



Seemal R. Desai, MD, FAAD President
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Elizabeth K. Usher, MBA Executive Director & CEO

**Written Testimony of Seemal R. Desai, MD, FAAD
President, American Academy of Dermatology Association
Founder & Medical Director, Innovative Dermatology**

**United States House Committee on Ways & Means Health Subcommittee Hearing:
“The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine”**

May 23, 2024

Chairman Buchanan, Ranking Member Doggett, and members of the subcommittee:

Thank you for holding today’s hearing and the opportunity to testify. This hearing is timely as physicians in the United States face critical challenges that inhibit their ability to continue serving patients.

My name is Dr. Seemal Desai, and I am the founder and medical director of Innovative Dermatology, a private practice with two locations in Plano, Texas. I currently serve as the president of the American Academy of Dermatology Association (the Academy), the leading society in dermatology, representing more than 17,000 members nationwide. The Academy is committed to advancing the diagnosis and medical, surgical, and cosmetic treatment of the skin, hair, and nails; advocating high standards in clinical practice, education and research in dermatology; and supporting and enhancing patient care because skin, hair, and nail conditions can have a serious impact on patients’ health and well-being.

Dermatologists diagnose and treat more than 3,000 diseases, including skin cancer, psoriasis, immunologic diseases, and many genetic disorders. We are committed to delivering high value, cost-effective, and innovative care to patients. As dermatologists are at the forefront in the fight against skin cancer and treating numerous skin diseases, the Academy appreciates the Committee’s attention to the issues that private practices face. Nearly one fifth of Academy members are in solo practices, and 46% are part of dermatology groups.

CORRESPONDENCE

PO Box 1968
Des Plaines, IL 60017-1968

EMAIL: mrc@aad.org
WEB: aad.org

ROSEMONT, IL OFFICE

9500 W Bryn Mawr Avenue, Suite 500
Rosemont, IL 60018-5216

MAIN: (847) 330-0230
FAX: (847) 240-1859

WASHINGTON, DC OFFICE

1201 Pennsylvania Avenue, NW, Suite 540
Washington, DC 20004-2401

MAIN: (202) 842-3555
FAX: (202) 842-4355

As president of the Academy, it is my goal to keep dermatologists united as we address challenges facing dermatology and frankly all of medicine head-on. This hearing is an important step towards addressing the problems our physicians and patients face every single day.

I have spent a lifetime watching the daily hurdles that physicians and patients face. I am a first generation American born in Birmingham, Alabama. My father was a dentist who immigrated here in the 1970s. He believed in a fundamental American value of giving back to his community. He quickly became involved in his community while also making sure my brother had access to dermatologic treatment for vitiligo, a disease that causes areas of skin to lose color, resulting in spots and patches of lighter skin. For many Americans, including those of color like me, a vitiligo diagnosis can have a devastating effect on how your community perceives you. Children and adults suffering from vitiligo frequently report feeling stigmatized, anxious, depressed, or withdrawn.

The experience of my family coping with my brother's condition was my first introduction to dermatology and the impact a physician can have on a patient's life. Seeing how profoundly treatment helped my brother is why I am where I am now. I went on to earn my medical degree from Morehouse School of Medicine and complete my dermatology residency at the University of Alabama at Birmingham.

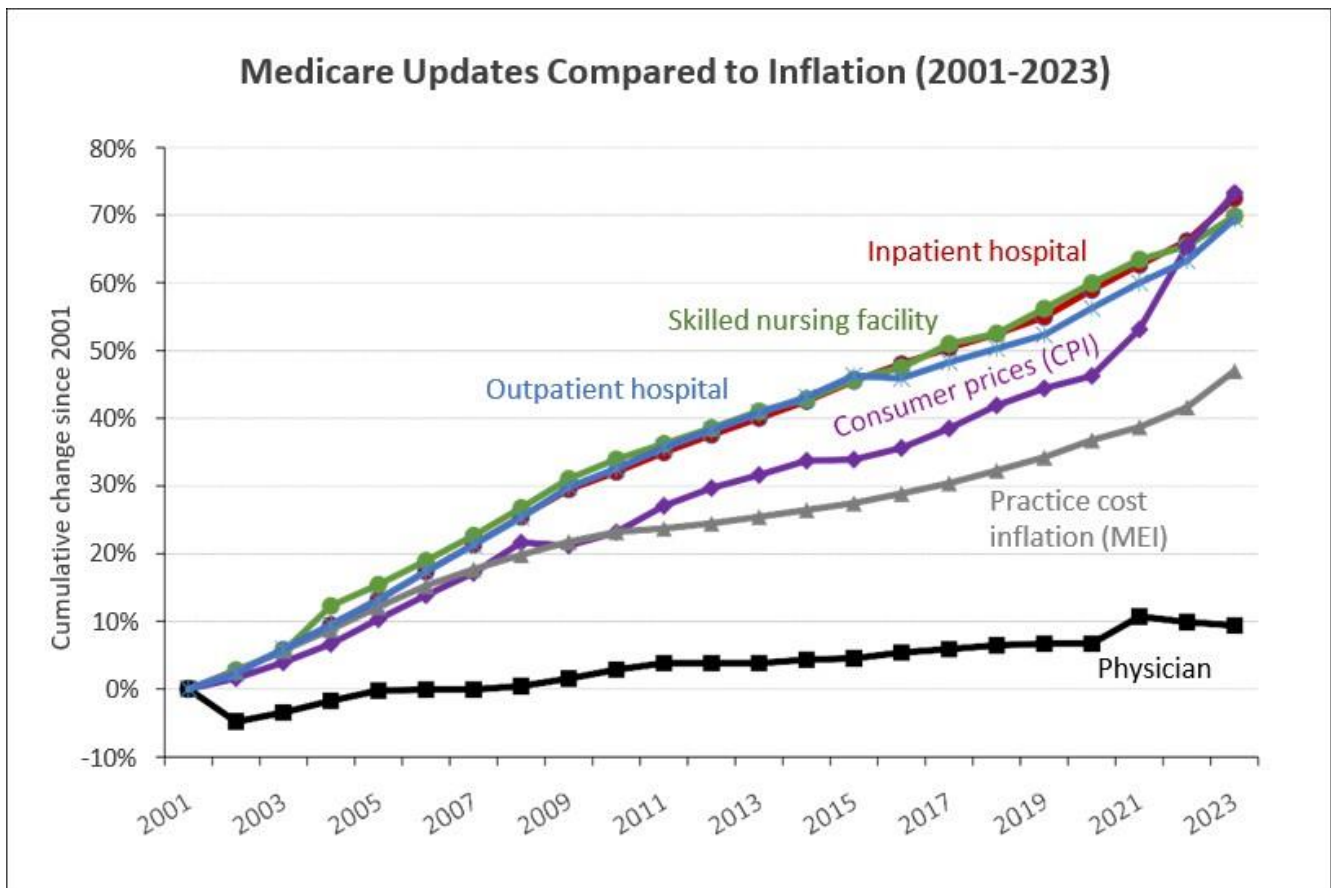
As someone who started his own solo private practice, and now having two offices that make up a group of private clinics, I can speak firsthand about the challenges facing independent medicine. I hear it daily when I travel the country speaking to other dermatologists as practices are being crushed by declining Medicare payments and increasing administrative burdens.

As you explore ways to reform the financial and regulatory burdens facing independent medical providers and how these burdens contribute to health industry consolidation and barriers to patient care, one critical aspect that needs immediate attention is the instability of the Medicare physician payment system. To stabilize Medicare and fortify practices nationwide, the Academy supports establishing a positive annual inflation adjustment and increasing the budget neutrality threshold, supporting a lookback period to correct errors associated with utilization assumptions, and allowing specific services to be excluded from budget neutrality requirements.

Inflation and the Siloed Medicare Program Structure

The failure of the Medicare Physician Fee Schedule (MPFS) to keep up with inflation is the greatest threat to access to care in physician offices. Physicians are the only Medicare providers who do not receive an inflationary increase to cover the cost of doing business. Hospitals and other healthcare facilities receive annual inflation-adjusted Medicare payment updates, but physicians receiving payments under the MPFS are excluded from this type of adjustment. In fact, CMS finalized a 3.4% cut in the Calendar Year (CY) 2024 MPFS final rule. While the Academy appreciates the partial relief Congress provided to the MPFS in the Consolidated Appropriations Act, 2024, physician payments still ultimately received a cut from 2023.

Since 2001, the cost of operating a medical practice has increased 47%. 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 30% from 2001 to 2024.* 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. This issue is further exacerbated by rising costs and inflation, leading to increased consolidation and hospital ownership of physician practices, resulting in higher expenses and reduced competition.



Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office

Congress and CMS need to re-examine the siloed approach to reimbursement tied to the Medicare program. According to the 2020 and 2021 Medicare Trustees' report, MPFS spending per enrollee was \$2,107 in 2011 and \$2,389 in 2021, growing at an average annual rate of 1.3%. However, in contrast, Medicare spending per enrollee in Part A fee-for-service (FFS) was \$5,178 in 2011 and \$5,576 in 2021 – a 7.7% increase and more than double the cost per patient treated under the MPFS.

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. Moreover, technology requirements associated with compliance of the Medicare's Quality Payment Program (QPP) are costly and contribute to the financial strain placed on physician offices.

Physician practices are often small businesses that contribute to the economy of their communities. Other industries can adjust their products' pricing to reflect rising costs and increased staff salaries. However, physicians do not have the ability to do this. In fact, in the face of crippling inflation, the MPFS serves to destabilize practices with year-after-year cuts. Such a structure is unsustainable, and we must not expect physicians delivering essential medical care to Medicare beneficiaries and their communities to endure it. Many physicians have already had to close their doors, leave their communities, retire early, or leave the practice of medicine. There are a staggering number of physicians leaving the workforce, and this trend will continue as nearly 45% of physicians are older than age 55. The loss of experienced physicians is detrimental to patient outcomes and the young physicians who rely on them as a learning resource.¹

THE HEALTHCARE PROFESSIONALS WHO LEFT THE WORKFORCE FROM 2021 THROUGH 2022

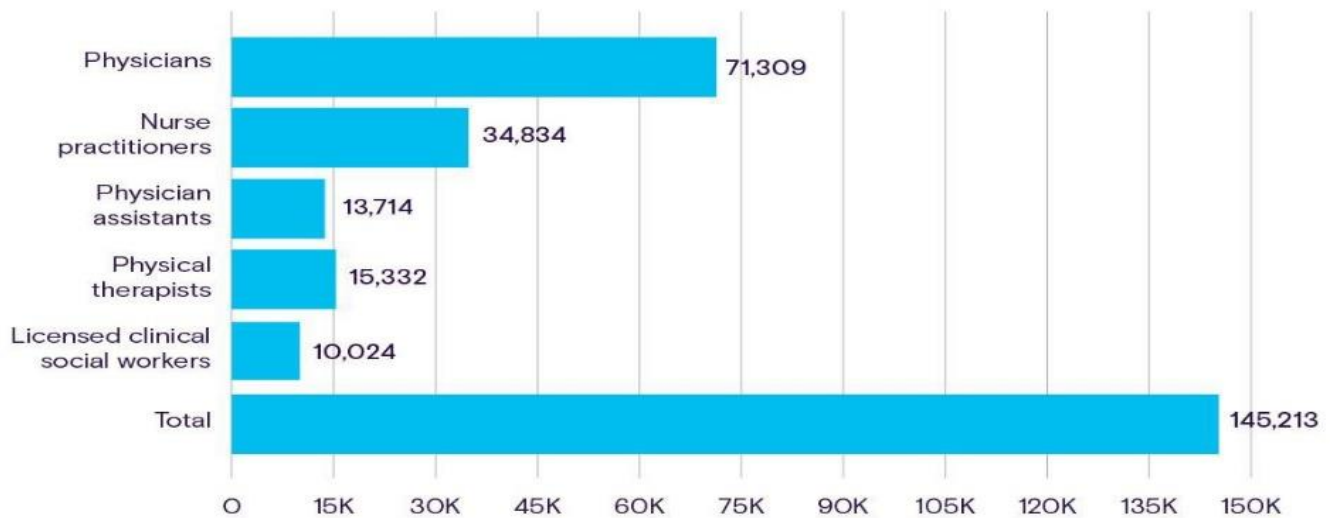


Fig. 1 Analysis of data from Definitive Healthcare's *Atlas All-Payer Claims* and *PhysicianView* products. Data sourced from a stable panel of billing organizations from Q1 2021 through Q1 2023. Physicians deemed as dropped out practiced in 2021 and ceased activity by Q4 of 2022. Some providers may still be practicing, but not filing claims. Data accessed September 2023.

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. With reduced staff

¹ <https://www.definitivehc.com/sites/default/files/resources/pdfs/Addressing-the-healthcare-staffing-shortage-2023.pdf>

comes a diminished capacity to provide quality health care and maintain patient access. Reduced staffing leads to barriers in communicating and coordinating care, such as scheduling appointments and discussing laboratory reports, which can impact patient satisfaction and outcomes.

The threat of additional cuts to Medicare physician reimbursement compounded by continued inflationary pressures jeopardizes physicians' ability to keep the doors open and care for patients in our communities. Fewer physicians in our communities means longer wait times for patients to receive care. 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. This is real, not theoretical, and is already occurring in our communities. Medicare patients will suffer in the end with delayed and second-rate care at a higher cost.

The Medicare Payment Advisory Commission (MedPAC) recommended that Congress tie physician payment updates to the MEI or practice cost inflation rates for 2025.² Specifically, MedPAC recommended that Congress update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50% of the projected increase in the MEI. Based on CMS's MEI projections at the time of the publication of the March 2024 MedPAC Report to Congress, the recommended update for 2025 would be equivalent to 1.3% above current law. The Academy appreciates MedPAC's acknowledgment that the current Medicare physician payment system has not kept up with the cost of practicing medicine. This step is crucial for ensuring financial stability in the Medicare physician payment system to maintain continued access to high-quality patient care.

Budget Neutrality

Downward pressure on Medicare reimbursement is due to budget neutrality requirements. This has resulted in a decline of 30% since 2001. The Medicare statute requires that changes made to fee schedule payments be implemented in a budget-neutral manner.

Furthermore, by law, CMS must also create utilization assumptions for newly introduced services. When an overestimation occurs, it remains uncorrectable, leading to irreversible reductions in the funding allocated to the Medicare physician payment pool. For example, in 2013, transitional care management services were added to the MPFS. While CMS estimated 5.6 million new claims annually, actual utilization was under 300,000 for the first year and less than a million claims after three years. This overestimation led to a \$5.2 billion reduction in Medicare physician payments from 2013 to 2021. This example highlights the unintended consequences of the current budget policies within the flawed system. We firmly believe that CMS should have the authority to rectify utilization assumption errors that impact budget neutrality and to update

² <https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-poly/>

the projected expenditure threshold triggering the budget neutrality adjustment, which has remained unchanged since 1992.

Reform Quality Payment Program

Traditional Medicare-based Incentive Payment System

Current value-based programs are extremely burdensome, have not demonstrated improved patient care, and are not clinically relevant to the physician or the patient. Therefore, the Academy has serious concerns with the viability and effectiveness of the Merit-based Incentive Payment System (MIPS) program.

Numerous studies have highlighted persistent challenges associated with MIPS, including practices serving high-risk patients and those that are small or in rural areas. A study titled "Evaluation of the Merit-Based Incentive Payment System and Surgeons Caring for Patients at High Social Risk," examined whether MIPS disproportionately penalized surgeons who care for patients at high social risk. This study found a connection between caring for high social risk patients, lower MIPS scores, and a higher likelihood of facing negative payment adjustments.³

Additionally, the Government Accountability Office (GAO) was tasked with reviewing several aspects concerning small and rural practices in relation to Medicare payment incentive programs, including MIPS. The GAO's findings indicated that physician practices with 15 or fewer providers, whether located in rural or non-rural areas, had a higher likelihood of receiving negative payment adjustments in Medicare incentive programs compared to larger practices.⁴

These studies highlight flaws in traditional MIPS, particularly in terms of potential disparities in care and the financial burdens placed on physicians when caring for high-risk patient populations and physicians in small practices.

MIPS Value Pathways

Since the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS routinely introduces new changes to MIPS, requiring physicians to adjust continuously. Physicians are increasingly frustrated by the frequent modifications to the QPP, including the associated administrative burdens of adhering to new program requirements and the lack of incentive payments to adequately compensate for participation efforts. While the Academy acknowledges CMS' attempt to address some of these concerns by introducing MIPS Value Pathways (MVPs) aimed at creating more meaningful groups of measures and activities to offer a more comprehensive assessment of quality of care, this new reporting option is falling short of achieving CMS' goal.

³ Byrd JN, Chung KC. Evaluation of the Merit-Based Incentive Payment System and Surgeons Caring for Patients at High Social Risk. *JAMA Surg.* 2021;156(11):1018-1024. doi:10.1001/jamasurg.2021.3746.

⁴ Medicare Small and Rural Practices' Experiences in Previous Programs and Expected Performance in the Merit-Based Incentive Payment System Report to Congressional Requesters United States Government Accountability Office.; 2018. <https://www.gao.gov/assets/gao-18-428.pdf>.

The Academy has significant concerns with the Agency's approach to constructing MVPs, as it is using excessively broad measure sets that lack alignment and provide no added benefit in terms of enhancing patient care or helping patients determine the value of the clinician managing their care. CMS' approach fails to account for the realities of clinical practice and adds yet another layer of complexity to an already confusing program. Take for example, CMS' candidate MVP for Dermatological Care. Despite over two years of discussions and meetings between CMS and the Academy, CMS continues to express interest in the use of a single MVP for dermatology. This decision ignores the critical problem of a one-size-fits-all approach, as it cannot effectively compare costs and quality of care. We have shared with CMS that each subspecialty within dermatology provides unique services to distinct patient populations with varying practice patterns. This diversity in the practice of dermatology makes a one-size-fits-all model ineffective for comparing the cost and quality of care. For instance, dermatologists who treat psoriasis, which is currently considered in the candidate MVP's quality measures may not treat melanoma, the deadliest form of cancer, which is currently the only measure related to cost available in the candidate MVP. Regardless of how CMS ultimately scores MVP participants, if CMS finalizes an MVP that includes a cost measure for a cancer-related disease and quality measures for an inflammatory skin disease, patients and clinicians will question its purpose and become skeptical of efforts to drive value-based care.

The Academy welcomes the opportunity to continue working with CMS and the Congress to identify opportunities to improve quality, patient outcomes, and efficiencies.

Burden on Physician Practices

Furthermore, the QPP must keep a keen focus on preventing physician and staff burnout based on the Department of Health and Human Services⁵ own priorities. This includes providing relief from systems-level factors that contribute to health care worker burnout by instituting measures that:

- Implement systems changes that reduce administrative requirements overall.
- Facilitate coordination at the systems level without adding administrative burden to health care practices and health care workers.
- Provide funds to purchase human-centered technology that facilitates providing value-based care.
- Ensure engagement in value-based care does not lead to additional workload, overhead, and work hours for specialists.

Independent practices are a significant component of the health care of our nation. As a private practice physician, I have the flexibility to see a patient without the red tape of a larger institution. Dermatologists treat serious diseases to save people's lives, but we can only save

⁵ <https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf>

them if we are able to see patients rather than be overburdened with paperwork and reporting requirements.

Reducing Barriers to Treatment and Care

Dermatologists are committed to providing the most effective and cost-efficient care and treatments to their patients. Prior authorization policies that require obtaining advance approval before performing a service to qualify for coverage can negatively impact patient outcomes and quality of life. It fundamentally interferes with the patient-physician relationship and is counter to the practice of personalized medicine. The prior authorization process typically requires physicians or their staff to spend the equivalent of two or more days negotiating with insurance companies to approve a medical procedure.

In dermatology, drugs and other therapies are frequently delayed or denied due to unnecessary prior authorization and step therapy policies. While we recognize there has been bipartisan support for prior authorization and step therapy reforms and appreciate recent action by CMS to address these burdens, further steps are needed to ensure patients' access to medically necessary and innovative treatments.

The Academy encourages CMS to remove barriers to care and strengthen private practices by:

- Providing increased oversight of Medicare Advantage (MA) plans to ensure that they are not unnecessarily delaying or denying patients access to innovative therapies.
- Extending its recent prior authorization policies as outlined in its final rule, "Advancing Interoperability and Improving Prior Authorization Processes," to include drugs to safeguard timely access to innovative treatments.

Conclusion

As president of the Academy, the most pressing challenge I hear about from my dermatology colleagues is the need for Medicare physician payment reform, and they are absolutely correct. While I enjoyed starting my own solo private practice and growing my patient centric model, I can attest firsthand to the often-insurmountable challenges that are faced by physicians around this country on a weekly, daily and even hourly basis. I am very concerned about the future of private practices and of healthcare in our nation as administrative burdens continue to grow and Medicare physician payment continues to decline. The last thing I want to see is our patients, the public and our families faced with such limited options of seeing a doctor that they can only see someone in a large hospital-based system or mega healthcare conglomerate.

On behalf of the Academy and our member dermatologists, I sincerely thank you for holding this hearing and for your commitment to ensuring patient access to life-changing dermatologic care. The Academy greatly appreciates your leadership and looks forward to working with the Committee as it considers the challenges facing physician private practices, and we look forward to being a reference for this issue and others in the future.