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United States House Committee on Energy & Commerce Health Subcommittee Hearing:

Examining Legislative Proposals to Reform Medicare Provider Payment and Bolster Health Care Cybersecurity

September 15, 2026

Chairman Guthrie, Ranking Member Pallone, Chairman Griffith, Ranking Member DeGette, 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. Murad Alam, and I am the Vice Chair and a Professor in the Department of Dermatology at Northwestern University Feinberg School of Medicine in Chicago. I currently serve as the president of the American Academy of Dermatology Association (the Academy), the leading society in dermatology, representing more than 18,000 members nationwide. The Academy is committed to excellence in

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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 skin disease.

Skin cancer is the most common cancer in the United States, and the majority of both non-melanoma and melanoma skin cancer patients are in patients age 65 or older. Dermatologists are physicians who are expert at evaluating concerning skin lesions, distinguishing benign from malignant disease, and treating skin cancer as well as precancer when it is still localized and most treatable. Most of this care is furnished in private, office-based practices rather than hospital outpatient departments. Prevention, early detection, and access to high-quality dermatologic care is particularly important for Medicare beneficiaries given their elevated risk of skin cancer and the essential role that timely access to dermatologic care plays in identifying disease at its earliest and most treatable stages. When detected early, 99% of skin cancers can be successfully treated and cured, commonly with a single in-office procedure in a dermatologist's office. When detected later, when they are advanced or have spread in the body far from where they began, skin cancers typically require lifelong treatment with very expensive and potentially toxic medications and even so are curable only about 35% of the time.

However, Medicare physician payment and administrative burdens threaten patient access to care. Every closed practice, every episode of delayed care, and every unfilled job in a practice, hampers care delivery and threatens the utility of Medicare for patients. Unfortunately, after more than twenty years of cuts to Medicare physician payment, these delays, closures, and unfilled roles are far too common.

Over my career, I have developed relationships with many individual patients with skin cancer and their families. Among these are patients particularly susceptible to harm from skin cancer, including transplant patients with compromised immune systems, patients with genetic syndromes associated with skin cancer, and patients with rare skin cancers requiring specialized treatment. For these high-risk patients, skin cancer can literally be a life-or-death situation. Many of my patients drive for hours from adjoining states to see me. While early detection is critical to ensuring good outcomes, some of my patients arrive with advanced stages of skin cancer because they did not have access to a local dermatologist in their community. When patient care is delayed, what could have been an early-stage cancer easily removed by a minor procedure can grow to become an advanced cancer that enters the blood vessels or lymph nodes, and from there affects other organs in the body. Even before advanced skin cancer results in distant organ involvement and risk for mortality, it can be very traumatic, disfiguring, and demoralizing for patients. Since skin cancer tends to occur preferentially on the head and neck, a patient with advanced skin cancer on their face may commonly require removal of much of their face, including nose, lips, eyelids, or ears. Imagine needing to have your nose removed and the impact this could have on your self-esteem, your ability to interact normally with others, and your relationship with your own grandchildren. I have seen this firsthand.

During COVID, it was important to me to continue seeing my patients. I told my staff we were essential, we treated cancer that could severely harm or kill people, and it was our obligation to stay open and continue to be available to see patients who needed us. I knew we had to continue to bring in and examine our patients for regularly scheduled exams because delays could lead to advanced skin cancer. Unfortunately, for many of us in our specialty, we had patients that put off exams during this time, and as a result developed advanced or life-threatening skin cancers. I very much regret that these patients had

poor outcomes when their lives could have been saved had they continued to see their dermatologists, and had their cancers detected early. This illustrates why maintaining an adequate and available physician workforce in all our communities – both rural and urban – is critical.

As a professor at Northwestern University Feinberg School of Medicine, I frequently have conversations with my students and trainees encouraging them to open independent practices in rural and underserved communities. They know how difficult this is given decreased reimbursement, bureaucratic requirements, and competition from large health systems, and it scares them. The uncertainty of physician reimbursement is a particularly impactful factor in their decision-making process as they are also thinking about how they will be able to support their own young families.

Now more than ever, Congress must take action to advance Medicare physician payment reform by establishing a positive annual inflation adjustment and increasing the budget neutrality threshold. Along with the expiration of the 2.5% update Congress provided only for calendar year 2026, CMS's proposed rule for the 2027 Medicare Physician Fee Schedule (MPFS) includes devastating cuts (9% for dermatology) to medically necessary services that would further erode the stability of private, independent practices already facing significant financial challenges. Despite accounting for only 4.1% of physician specialty spending and just 0.28% of total Medicare Part B expenditures, dermatology would absorb approximately 30% ($291 million) of all national Modifier 25 cuts. By the time these proposed cuts are fully phased in, a third-party analysis shows that the cumulative cut for dermatology services would be at least 16%. These proposed cuts directly threaten patient access as physicians would be forced to reduce staffing and limit the number of Medicare beneficiaries they serve.

We extend our gratitude to the co-chairs of the House GOP and Democratic Doctors Caucuses, Reps. John Joyce, MD, FAAD (R-PA), Greg Murphy, MD (R-NC), and Kim Schrier, MD (D-WA) for their leadership in proposing bipartisan solutions to modernize the Medicare Access and CHIP Reauthorization Act (MACRA) through their introduction of H.R. 9693, the Patients First Act, which would strengthen and stabilize the Medicare physician payment system. H.R. 9693 would modernize MACRA with a three-pronged approach to:

1. Provide a permanent inflationary update at the Medicare Economic Index (MEI) minus 1%;
2. Reform budget neutrality rules and raise the outdated threshold, utilizing the policies from H.R. 8163, the Provider Reimbursement Stability Act; and
3. Overhaul the Merit-based Incentive Payment System, better known as MIPS, to reduce physician burdens and provide greater input on quality metrics.

Inflation

The failure of the MPFS to keep up with inflation is the greatest threat to access to care in physician offices. Since 2001, the cost of operating a medical practice has increased 63%. Adjusted for inflation in practice costs, Medicare physician reimbursement declined 33% from 2001 to 2026. Physicians rely on reimbursement to cover a multitude of practice expenses, including office overhead, medical supplies, staff salaries and benefits, governmental regulatory compliance costs, and expenses associated with insurance mandates. Inflation and practice expenses keep rising and reimbursement continues to decline.

Dermatologists have had to reevaluate how to operate their practices. Many have considered closing their doors, changing their payer mix, leaving their communities, or simply retiring early. 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. Solo and small-group dermatology practices are especially exposed, 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%.

Fewer physicians in our communities means longer waiting times for patients to receive care. According to the Health Resources and Services Administration, currently, dermatology is only able to meet approximately 37.1% of patient demand in non-metro areas. 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.

To make matters worse, in the CY 2026 MPFS, CMS finalized a proposal to apply a 2.5 percent “efficiency adjustment” policy, which is not supported by valid data, is inconsistent with the Medicare statute, undermines the relativity of the resource-based relative value scale, and most importantly, risks harming patient care. CMS has not explained the rationale for selecting 2.5 percent for the efficiency adjustment beyond citing productivity adjustments in the MEI, which has no meaningful relationship to physician

work. Applying an economy-wide productivity factor to physician services is arbitrary and ignores the realities of clinical care. There is no evidence that dermatologists, or physicians in general, are performing procedures more efficiently today than in the past.

Declining Medicare physician payment ultimately means fewer options for patients to choose their own physician and health insurance that best meets their needs. This poses significant access and affordability challenges for patients. The MPFS today is unsustainable for physician practices, which is why Congress must enact reforms to modernize the system. Stable and predictable Medicare reimbursement will help lead to greater access for patients and increase the bandwidth of health professionals to coordinate care.

The permanent inflationary update policy in the Patients First Act is drawn from the recommendation by the Medicare Payment Advisory Commission (MedPAC) to tie Medicare physician payment to the MEI. In making this recommendation, MedPAC has noted their 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.

Stabilizing the MPFS is critical to fortify independent medical practice, combat consolidation and maintain access for patients. While physicians have long advocated for inflation updates tied to full MEI,

the inflationary update policy in the Patients First Act would be a vital building block towards long-term, sustainable reform of predictable annual inflationary adjustments.

Budget Neutrality

In addition to the lack of an inflationary update, downward pressure on Medicare reimbursement is due to statutory budget neutrality requirements. 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 2013-2021. 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 the projected expenditure threshold triggering the budget neutrality adjustment, which has remained unchanged since 1992.

The Academy supports reforms to budget neutrality policy included in the Patients First Act, which is based on H.R. 8163, the Provider Reimbursement Stability Act introduced by Reps. Greg Murphy, MD (R-NC) and Tom Suozzi (D-NY). H.R. 8163 raises the outdated budget neutrality threshold in the MPFS, ties

future updates to MEI every five years, allows CMS to make corrections when they overestimate utilization, and limits the year-to-year variance in the conversion factor. Senators John Boozman (R-AR) and Peter Welch (D-VT) have introduced companion legislation in the Senate, S. 5180.

Quality Payment Program

DataDerm

The Academy launched DataDerm, our clinical data registry, in 2016. It is the largest dermatology registry in the world and as of December 2024, it contained data from more than 16 million unique patients with more than 68 million unique patient visits from 288 practices representing 1289 clinicians. Since its creation we have expanded and adapted our platform to better meet the needs of our members, including meeting evolving regulatory requirements, conducting research, and informing our advocacy efforts. Data registries help inform clinical guidelines and best practices in medicine. Access to claims data for registries is critical for research and evaluating the long-term efficacy of treatments and procedures for patients. The Patients First Act creates a mechanism for qualified clinical data registries to receive access to claims level data for research, quality of care measurement, and reporting. This would provide clinicians with a longitudinal view of efficacy of certain treatments or procedures. This data would also inform best practices, clinical guidelines, and ultimately potentially improve patient outcomes. While changing MIPS reporting requirements and quality measures would likely be a significant financial burden for specialty societies, the ultimate objective of reducing burden, mitigating penalties, and improving patient outcomes is an important goal with widespread support.

Current value-based programs are extremely burdensome, have not demonstrated improved patient care, and are not clinically relevant to the physician or the patient. Since the passage of the Medicare

Access and CHIP Reauthorization Act (MACRA) of 2015, CMS has consistently introduced new changes to Merit-based Incentive Payment System (MIPS), requiring physicians to invest time and resources into continually adapting to evolving requirements. The constant changes have led to confusion and growing frustration among physicians, who face significant administrative burdens without adequate incentive payments to compensate for the time and resources required to meet these new demands, and amplify physician burnout.

The Academy has significant concerns about MIPS and the increased burdens on physicians. Numerous studies have highlighted persistent challenges associated with MIPS, including for practices serving high-risk patients and those that are small or in rural areas. For instance, in a study titled "Evaluation of the Merit-Based Incentive Payment System and Surgeons Caring for Patients at High Social Risk," researchers examined whether MIPS disproportionately penalized surgeons who care for patients at high social risk.[1] This study found a connection between caring for high social risk patients, lower MIPS scores, and a higher likelihood of facing negative payment adjustments. 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. At a time when rural medicine is in crisis regarding sustainability, the added burden of MIPS and the structural impacts of negative adjustments puts at risk access to care in many states.

[1] 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.

CMS now proposes to make this worse. In the CY 2027 Medicare Physician Fee Schedule proposed rule, CMS proposes to sunset traditional MIPS after the 2028 performance year and to require all MIPS-eligible clinicians to report through MIPS Value Pathways (MVPs) if they are not participating in an alternative payment model. While we acknowledge CMS's effort to address some of these challenges by introducing MVPs, which aim to offer more targeted measures and a comprehensive assessment of care quality and value, the MVP framework is falling short of achieving its intended goals. CMS's approach to developing MVPs relies on excessively broad measure sets that lack alignment and cannot deliver meaningful feedback to improve patient care. The current Dermatological Care MVP measures cost in melanoma and quality in inflammatory disease — a decoupling that undermines the basic principle of value-based care, which requires that quality and cost for the same condition be measured together. MVPs also fail to address ongoing gaps in measures for subspecialists, who lack opportunities to participate.

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 Services[2] 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.

[2] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf

- 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. Dermatologists treat serious diseases to save people's lives, but we can only save them if we are able to see patients rather than be overburdened with paperwork and reporting requirements.

The Academy supports the policy changes in the Patients First Act to overhaul the MIPS program to reduce burdens and provide greater input on quality metrics. The Academy also supports H.R. 8622, the Medicare Physician Data-driven Performance Payment System Act, introduced by Reps. Mariannette Miller-Meeks, MD (R-IA) and Herb Conaway, MD (D-NJ), that would eliminate MIPS "tournament style" penalties and instead would link physicians' MIPS performance to a portion of their annual payment updates. The Academy welcomes the opportunity to continue working with CMS and the Congress to identify opportunities to improve quality, patient outcomes, and efficiencies.

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 enjoy taking care of my patients, 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, and even that after an unacceptably long wait that results in increased, avoidable morbidity and mortality.

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. Together, we can make a positive difference for patients across the nation.