May 23, 2025

Abigail Slater, Assistant Attorney General
Antitrust Division
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-001

Submitted electronically via regulations.gov

RE: Docket No. ATR-2025-0001, Anticompetitive Regulations Task Force

Dear Assistant Attorney General Slater:

On behalf of the American Academy of Family Physicians (AAFP), which represents 128,300 family physicians and medical students across the country, I write in response to the March 27, 2025, announcement of the Anticompetitive Regulations Task Force regarding healthcare laws and regulations that reduce competition in healthcare markets.

Family physicians are trained to care for people of all ages and health conditions. As a trusted first contact for health concerns, they are the focal point of care for patients and provide referrals to other health care services and sites when necessary. They have significant influence over the services and settings in which patients seek care and coordinate the care patients receive beyond their office.

The trust placed in family physicians and other primary care clinicians by their patients makes them an appealing acquisition target for hospitals, health systems, and for-profit corporations. More than half of primary care practices are affiliated with a hospital (either by common ownership or joint management) compared to 38 percent in 2016.[i,ii] With fewer opportunities to join an independent primary care practice, nearly three-quarters of all primary care physicians are now employed by hospitals or corporations (53 percent by hospitals and 20 percent by corporate entities).[iii]

The AAFP has called for policy reforms to address the drivers of healthcare consolidation and provided comments on the impacts of consolidation. To address anticompetitive behaviors in healthcare markets, we have urged policymakers to adopt payment system reforms, eliminate burdensome administrative requirements, and prohibit the use of overly restrictive non-compete clauses in employment contracts.

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033 www.aafp.org

The AAFP greatly appreciates the opportunity to share information that will be used to inform future action and enforcement priorities for the Department. **Specifically, we recommend the Task Force work to eliminate the following laws and regulations that reduce competition in healthcare markets:**

- Expiration dates for the Advanced Alternative Payment Model (AAPM) bonus and restrictive AAPM qualifying participant thresholds;
- Site-based payment differentials that create barriers to fair competition;
- Budget neutrality requirements for updates to the Medicare Physician Fee Schedule (MPFS);
- Annual requirements to code persistent, chronic conditions in risk-adjustment methodologies used by the Centers for Medicare & Medicaid Services;
- Required estimates imposed on primary care practices by the No Surprises Act;
- Proposed HIPAA implementation requirements that create unnecessary burden on physicians;
- Restrictions on using Health Savings Account (HSA) funds for high value services, including direct primary care arrangements; and
- Cost-sharing requirements for Medicare beneficiaries receiving high-value primary care services.

Administratively burdensome requirements and physician payment policies that reduce competition

The AAFP has previously testified about healthcare consolidation, including the loss of physician-owned and led independent practices. One driver of primary care consolidation is the administratively burdensome fee-for-service payment model which undervalues primary care and makes maintaining an independent practice financially unsustainable. Without physician payment reform, the current piecemeal fee-for-service approach will continue to undermine the stability of independent primary care practice, leading to increased consolidation and reduced competition.

The AAFP believes that a transition from undervalued fee-for-service models to adequately funded and administratively simplified payment system is needed to provide the resources practices need to remain independent while delivering high-value, comprehensive care. Adequate, streamlined funding of primary care will also contribute to improved health outcomes while reducing the per-capita cost of care over time. The reform of the current fee-for-service system will help to ensure healthcare markets remain competitive while also improving patient outcomes and reducing physician burnout.

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033 www.aafp.org

Eliminate expiration dates for incentives (and other barriers) to participate in advanced alternative payment models

The AAFP continues to call for greater federal resources to appropriately support and sustain physician practices moving into alternative payment models (APMs). APMs are specific payment models or structures that are aligned with the concept of value-based payment. Well-designed APMs can provide practices with predictable, sustainable revenue streams needed to provide high-value, comprehensive care and support competition by enabling practices to remain independent.

One incentive to encourage and sustain participation in APMs is the bonus payment to advanced APMs participants, which was originally enacted at five percent. However, these statutory bonuses have expired, effectively closing the door to new physicians seeking to participate in advanced APMs, which require significant upfront (and ongoing) investments in new staff, technology, and other practice improvements. **We recommend the Task Force work with Congress to eliminate the expiration date, which makes the decision to participate in APMs more complex and financially uncertain for practices.**

We also urge the Task for Force to grant CMS the authority to eliminate other requirements that create unnecessary barriers for independent physician practices transitioning to APMs. The Medicare Access and CHIP Reauthorization Act (MACRA) includes specific participation thresholds that a physician must meet to be considered a qualifying APM participant (QPs). As a reward for the financial risk assumed by those participating in AAPMs, QPs are eligible to receive financial incentives, including the AAPM bonus and a higher conversion factor update, and are exempt from many of the burdensome reporting requirements of the Merit-based Incentive Payment System (MIPS). The QP thresholds are explicitly defined in MACRA, which required CMS to dramatically increase them over the course of just a few years. Congress recognized the difficulties this created and temporarily froze the thresholds. However, that freeze has expired, and they have increased to levels that are unattainable for many independent practices. CMS also still lacks the authority to make adjustments that would encourage and allow smaller independent physician practices to participate. We encourage the Task Force to work with Congress to eliminate these detailed requirements and defer to CMS, which would allow for more nuanced policy that supports independent practices and encourages greater market competition.

Eliminate site-based payment differentials

Medicare provides higher payments when services are provided at a hospital outpatient facility than services provided in a physician's office. This payment differential is not aligned with the resources needed to deliver the service and encourages facilities to direct care to more expensive settings even if it may be safely and effectively delivered in a lower-cost setting. The payment differential incentivizes hospitals to acquire physician practices, as they

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033 www.aafp.org

can receive higher payments for services. The site-based payment differential not only encourages physician consolidation, it also increases out-of-pocket costs for patients who are suddenly forced to pay higher cost-sharing amounts to see their physician after their physician's practice is acquired by a hospital.

While some reforms have been made, such as site-neutral payments for some off-campus hospital outpatient departments (HOPDs), Congress should build upon these efforts and avoid pressure to reverse these changes. The AAFP supports site neutral payment policies that would establish payment parity across care settings and has called for an expansion of site neutrality to all on-campus and off-campus hospital-based departments, as well as other facilities. Site-neutral payment would discourage anticompetitive forms of provider consolidation. **We recommend that the Task Force partner with Congress to eliminate site-based payment differentials and improve market efficiency.**

Eliminate budget-neutrality requirements and simplify annual payment adjustments

Each year, CMS sets payment rate updates for physicians in the Medicare Physician Fee Schedule (MPFS). The MPFS considers the estimated time and resources required to provide services; these estimate values are later multiplied by a conversion factor to establish specific payment rates for each service. Currently, Congress requires that CMS derive a conversion factor, and the conversion factor must ensure that updates made to the MPFS are budget neutral or do not result in increased Medicare Part B spending.

These budget neutral requirements make annual updates to the MPFS unpredictable and do not consider the impact of inflation on practice costs. The resulting financial uncertainty drives physician consolidation, as erratic payment changes leave independent practices unable to keep their doors open, reducing market competition. **We urge the Task Force to work with Congress to eliminate anticompetitive budget neutrality requirements** and to include a required annual inflationary update to make payment updates more predictable and more likely to sustain independent physician practices.

Eliminate unnecessary administrative burden in risk-adjustment

Risk adjustment is an actuarial model used to estimate the healthcare costs for a group of patients. Risk adjustment is prevalent across all payers and payment models; however, some risk-adjustment methodologies require a physician to submit extensive documentation and conduct annual chart audits, creating a significant administrative burden. For example, the CMS-Hierarchical Condition Categories (HCC) model requires physicians to re-code diagnoses every year to calculate a risk score even for lifelong conditions. Family physicians have noted they must annually code a patient's amputation, otherwise the patient's risk score does not accurately predict their healthcare costs. This step is time-consuming and wasteful; eliminating this annual requirement would save physicians time and allow them to focus

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033 www.aafp.org

more on patients. **We therefore recommend the Task Force encourage CMS to eliminate these unnecessary requirements by classifying certain chronic conditions as persistent and automatically renewing persistent conditions each year in the RAF score, instead of requiring repetitive and wasteful documentation.**

Eliminate unnecessary and burdensome regulatory requirements imposed on primary care practices by the No Surprises Act

The AAFP recognizes the value of transparency in health care and has long supported federal policies promoting price transparency. These policies improve data collection and enable patients and their health care teams to compare prices across facilities and insurers, information that is key to ensuring an efficient and competitive market that supports patient choice.

The Academy appreciates and supports continued efforts to improve price transparency for patients. However, primary care services, which are most often low-cost and high-value, are not the drivers of high, distorted health care prices. The AAFP has repeatedly shared concerns regarding the administrative burdens imposed on primary care practices by the good faith estimate (GFE) requirements and proposed advanced explanation of benefits (AEOB) requirements, resulting from the No Surprises Act (NSA). Congress did not intend for the NSA to impose burdensome regulatory requirements on primary care practices, which are already overwhelmed with administrative tasks. We urge the Task Force to ensure transparency reporting requirements are designed to target the services and sectors that are driving price increases, and to prevent the adoption of burdensome requirements on primary care practices. We continue to encourage delayed or non-enforcement of the GFE and AEOB requirements.

Keep existing HIPAA implementation specification flexibilities instead of finalizing a Biden Administration regulation that would significantly increase burden on physicians

In a recent proposed rule, HHS and the Office for Civil Rights (OCR) proposed to update HIPAA implementation specifications so as to remove the current categories of "addressable" and "required" and instead clarify that compliance with all implementation specifications included in the regulation would be required. The AAFP advocated strongly against this proposal, and we urged the Department not to move forward with this change. It is essential for physician practices to have the flexibility to assess HIPAA requirements and implement the solutions most reasonable and appropriate for their particular circumstance. Expanding physicians' administrative burdens by increasing requirements while eliminating practices' autonomy is not an effective way to improve the cybersecurity of electronic protected health information, further, the additional administrative burden will only drive further consolidation that results in less choice for patients. We strongly recommend this proposal not be finalized.

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033 www.aafp.org

Further, the Administration should rescind provisions of the final rule, *21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking*, which bans a provider who has committed information blocking from the Medicare Shared Savings Program (MSSP) for one year. As noted in our response to the proposed rule, we remain concerned that the disincentives framework outlined in the rule disproportionately penalizes independent, small, rural, and other under-resourced practices, particularly because of the all-or-nothing approach taken to clinician disincentives, regardless of whether information blocking was intentional or whether the actor has taken steps to address outstanding issues. We urge the agencies to rescind the disincentives for clinicians and practices in MIPS and MSSP.

Anticompetitive policies that block patient choice and access

The AAFP believes that patients should retain the freedom to choose where and how they access care, including the removal of cost barriers. There is evidence suggesting that patients may not be receiving the care they need and that cost is frequently cited as the primary obstacle.[iv] This is true for patients with all forms of insurance but is acutely felt by those in high-deductible health plans (HDHP). For patients enrolled in a qualified HDHP, their eligibility for a health savings account (HSA) provides an important vehicle to facilitate patients' ability to access high value care.

Eliminate cost-sharing requirements for high-value primary care services in Medicare including Advance Primary Care Management (APCM) and Chronic Care Management (CCM)
In 2025, CMS implemented a new set of Advanced Primary Care Management (APCM) service codes. APCM codes aim to provide additional payment for the teams, technology, and community partnerships needed to deliver advanced primary care services. CMS also established Chronic Care Management (CCM) codes to more adequately support the additional coordinated, comprehensive care management to patients with chronic conditions. Both APCM and CCM codes help physician practices deliver high value primary care. As discussed above, payment reform that supports comprehensive and longitudinal primary care will help to prevent further physician consolidation, which in turn encourages greater market competition.

However, barriers exist to adoption of APCM and CCM codes. Both programs require beneficiary cost-sharing to receive these services, which makes patient enrollment more challenging and reduces utilization. We continue to ask CMS to work with Congress to eliminate or waive cost-sharing requirements for these services. Cost sharing requirements are currently waived for Medicare preventive services, including the Annual Wellness Visit Cost-sharing should also be waived for APCM and CCM services. Like the AWV, APCM and CCM services are meant to keep patients healthy and prevent chronic disease. These high-

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033 www.aafp.org

value services improve care for Medicare beneficiaries and support physicians transitioning to more sustainable payment models, which is key to slowing the current trend toward physician consolidation.

Eliminate prohibitions against using HSA funds for high-value innovative care models
Direct Primary Care (DPC) is an innovative practice model in which patients pay a flat fee (monthly or annually) to receive a range of primary care services, most of which have no additional cost when provided directly by DPC physicians and their teams. The AAFP supports DPC as a way for family physicians to retain their professional autonomy and reduce the administrative burdens associated with insurance-based practices. Most DPC practices are physician-owned and led which the AAFP believes is essential to maintaining a competitive practice environment that ensures patient choice.

However, current interpretations of the Internal Revenue Code prohibit individuals from using health savings account (HSA) funds to pay for the monthly or annual fee to join a DPC practice. This barrier limits choice in selecting a PCP and prevents family physicians from adopting this innovative model. These HSA restrictions are a barrier for new DPC practices entering a market. The AAFP has supported legislation that would clarify the Internal Revenue Code and allow HSA funds to cover DPC fees. **We encourage the Task Force to work with the Internal Revenue Service to eliminate the prohibition against using HSA funds for DPC fees, which will reduce barriers to market entry for new DPC practices.**

Prohibit the use of restrictive non-compete clauses in physician employment contracts
The AAFP opposes restrictive covenants in physician employment contracts. Overly restrictive noncompete clauses often force physicians to stop practicing entirely should they choose to leave their employer. For example, many family physicians have said that if they resign, their noncompete would prevent them from practicing within 100 miles or more of their current location. These agreements are overly coercive, forcing physicians to uproot their family and move to another region should they choose to resign from their current employer. Noncompete agreements also reduce patient access and limit patient choice. Many family physicians have said that after they changed employers, they were unable to practice in the same region and the patients left behind were unable to find another primary care physician.

We strongly urge the Task Force to work with the Federal Trade Commission (FTC) to implement 2024 rule banning the use of noncompete clauses in employment contracts, which we supported. Should the FTC decide to withdraw its defense of the rule banning noncompetes in court, we encourage the Task Force to work with Congress to pass legislation would prevent the use of overly restrictive noncompete clauses in physician employment contracts.

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033 www.aafp.org

In closing, we greatly appreciate the opportunity to highlight unnecessary or restrictive policies that limit competition in healthcare markets. We applaud the Department's interest in unnecessary regulations but note that many barriers to competition are imposed by private firms and organizations and stemming such behavior would require additional laws or regulations are needed to foster competition. As such, the AAFP stands ready to offer the Task Force additional information or recommendations to address a myriad of other anticompetitive behaviors which reduce and drive consolidation, increase spending, and reduce patient choice. Should you need further information or have any questions, please contact Julie Riley, Regulatory and Policy Strategist, at jriley@aafp.org.

Sincerely,

Steve Furr, M.D., FAAFP

Steven Furr, MD, FAAFP
American Academy of Physicians, Board Chair

[i] Contreary K, Chatrath S, Jones DJ, Cohen G, Miller D, Rich E. Consolidation and Mergers Among Health Systems in 2021: New Data From the AHRQ Compendium. Health Affairs Forefront. June 20, 2023. https://www.healthaffairs.org/content/forefront/consolidation-and-mergers-among-health-systems-2021-new-data-ahrq-compendium.

[ii] Consolidation Of Providers Into Health Systems Increased Substantially, 2016–18
Michael F. Furukawa, Laura Kimmey, David J. Jones, Rachel M. Machta, Jing Guo, and Eugene C. Rich
Health Affairs 2020 39:8, 1321-1325 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00017

[iii] Physicians Advocacy Institute and Avalere Health, Physician Employment and Practice Trends Research, Specialty Edition, 2019-2022. https://www.physiciansadvocacyinstitute.org/PAI-Research/PhysicianEmployment-Trends-Specialty-Edition-2019-2021

[iv] Austin Littrell, "Insured but skipping care: 38% of Americans delay treatment over costs, study finds," Medical Economics, April 30, 2025. Available: https://www.medicaleconomics.com/view/insured-but-skipping-care-38-of-americans-delay-treatment-over-costs-study-finds

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033 www.aafp.org