May 23, 2025

The Honorable Pam Bondi, JD
Attorney General
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Submitted electronically via https://www.regulations.gov/

RE: Anti-Competitive Practices in Healthcare [Docket No. ATR-2025-0001]

Dear Attorney General Pam Bondi,

The American Academy of Dermatology Association (AADA) appreciates the opportunity to provide comments to the Department of Justice's (DOJ) Antitrust Division in response to its public inquiry to identify unnecessary laws and regulations that raise the highest barriers to competition.

As the leading society in dermatological care, representing nearly 17,500 dermatologists nationwide, AADA is committed to excellence in the medical and surgical treatment of skin disease; advocating for high standards in clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of disease.

As the DOJ works to identify and eliminate anticompetitive state and federal laws and regulations that undermine competition, we urge the agency to advocate for reforms to current Medicare physician payment policies, which serve as structural barriers that reduce competition and accelerate market consolidation in healthcare. We also encourage the agency to review recent changes to Clinical Laboratory Improvement Amendments (CLIA) laboratory director qualifications, which restrict board-certified dermatologists from practicing within the full scope of their training, ultimately limiting

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patients' access to care and impacting health outcomes.

I. Medicare Physician Payment Instability is Driving Market Consolidation

The AADA is concerned that continued instability in Medicare physician payment is accelerating the consolidation of medical practices and reducing competition in the healthcare market. As financial pressures increase, physicians in small or solo practices often cannot sustain operations independently and are left with little choice but to sell or merge with larger hospital systems. The shift from small practices reduces access to care in local communities, limits patient choice, and increases the overall cost of services delivered to Medicare beneficiaries.

Consolidation in healthcare has wide-ranging consequences. When physician practices are absorbed into large conglomerates, care is often delivered in more expensive settings, and decisions may be influenced by institutional financial priorities rather than clinical need. Patients in underserved or rural areas may face longer wait times, less personalized care, and disruptions in accessing care with their regular physicians. As consolidation continues and large health systems expand, competition decreases, and local access to care erodes.

Policies that govern how Medicare Physician Fee Schedule (PFS) are updated on an annual basis have created conditions that distort competition in the physician marketplace and unintentionally favor consolidation over independent practice. Indeed, physicians are now facing the fifth consecutive year of payment cuts under the PFS, including a 2.8 percent reduction to the conversion factor for calendar year (CY) 2025, and since 2020, payment rates have been reduced by more than 10 percent.

Medicare physician reductions stem from two key problems: outdated statutory formulas and recent CMS policy decisions, compounded by flawed assumptions. The Medicare PFS is one of the few Medicare payment systems that does not receive inflation-based updates. Instead, annual PFS updates are fixed in law—set at 0 percent from 2020 through 2025. Beginning in 2026, modest updates of 0.25 or 0.75 percent are scheduled, but these are far short of keeping pace with rising practice costs. For example, the Medicare Economic Index (MEI), which measures practice cost inflation, projects increases of 3.5 percent in 2025 and 2.3 percent in 2026.

Additionally, annual payment updates are subject to statutory budget neutrality adjustments that must be applied if certain policy changes are expected to increase or decrease payments under the PFS by more than $20 million relative to what payments would have been absent such changes. However, Congress has not updated this $20 million threshold since 1992, despite significant increases in total PFS spending over this time. Additionally, budget neutrality

adjustments can result in significant reductions to the PFS conversion factor when policy changes have significant payment impacts, as has occurred in recent years. Lastly, it is worth noting that the budget neutrality adjustments are often overstated, and high utilizations assumptions that are built into the calculation of the adjustments do not materialize; when an overestimation occurs, it contributes to budget neutrality reductions that remain uncorrected under current policy, resulting in unwarranted yet sustained reductions in the Medicare physician payment pool.

Together, these factors have depressed physician payment rates under the PFS and increased consolidation pressures. Adjusted for inflation, physician payment has declined by 33 percent from 2001 to 2025.[1] In contrast, Medicare payments to hospitals and other facility-based providers have steadily increased.[2] This imbalance creates a financial environment that favors large institutional providers and leaves independent practices at a severe disadvantage.

To preserve Medicare beneficiaries access to care and prevent further consolidation of healthcare practices, the AADA recommends increasing the budget neutrality threshold to reflect inflation since 1992; correcting utilization assumption errors that result in irreversible payment cuts; promoting legislative reforms that establish positive, inflation-adjusted updates for physicians; and working with CMS and Congress to stabilize the Medicare PFS. Without these reforms, more physician practices, particularly small and independent ones, will be forced to close or consolidate, which ultimately impacts Medicare beneficiaries' access to care.

Given the impact of Medicare PFS policies in discouraging physician-led practices, reducing competition, and increasing financial pressure to consolidate, the AADA encourages the DOJ to support increases to the statutory budget neutrality threshold, correction of erroneous CMS utilization assumptions, and statutory reforms that provide for positive, inflation-adjusted physician payment updates. These changes would advance the DOJ's broader effort to identify and eliminate anticompetitive laws and regulations that negatively impact physicians' ability to care for the Medicare population.

II. CLIA Laboratory Director Requirements Place Unnecessary Restrictions on Physician Eligibility

The AADA is deeply concerned that recent updates to CLIA laboratory director qualifications unnecessarily restrict competition by excluding board-certified dermatologists from directing moderate- and high-complexity laboratories if they do not

[1] American Medical Association. Medicare Gap Chart 2025. Published January 2025. Accessed May 13, 2025. https://fixmedicarenow.org/sites/default/files/2025-01/Medicare%20Gap%20Chart_2025.pdf.
[2] American Medical Association. Medicare provider updates for 2025. Published January 2025. Accessed May 13, 2025. https://www.ama-assn.org/system/files/medicare-provider-updates-chart-2025.pdf.

first meet unnecessary and burdensome experience and continuing education requirements. Under the revised rule, effective December 28, 2024, only physicians certified in anatomic or clinical pathology may qualify to serve as lab directors on the basis of their board certification alone.[3] These regulatory changes to the CLIA requirements eliminate a longstanding training-based pathway for demonstrating qualifications and restrict the ability of board-certified dermatologists to direct labs that are well within their scope of practice.

Dermatologists have the training and expertise to safely and effectively serve in the lab director role. Dermatology is among the first specialties to integrate laboratory diagnostics as a core part of training and clinical decision-making. Dermatopathology fellowships are jointly administered by the American Board of Dermatology and the American Board of Pathology. In many institutions, dermatology-trained fellows complete the same laboratory management coursework as pathology residents. In the case of Mohs surgery, laboratory work is integrated into both training and clinical care. Mohs surgeons are responsible for obtaining and processing tissue, interpreting slides, and determining whether additional excision is needed—all within the same patient visit. Despite this experience, dermatologists are not recognized under the updated CLIA framework, which reduces their ability to compete for lab director positions.

Moreover, the exclusion of dermatologists from lab director eligibility has direct consequences for patient access and the delivery of care. In-office laboratories play an important role in dermatology, particularly for subspecialties such as dermatopathology, immunodermatology, and Mohs surgery. If dermatologists are unable to serve as laboratory directors in their own practices, patients may face delays and disruptions in care. For example, diagnosing conditions such as scabies often relies on immediate, in-office microscopy, which is testing that is not typically performed by outside laboratories. Without the ability to maintain CLIA certification, dermatology practices may be forced to forgo point-of-care testing, resulting in delayed diagnoses and patient disruptions to timely access of high-quality care.

The AADA has recommended that CMS amend 42 CFR §§ 493.1405 and 493.1443 to include dermatologists certified by the American Board of Dermatology or the American Osteopathic Board of Dermatology among the physician specialties eligible to direct moderate- and high-complexity laboratories, respectively, without additional experience or continuing education. This revision to the regulation would align with existing CLIA provisions at 42 CFR § 493.1449, which already recognize dermatologists as qualified technical supervisors for dermatopathology testing.

The AADA urges the DOJ to recognize the revised CLIA lab director requirements as a

[3] Centers for Medicare & Medicaid Services. Clinical Laboratory Improvement Amendments of 1988 (CLIA) Fees, Histocompatibility, Personnel, and Alternative Sanctions for Certificate of Waiver Laboratories. Fed Regist. 2023;88(248):89780-89809

regulatory barrier that limits board-certified dermatologists' ability to practice medicine within the full scope of their training. We encourage the DOJ to support the Academy's recommendation that CMS amend 42 CFR §§ 493.1405 and 493.1443 to include dermatologists certified by the American Board of Dermatology or the American Osteopathic Board of Dermatology among the physician specialties eligible to direct moderate- and high-complexity laboratories. Supporting these revisions would align with the DOJ's broader effort to identify and eliminate anticompetitive regulations that discourage physicians from delivering high-quality, affordable care.

III. Conclusion

Thank you again for the opportunity to provide comments on the DOJ's consideration of anticompetitive regulatory barriers. We welcome the agency's continued efforts to examine structural barriers to access and competition in healthcare and would be pleased to serve as a resource in support of policies that promote fair competition, reduce unnecessary regulatory burdens, and improve access to affordable, high-quality care.

Please do not hesitate to reach out to Jillian Winans, Associate Director of Regulatory & Payment Policy, at jwinans@aad.org if you have any questions or need additional information. Thank you for your time and consideration.

Sincerely,

Susan C. Taylor, MD, FAAD
President, American Academy of Dermatology Association