations to submit provider directory data for integration into the Medicare Plan Finder (MFP) and attest that such information is accurate and consistent with data submitted to comply with CMS's MA network adequacy requirements. While CMS deferred finalizing this policy in the final rule and plans to address in future rulemaking, there are concerns to be addressed.

We appreciate efforts to provide consumers with ready access to provider network information and ensure provider directories are accurate. The AADA is concerned about potential downstream impacts to physician practices imposed by MA carriers. We continue to hear from dermatology practices reporting increasing demands from MA plans to provide information for a range of reasons, for example related to credentialing, prior authorization, and step therapy, as well as to justify the plans' risk scores. To force compliance, health plans impose penalties that impact payments or network participation.

There is concern that MA plans will employ similar harsh measures on physician practices to support the provider directory attestation. CMS and payers need to recognize that poorly designed information requirements and administrative burdens increase practice administrative costs, take clinical staff away from patient care, and contribute to professional burnout. To prevent the shifting of the attestation burden to physician practices, we encourage both CMS and congressional oversight to ensure that MA plans do not impose financial penalties or undue administrative burdens on physician practices in support of their obligation to attest to the accuracy of their provider network data.

Additionally, the Academy is concerned about substantial burden imposed upon physicians by MA plans related to medical record requests. These requests are numerous and place a significant burden on our members, especially for those who are solo practitioners or part of a small practices as they have limited resources that can be diverted from patient care.

MA plans routinely request an excessive volume of records, with members reporting that requests for 100 or more records are not uncommon, and often fail to provide a clear reason(s) for the request. To accommodate these requests, office staff must dedicate time and financial resources to research, abstract, print or copy, and transmit records – activities that are particularly disruptive for small practices. In addition to the large volume of requests, MA plans routinely impose additional requirements or restrictions related to the production of the requested records that further place burden on physician practices. For example, MA plans often impose unreasonable and rigid timelines for returning requested records, with limited flexibility for practices facing extenuating circumstances. MA plans may also limit providers' ability to submit medical records through submission methods that are least burdensome to practices. In addition, practices must also contend with an array of disparate processes for receiving, processing, and submitting medical record requests across all of their contracted MA plans.

We have urged CMS to mitigate these unnecessary administrative burdens on physician practices. While we understand that CMS is generally reluctant to intervene in the relationship between MA plans and

their contracting physicians, we believe that changes are necessary to curtail egregious plan practices that do not support patient care and place unnecessary burden and costs on the physicians who furnish care to MA beneficiaries. Particularly for solo and small practices, who are least likely to have leverage in contract negotiations and most likely to have limited resources to accommodate the record requests, the changes outlined above would better enable physicians to maximize their limited resources on furnishing high-quality care, rather than on meeting onerous administrative requirements. Equally importantly, it would assist CMS in addressing longstanding challenges with MA "coding intensity," protecting the Medicare Trust Funds from potential fraud and abuse.

Guardrails for Artificial Intelligence

AI has the potential to transform our individual and collective experience of health, healthcare, and wellness. To achieve this potential, deliberate and diligent effort must be taken to engage and collaborate with stakeholders and policymakers. The Academy is committed to working with the Administration and Congress to create policies that promote AI that is high-quality, inclusive, equitable, and accessible. Through collaboration and research, the AADA strives to guide the design, implementation, and regulation of these technologies to augment care for all healthcare consumers.

The Academy supports the development of artificial intelligence (AI) technology provided that it is designed and evaluated in a manner that enables the delivery of high-quality care to patients. AI should not impede access to medically necessary and appropriate dermatologic care nor should it impede access to in-person dermatologic care if a patient desires such access. The AADA opposes using AI to deny coverage or payment without further review by a physician of the same specialty.

As the validity and generalizability of AI technology are dependent on the quality and source of the data that are used to develop AI models, data used to train AI models must be fully representative of the target population and auditable, and all data sources must be clearly and accurately identified.

On behalf of the Academy, thank you for your leadership and help ensuring that Medicare and Medicare Advantage meet the needs of Americans. The American Academy of Dermatology Association (AADA) is committed to excellence in the medical and surgical treatment of skin diseases; advocating for high standards of clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of disease. The AADA welcomes the opportunity to continue working with Congress to identify opportunities to maintain patient access to care and improve outcomes. Together, we can make a positive difference for patients across the nation.

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[i] https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer
[ii] https://data.hrsa.gov/topics/health-workforce/workforce-projections