Alliance of Specialty Medicine

25TH ANNIVERSARY

Sound Policy. Quality Care.

May 27, 2025

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

Re: Anticompetitive Regulations Task Force Public Inquiry (Docket No. ATR-2025-0001)

Dear Attorney General Bondi:

The Alliance of Specialty Medicine (Alliance) appreciates the opportunity to share information on unnecessary laws and regulations that raise barriers to competition and encourage consolidation in the healthcare market. The Alliance, which represents 15 specialty organizations and more than 100,000 physicians, is dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care. Our comments below focus on current Medicare laws and regulations that are particularly burdensome to specialty physicians and interfere with providing the highest quality patient care.

The Need for Stable and Sustainable Payment under the Medicare Program

Since 2020, Medicare payment rates for services under the Medicare Physician Fee Schedule (MPFS) – as represented by the MPFS conversion factor – have declined by more than 10 percent, reflecting five consecutive years of payment reductions. These payment reductions are the result of longstanding structural problems with the Medicare physician payment system, combined with policy decisions and flawed analyses that further exacerbate payment challenges.

Like other Medicare providers, physician practice costs have increased considerably over the past several years, including as a result of historically high inflation related to the public health emergency for COVID-19. However, statute does not provide any mechanism for payment updates to meaningfully account for the impact of inflation. In fact, for each year from 2020 through 2025, statute specifies that base annual payment updates under the MPFS are equal to 0 percent (see Social Security Act section 1848(d)).

Beginning in 2026, physician payment rate updates under the MPFS will rise to either 0.25 percent or 0.75 percent, based on physicians' participation in one of two tracks of the Quality Payment Program, which we address in our comments further below. While an improvement over the flat updates over the

past several years, these nominal updates will not vary when practice costs expense growth is high, are not sustainable, and will ultimately impact beneficiary access to care.

Notably, in its April 2025 public meeting,[1] the Medicare Payment Advisory Commission (MedPAC, or Commission) recognized the challenges that lack of inflationary updates can pose, further highlighting that growth in physician practice costs (as measured by the Medicare Economic Index, or MEI) is projected to exceed updates under the MPFS to a greater extent than it has in the past. In response, the Commission voted to recommend that Congress replace the current-law updates to the MPFS with an annual update based on a portion of the growth in the MEI (such as MEI minus 1 percentage point). This recommendation is scheduled to be included in its June 2025 *Report to the Congress.*

In addition to payment rates that do not keep up with costs, payments under the MPFS are further subject to budget neutrality adjustments when changes to service valuation are estimated to impact total expenditures under the MPFS by more than $20 million from what they would have been in the absence of such changes (see Social Security Act section 1848(c)(2)(B)(ii)(II)). Problematically, policy changes in the last five years have contributed to sizeable negative budget neutrality adjustments (i.e., reductions to the MPFS conversion factor) that – in combination with lack of inflationary updates and other downward financial pressures – have brought physician payments levels to nominal levels not seen since 1993.

The increasing financial challenges are forcing many physicians to sell their practices to consolidate with hospitals and health systems or sell to private equity groups. Consolidation and private equity ownership remain growing concerns of policymakers and their advisors. For example, in its March 2025 *Report to the Congress*, MedPAC noted that "*[o]ver the last several decades, health care providers have pursued horizontal mergers and vertical acquisitions – in part to obtain higher payment rates from both Medicare and private payers."*[2] Likewise, a recent Senate Budget Committee Bipartisan Staff Report focused on the harmful effects of private equity on the U.S. Health Care System and highlighted that reduced services, compromised patient care, and even complete hospital closures are consequences of the private equity ownership model that can pose a threat to health care infrastructure.[3]

In light of the above, it is clear that there is an urgent need to enact significant long-term reform to how Medicare physician payments are established under statute in order to provide stable, predictable, and fiscally sustainable annual payment updates, protect against consolidation and private equity buy outs, and preserve beneficiary access. We urge the Administration to work with Congress to pursue such reform.

We also highlight that the Centers for Medicare and Medicaid Services (CMS) can be more cautious when proposing and finalizing policies that adversely impact the conversion factor. This includes policies that prompt significant, negative budget neutrality adjustments. In many cases, we are concerned that the benefits of such policies do not outweigh the costs of the resulting across-the-board payment reductions that further impair physicians' ability to receive fair and reasonable payment updates. ***We***

[1] https://www.medpac.gov/meeting/april-10-11-2025/

[2] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf

[3] https://www.budget.senate.gov/imo/media/doc/profits_over_patients_the_harmful_effects_of_private_equity_on_the_ushealthcaresystem1.pdf

therefore urge the Administration to carefully assess costs and benefits when implementing policies with significant budget neutrality adjustments under the MPFS.

We also note that, too often, CMS' estimates for budget neutrality impacts are overstated. That is, CMS may estimate a level of utilization associated with the introduction of a new service code that requires a substantial negative budget neutrality adjustment that is not supported by actual utilization data; rather, the actual utilization data suggest that a much lower budget neutrality adjustment should have been applied. However, once budget neutrality adjustments are applied, reductions to MPFS payment rates are "baked in" under current CMS policy and not corrected after the fact. As a result, payment rates are improperly suppressed on a permanent basis. Notably, recent analysis by the American Medical Association (AMA) suggests that such an overstatement of budget neutrality impacts occurred in calendar year 2024 MPFS rulemaking, when CMS established separate payment for HCPCS code G2211 *(Visit complexity inherent to evaluation and management).* While CMS estimated that the code would be used with 38 percent of all office and outpatient evaluation and management (E&M) visits, contributing to a budget neutrality adjustment of more than 2 percent, actual utilization data for 2024 suggest much lower utilization, estimated at roughly 11 percent of office and outpatient E&M visits. AMA estimates that this discrepancy inappropriately reduces spending under the MPFS by almost $1 billion annually. ***The Alliance believes that, when data substantiate that initial budget neutrality adjustments are overstated, CMS should exercise its administrative authority to adjust the MPFS conversion factor and correct the overstatement. As an immediate step, CMS should apply this approach to correct the underpayment associated with HCPCS code G2211 based on actual utilization as expeditiously as possible – that is, by adjusting the conversion factor in the CY 2026 MPFS proposed and final rules.*** Such a change would help to rationalize payment rates and protect physician practices' ability to stay independent.

Excessive Regulatory Burden Under the Merit-based Incentive Payment System (MIPS)

A 2022 report by the American Medical Association found that "the need to better negotiate favorable (higher) payment rates with payers, better manage payers' regulatory and administrative requirements, and improve access to costly resources were the most important motivations for private practices selling to hospitals or health systems."[4] Under the Medicare program, perhaps the greatest source of regulatory burden physicians bear is due to the Merit-based Incentive Payment System (MIPS). As one of the two tracks of the Quality Payment Program, this pay-for-performance system adjusts payments under the Medicare Physician Fee Schedule based on performance across four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability.

The Alliance will be submitting detailed comments to CMS on the shortcomings of the program and ways to reduce regulatory burden in response to CMS' "Unleashing Prosperity through Deregulation of the Medicare Program (Executive Order 14192) Request for Information." However, we note that MIPS has failed to demonstrate a positive impact on outcomes and value to patients and physicians and has in no way prepared clinicians to transition to alternative payment models, which was the primary intent of the program as envisioned by Congress. In fact, in an October 2021 report, the Government Accountability Office (GAO) questioned whether the program helps improve quality and patient outcomes, highlighting the program's low return on investment.[5] The program's complexity has also resulted in a resource-

[4] https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf
[5] https://www.gao.gov/assets/gao-22-104667.pdf

intensive program, where practices spend over $12,000 and over 200 hours per physician per year[6] to avoid a 9% Medicare payment penalty and potentially qualify for a maximum bonus payment that has historically hovered around a meager 2%. The challenge of compliance is even greater for small practices and those with at-risk patient populations, with published performance data showing that small and rural practices receive lower scores, on average, under the program than other practice types.[7]

Prioritizing Opportunities for Specialists to Participate in Alternative Payment Models (APMs)
Under the second track of the Quality Payment Program, the Advanced APM Track, physicians can benefit from reduced reporting burden and increased financial incentives relative to those that are available under MIPS. However, specialists have limited opportunities to participate in the Advanced APM Track, given there is a scarcity of advanced alternative payment models (A-APMs) and the majority of A-APMs focus on the delivery of primary care services, including models that center on accountable care organizations (ACOs). As with MIPS burden, the Alliance will be submitting detailed comments to CMS on this issue, but we flag the need to address the lack of meaningful pathways for specialists to engage in A-APMs and to eliminate policies that disincentivize the inclusion of specialists in A-APMs. Without meaningful opportunities to participate in A-APMs, specialists will remain under-resourced and disadvantaged relative to those clinicians who do qualify for the Advanced APM Track.

Lifting the Ban on Physician-Owned Hospitals
Section 6001 of the Affordable Care Act of 2010 (ACA) effectively barred the expansion of existing physician-led hospitals and prohibited the establishment of new ones. However, physician-led hospitals often provide higher quality, lower cost care and better patient experience compared to other hospitals.[8] [9] [10] Permitting them into the market would result in more efficient care and savings to Medicare. Lifting the ban also would address consolidation and concerns about monopolies that drive up costs and limit access to care, while facilitating the provision of critical services in rural communities.

The Alliance urges the Administration to work with Congress to repeal the ACA's ban on physician-owned hospitals, or at least provide critical exemptions for communities that face the greatest demand for hospital services in order to enhance patient choice and improve competition in the health care marketplace.

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Thank you for the opportunity to comment on these important issues. If you have any questions, please do not hesitate to contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology – Head and Neck Surgery
American Association of Neurological Surgeons

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[6] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947
[7] *See, for example,* https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2817/2022ExperienceReport.pdf
[8] https://www.jstor.org/stable/2587004
[9] https://pmc.ncbi.nlm.nih.gov/articles/PMC3423176/
[10] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806510?resultClick=3

American College of Mohs Surgery
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society