June 14, 2024

The Honorable Ron Wyden
Chairman, Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member, Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Submitted via email to marisa_salemme@finance.senate.gov and conor_sheehy@finance.senate.gov

RE: United States of Care's Response to "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B"

Dear Chairman Wyden and Ranking Member Crapo,

United States of Care (USofCare) is pleased to submit the following comments in response to the Senate Committee on Finance's white paper entitled "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B." We appreciate the opportunity to provide feedback as the Committee considers changes to physician payment to accelerate the transition toward accountable care that prioritizes patients, lowers costs, and improves health outcomes.

USofCare is a nonpartisan, nonprofit organization working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We drive change at the state and federal level in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our work in states, we are able to identify unique perspectives from people on the ground to amplify on both the state and federal levels.

Our listening work has shown that people desire affordable, high-quality health care. They crave more time with providers and an approach in which their providers communicate with each other to provide them with more personalized, holistic care where the patient is involved in key care decision making. We call this "patient-first care" (or value-based care) to underscore the importance of patient engagement and involvement before, during, and after care delivery and model development.

USofCare applauds the Committee's continued efforts to make Medicare work better for beneficiaries, including those with chronic conditions, through changes to physician payment policy. We value the Committee's focus on crafting policy that re-aligns provider incentives and adjusts how physicians and other providers are paid, which are critical components of patient-first care.

In order to improve patient care and build upon the Medicare Access and CHIP Reauthorization Act (MACRA) however, further action is needed by lawmakers. **Moving from a system of physician payment largely based on volume of care delivered toward a system that pays physicians for delivering outcomes will better address patient needs while also lowering costs for beneficiaries and building a more sustainable health care system overall.** We hope the policy solutions developed by the Committee can be used as a template for other payers that often structure their own policies to reflect those put in place by Medicare, so that even more people benefit.

The need to address physician payment extends beyond the direct impact on patient outcomes. It has also, in part, fueled much of the consolidation found in health care today as more and more hospitals and health systems gain market share and benefit financially by purchasing independent physicians' offices across the country. The research is clear: when this happens, competition decreases and patients are often left worse off, facing higher costs and decreased access to essential services. Moving toward a system of physician payment that prioritizes patient outcomes over patient volume would benefit patients and providers alike by removing some of the harmful drivers of health care consolidation at the expense of patients. **In the absence of broader site-neutral provider payment reforms, we urge the Committee to consider solutions that slow the trend toward consolidation by providing physician practices with the financial and operational stability needed to reorient the system toward patient-first care.**

Our response to the questions for consideration included in the Committee's white paper centers the patient perspective identified through our years of listening work, and we hope these critical perspectives continue to be at the forefront of any policy changes advanced by the Committee. To that end, our response to the white paper focuses on the following areas:

I. Promoting a Health System Grounded in Primary Care
II. Addressing Health Disparities
III. Encouraging Care Coordination
IV. Emphasizing Beneficiary and Caregiver Engagement

Promoting a Health System Grounded in Primary Care

It is critical that any efforts to reform physician payment must recognize the critical role primary care plays as the foundation for any large-scale payment reform changes. The evidence is clear: increased patient access to primary care leads to better health outcomes, increased life expectancy, and fewer health disparities. We appreciate recent actions by the Centers for Medicare & Medicaid Services (CMS) to add or complement existing billing codes within the fee schedule to take into account the complexity of certain kinds of primary care delivery, including chronic care, and applaud the CMS Innovation Center's (CMMI) efforts to test models, such as the upcoming ACO Primary Care Flex (PC Flex) Model, that focus on primary care by improving health outcomes, centering the patient experience, and reducing health disparities. Further, we appreciate the Committee's continued efforts to highlight the need to increase investment in primary care as a way to improve access for patients.

Despite these efforts, primary care often remains at a disadvantage within the Medicare program. Existing performance measures found within MACRA may not fully capture the quality of care delivered to patients and primary care services continue to be undervalued throughout the program. Perhaps because of this, a majority of primary care providers are not in an accountable care relationship, despite the fact that these providers are often best equipped to

deliver accountable care, especially for beneficiaries with complex conditions, and have demonstrated greater savings for the Medicare program. Many providers report increased administrative burden requirements, limited resources, and various complexities associated with the transition to alternative payment models as barriers to participation.

We encourage the Committee to pursue solutions that center beneficiaries' access to primary care alongside provider relief efforts as part of any proposed Medicare physician payment reforms. Changes that restructure primary care physician payment toward a hybrid model that incorporates elements of fee-for-service as well as capitation payment, as recommended by the National Academies of Sciences, Engineering, and Medicine (NASEM), could provide stability to practices and incentivize the transition toward patient-first care.

In addition, the Committee should take steps, where possible, to remove financial barriers people face in accessing primary care. Even cost-sharing as low as $1 has been associated with reduced use of preventive care, potentially leading to more costly treatments for patients later on. For seniors on a fixed income, many of whom are enrolled in Medicare, these out-of-pocket costs have skyrocketed in recent years. **We encourage the Committee to expand out-of-pocket cost protections currently limited to Medicare Advantage (MA) beneficiaries to encourage further utilization of critical preventive and primary care services by all Medicare beneficiaries.**

Addressing Health Disparities

Through our research, we have found that health care access for certain underserved communities, such as communities of color, people with chronic conditions, and people who live in rural communities, is disproportionately affected by high costs. Despite action taken by the Committee, CMS, and other actors to address these access challenges, health disparities remain embedded within the Medicare program. **Any proposed changes to Medicare physician payment must ensure that providers of all types are focused on reducing health disparities for all beneficiaries, especially those who have been underserved by the health care system.**

Unfortunately, previous physician payment policies have, at times, inadvertently penalized providers with a higher percentage of underserved patients, such as safety-net providers. **We encourage the Committee to ensure that any proposed changes to physician payment policies continue to incentivize providers to provide care to historically underserved communities through additional reimbursements like "improvement activities" or bonus payments and avoid unfairly penalizing safety-net providers.**

Lessons learned by CMS, CMMI, and states can guide Congressional Medicare payment policy discussions in order to address health disparities. New payment models have begun incorporating social risk when determining payments to hospitals to more fully account for the greater financial resources needed to care for underserved patients. Recent regulations have expanded Medicare coverage of services, such as certain dental procedures, that are "inextricably linked" to covered medical treatments, improving access for certain populations, such as Black Americans, who disproportionately suffer from specific health outcomes. Colorado's culturally responsive networks policy requires providers and front office staff to undergo anti-bias training in order to offer care that understands and affirms people's unique needs and identities. Our recently released report offers solutions states and the federal government can pursue to build on Colorado's progress.

The Committee may further consider lessons learned within MA for additional solutions on how to center health disparities when considering changes to Medicare payment policy. For example, beneficiaries enrolled in MA plans have access to certain non-medical, health-related services, such as transportation and certain foods, as supplemental benefits to address certain social determinants of health (SDoH). When left unaddressed, SDoH often lead to unequal health outcomes for certain underserved populations and add to a provider's overall burden. **We encourage the Committee to expand coverage of these services to beneficiaries enrolled in traditional Medicare to improve access to non-medical benefits for Medicare populations that address their health-related social needs.** When thinking about which services to include in traditional Medicare, the Committee should consider the non-medical benefits that are most commonly utilized by MA beneficiaries and explore the impacts of non-medical benefits on various demographic groups.

Encouraging Care Coordination

A persistent, nationwide physician shortage has led to an increase in the number of health care services being delivered by non-physician providers, often in new care settings. In recent years, new providers, including mental health counselors and marriage and family therapists, have been able to bill Medicare, increasing beneficiary and caregiver exposure to these providers, including amongst Black, American Indian, and Alaska Native people, who have historically used mental health services at significantly lower rates than white people. Additionally, changes made during the pandemic and since the end of the public health emergency have vastly expanded beneficiary and caregiver access to telehealth services that have allowed people to access needed care from the comfort of their own homes.

While increased access to these services is filling a real need for beneficiaries, coordination between providers who offer them has often lagged, leading to fragmented care and adverse health outcomes, especially for beneficiaries with chronic conditions. As noted in the RFI itself, more than one third of Medicare beneficiaries received care from five or more physicians in 2019, underscoring the need for increased coordination. People often express confusion or frustration having to deal with multiple providers that do not talk to each other or share information, and our listening work confirms that people favor care delivery that incentivizes care coordination.

We appreciate the Committee's recognition of the importance of care coordination and encourage the consideration of innovative solutions to further incentivize coordination among providers. An encouraging bright spot for coordination and innovation exists within CMMI's Accountable Care Organization (ACO) portfolio, in which a Congressional Budget Office report found that ACOs with a higher percentage of primary care providers led to larger savings due to increased focus on preventive care and chronic care management to avoid treatment in higher-cost settings. Allowing doctors, hospitals, and other providers to coordinate care improves outcomes and has shown how these care teams can respond to patient needs and provide them with better care at lower cost, especially for those with multiple chronic conditions.

Emphasizing Beneficiary and Caregiver Engagement

Through our listening work, we know that people want to understand their health care, yet far too often, they are left out of the conversations that decide what their care looks like. Any changes to physician payment must incorporate beneficiaries' and caregivers' experiences and perspectives. **We encourage the Committee to conduct meaningful outreach to these groups as part of the stakeholder engagement process when developing any new proposals that impact them, including those related to physician payment.**

Alongside providers, any new proposal should also involve the input of beneficiaries and their caregivers throughout the design and implementation process.

Conclusion

We appreciate the work the Committee has done in prioritizing efforts to better facilitate and improve the transition toward patient-first care by rethinking Medicare physician payment policy. Thank you for the opportunity to respond to the Committee's white paper, which builds towards USofCare's mission to ensure that everyone has high-quality, affordable, personalizable, and understandable access to care. Please reach out to Lezah Calvin, Senior Manager of Federal Affairs at lcalvin@usofcare.org or Eric Waskowicz, Senior Policy Manager, at ewaskowicz@usofcare.org, with any questions.

Sincerely,

Lisa Hunter (she/her)
Senior Director for Policy & External Affairs
United States of Care