**September 9, 2024**

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services, Department of Health and Human Services
**Attention:** CMS–9904–P, P.O. Box 8010, Baltimore, MD 21244–8010.

*Submitted via regulations.gov.*

**RE:** "CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments"

Dear Administrator Brooks-LaSure,

United States of Care (USofCare) is pleased to submit comments in support of the proposed rule by the Centers for Medicare & Medicaid Services (CMS) entitled "CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments."

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. We uplift voices of real people engaging with the health care system whose perspectives shape our advocacy work.

Our response to the proposed rule centers the patient perspective identified through our years of listening work, which has shown that people, including Medicare beneficiaries, desire high-quality, affordable 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 at the forefront of care and decision-making. We call this "patient-first care" (or value-based care) to underscore the importance of addressing patients' health care needs in care delivery by moving away from a system that incentivizes volume over quality. Promoting such a system will improve health outcomes and respond to what we know patients want while also lowering costs for patients and building toward a more sustainable system overall.

Unfortunately, our system's reliance on fee-for-service, in which providers are paid by the number of services delivered rather than the outcomes they achieve, is partly to blame. Some services, including primary care, continue to be undervalued within the Medicare Physician Fee Schedule ("Fee Schedule"), causing fewer physicians to enter these and other subspecialities and contributing to the overall primary care access shortage nationwide. In some cases, certain services, such as patient education or care coordination services, may not even be reimbursable by Medicare, leaving the providers who enter primary care no choice but to not offer these services entirely. **This instability within the health care system has fueled regional consolidation, in which health systems and hospitals purchase local physician**

**practices, which has led to patients paying higher costs for the same services delivered in an independent physician's office, often with little to no improvement in quality care or outcomes.**

Broader action is needed to address the upstream and downstream effects of consolidation and incentivize the transition toward patient-first care. We were pleased to provide comments to inform legislative efforts that address Medicare payment reform, particularly in primary care, as Congress considers changes to the Medicare Access and CHIP Reauthorization Act (MACRA). At the same time, CMS has an important role to play in promoting patient-first care through changes in payment policy through the Fee Schedule. **USofCare applauds CMS's continued efforts to make Medicare work better for beneficiaries, including those from underserved communities and/or with chronic and complex conditions, through this year's proposed rule.** Given that many changes made to Medicare physician payment are later adopted by private payers, we are hopeful that this emphasis on patient-first care will be mirrored by plans on the private market.

We cannot underestimate the importance of CMS's decision to frame this year's rule within the context of advancing health equity and supporting whole-person care. **We appreciate the emphasis in this year's proposed rule on addressing longstanding barriers to care and health disparities that disproportionately affect underserved groups, including communities of color, the LGBTQ+ population, and disabled people.** The proposed rule's focus on whole-person care understands that different individuals have different needs, influenced not just by their physical and behavioral health conditions but the social determinants of health that dictate their day-to-day lives.

Additionally, we value CMS's focus on crafting policy that re-aligns provider incentives, adjusts how physicians and other providers are paid, and prioritizes access to critical primary care services, which are all key components of patient-first care. **Moving forward, we encourage CMS to continue to explore ways in which it can move beyond the existing fee-for-service chassis toward some sort of hybrid payment model to form the basis of physician payment, particularly in primary care.**

To that end, our response centers on the following areas:

I. Facilitating a Transition Towards Patient-First Care, Grounded in Primary Care
II. Promoting Health Equity Through Expanded Access to Services
III. Extending Telehealth Flexibilities
IV. Preserving No-Cost Access to Preventive Care
V. Lowering the Cost of Prescription Drugs

**Facilitating a Transition Towards Patient-First Care, Grounded in Primary Care**

CMS is right to realize that any new regulations to adjust physician payment must recognize the critical, essential role primary care plays as the foundation of our health care system. **The evidence is clear: increased patient access to primary care leads to better health outcomes, increased life expectancy, and fewer health disparities.**

Despite these demonstrated benefits, primary care has long been subject to chronic underinvestment in the United States. The U.S., on average, spends approximately one-third of that of what other high-income countries spend on primary care. Primary care is the preferred point of entry into the health care system for many, including for people of color, individuals with limited English proficiency, as well as people in rural areas, yet it is often difficult for

people to access a primary care physician or provider. **Our listening work shows that people crave a provider who genuinely cares and develops a relationship with the patient – in other words, a primary care physician or other provider –** yet far too often, people settle for a visit to urgent care that may or may not satisfy their care needs or address their problem's root cause because they're unable to access a primary care provider.

Thankfully, CMS has recognized this primary care provider access problem and has pursued policies that may address some of the underlying challenges facing primary care. **We applaud CMS for the many efforts taken to address the shortcomings inherent with regular fee-for-service payments and undervaluation in primary care,** including actions taken by CMS in last year's Fee Schedule – and supported by USofCare – that more fully quantify the quality of primary care delivered to patients. For example, the addition of the G2211 add-on code better accounts for the complexity of certain kinds of primary care delivery, including chronic care, while also promoting care continuity between provider and patient.

***Addressing Primary Care Undervaluation***

Despite meaningful progress made by CMS to more fully account for physician primary care payment within the Fee Schedule, primary care reimbursement within Medicare does not reflect the time and effort put in by primary care providers, nor the value of primary care services more generally. **This persistent undervaluation and significant underpayment, especially compared to their specialist colleagues, has notable impacts on patient access to needed primary care services**. This underpayment, for example, only discourages younger physicians from entering primary care, deepening the primary care physician shortage. In response, this forces many patients to turn to specialists for care likely better suited for the primary care setting, or, in certain underserved communities like rural areas that face overall workforce shortages, to delay care entirely.

This goes against what people want from their health care. Instead of additional visits to urgent care or specialists that may or may not treat their underlying needs, people desire a system in which they have a relationship with their doctor and are treated as a whole person. Unfortunately, the way in which we structure our primary care system – or lack of it – doesn't match patients' needs and desires.

> *"When you think about fragmented, especially when you're not under one roof…, you talk to one doctor, they talk about one thing, you go to a different doctor, totally different symptoms, they're prescribing medicine that don't even work together and one medicine makes you sick because you took the other. So that is what is fragmented and complicated, nobody talking to each other, nobody getting their records, you're responsible for carrying your records around. It's not a good look."*
> *~Black patient who has had mostly negative experiences receiving health care*

A more comprehensive understanding of primary care is needed – beginning with how we pay primary care providers. **USofCare is supportive of efforts to more fully capture the unique, continuous nature of primary care in valuation and provider payment by expanding the role of primary care providers on any existing or new advisory panel that contributes to this process.** It is critical that any panel tasked with the responsibility of determining physician payment fully accounts for all services offered by primary care physicians that allow them to properly manage patients' overall health.

Additional primary care provider input could balance some of the overreliance on specialist physicians found in the AMA/Specialty Society Relative Value Scale Update Committee (RUC), a group of experts that works with CMS to help determine the valuation of services in the Fee Schedule. In theory, the RUC's recommendations – which are almost always adopted by CMS – should avoid incentivizing one service over another, yet given the preference toward specialty care, it is clear the physicians who provide primary care services, and the patients that receive them, emerge at a disadvantage.

***Advanced Primary Care Management (APCM) Services***

A move toward proper payment for primary care will likely take years given the complexity of such a shift, as primary care practices of all sizes must have the support and resources necessary to make such a transition. **In the interim, USofCare is pleased to see CMS take steps to reorient Medicare physician payment towards more robust support of advanced primary care delivery that would allow providers more time to deliver more comprehensive care to their patients.** In particular, CMS's proposal to establish three new codes for advanced primary care management (APCM) services will improve providers' ability to deliver – and get paid for – these services, while at the same time simplifying the often-burdensome paperwork volume that threatens to overwhelm physicians and non-physician providers alike. We support finalizing the proposal to make these APCM codes permanent and extended throughout the Medicare program. **Having incorporated lessons learned from previous models, such as the CMS Innovation Center's (CMMI) Primary Care First, CMS's APCM proposal is a prime example of how models tested by CMMI on a more limited basis can be scaled nationwide once proven to improve patient outcomes and lower costs.**

**Similarly, we appreciate CMS allowing for appropriate flexibility when satisfying the provider requirements in order to bill these codes.** Providers already enrolled in alternative payment models, such as Accountable Care Organizations, have been shown to improve health outcomes, promote health equity, and lower costs while also providing the care coordination services patients have said they desire in a patient-first care model. Primary care providers enrolled in ACOs and other care models should also be able to participate in and bill the new APCM codes without having to end their participation in ACOs, which would otherwise undermine overall efforts toward whole-person, accountable care.

This year's proposed rule's new coding and payment rules for a new set of APCM services is a good step toward better valuation and payment of primary care services delivered by providers and will benefit all patients. Proper billing and payment for these services, such as principal care management and transitional care management services, is critical for advanced primary care delivery, especially for patients with chronic, complex conditions. Without these codes, it will remain difficult for providers to take the time needed to provide these services without commensurate reimbursement. **While CMS's proposed APCM services bundle remains tied to fee-for-service, we believe it represents a solid first step toward a system that abandons fee-for-service entirely, especially for those practices that aren't currently enrolled in any alternative payment arrangement.**

Future moves toward a hybrid capitated payment model, as recommended by the National Academies of Sciences, Engineering, and Medicine, would further incentivize the delivery to flexible, comprehensive advanced primary care services and begin to address the inherent "specialty bias" found in the Fee Schedule that favors specialist physicians over primary care. In addition, this new hybrid model would give providers greater financial certainty to deliver services, such as preventive care, that we know keeps people healthy. With proper adjustments

for medical and social complexity where necessary to account for specific populations' needs, this primary care payment model is better positioned to deliver comprehensive, quality care to people of all backgrounds.

***Request for Information on Advanced Primary Care Hybrid Payment***

To this end, we appreciate CMS's interest in gathering more information on advanced primary care hybrid payment through its Request for Information on Advanced Primary Care Hybrid Payment. We believe that critical investments in advanced primary care delivery services are necessary in order for CMS to achieve its goal of having 100 percent of traditional Medicare beneficiaries enrolled in an accountable care relationship by 2030. **We strongly encourage CMS to consider taking steps to consider the implementation of hybrid payment structures within primary care, which contain elements of both fee-for-service and capitation payments.** Not only have hybrid models demonstrated improvements to quality of care for patients and long-term cost savings, they give providers a consistent stream of upfront payments, mitigating some of the financial risk that may prevent interested providers from participating.

> *"It goes back to they are on that time limit thing so how can they get a full aspect of what is going on within your body…and if you say you're coming in for such and such, well when you get there that is all they are going to talk to you about. If you have got anything else you have got to make another appointment for that."*
> *~ Rural participant who has had mostly negative experiences receiving health care*

At the same time, CMS is right to be mindful that any shift toward hybrid payment should not come at the expense of greater participation in alternative payment models more generally. Existing models have shown how certain ACOs, such as those with a larger percentage of primary care providers, have been tied to greater savings and are designed to incentivize providers to coordinate their patients' care, which we know patients prefer. **By "nesting" hybrid payments within existing models, CMS can take advantage of the existing infrastructure while, at the same time, still encouraging participation in alternative payment model tracks.** Current models, such as the newly released ACO Primary Care Flex Model, could be expanded to more states in order to facilitate participation and expand implementation of hybrid payments across practices.

Chief among design considerations as CMS considers advanced primary care hybrid payment design is how to promote health equity through the consideration of social and clinical risk. When considering solutions, such as hybrid payments, to expand access to and properly compensate providers for delivering critical primary care services, CMS should be careful to pursue changes in a way that reduce health disparities, not exacerbate them. **Basing risk adjustment on historic averages – even when using the entire Medicare fee-for-service population – may inadvertently perpetuate longstanding underinvestment in certain communities.** Furthermore, basing risk adjustment upon historic utilization patterns would only likely reinforce the under-utilization of primary care, the very type of care hybrid payments seeks to promote. **While payment rate calculations shouldn't discard historical cost data entirely, payments should take into account these historic disparities and establish adjustments to ensure that any hybrid payment rates are modified to account for decades of discriminatory policy choices.**

We applaud CMS's deep interest in primary care through greater, more comprehensive valuation of primary care services and consideration of hybrid payment models to promote patients' affordable, equitable access to this type of care. We encourage CMS to continue to explore ways in which it can further support primary care providers and the patients they serve while further incentivizing the transition toward accountable patient-first care.

**Promoting Health Equity Through Expanded Access to Services**

Over the past year, 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. Other services, such as access to caregiving supports, are simply not available. Despite significant action taken by CMS and others to address these access challenges, health disparities remain embedded within the Medicare program.

***Dental & Oral Health Services***

These shortcomings are particularly acute when it comes to people's oral health needs. While Medicare generally does not cover dental care, we were pleased to see CMS expand coverage of medically necessary dental services in the 2023 Medicare PFS final rule, which USofCare strongly supported. Despite this action, however, nearly half of all Medicare beneficiaries still lack dental coverage, and this lack of access may contribute to existing oral health disparities that disproportionately impact low-income older adults and communities of color.

In the absence of more comprehensive dental health coverage through Medicare, it is critical for Medicare to pursue targeted solutions to expand access to needed oral health services, given the link between dental health and physical health. **To this end, we support CMS's proposal to add to the list of instances where Medicare can pay for dental services "inextricably linked" to covered services, including oral examinations for people with end-stage renal disease (ESRD) and other conditions.** Many of these conditions disproportionately affect communities of color; for instance, Black people are nearly four times more likely to be affected by kidney disease than white people, and more than one-third of people with ESRD come from neighborhoods that are disproportionately impoverished. Expanding access to these services will allow communities that have long been underserved by medical and dental care to address these disparities.

***Caregiver Training Services***

Caregiver training for direct care services and supports ensures that caregivers are well-equipped to provide high-quality care. For far too long, informal caregivers have often been tasked with handling complex medical tasks at home, often with little to no instruction, despite providing an estimated $600 billion in unpaid care every year. Our listening research with informal caregivers revealed that they had difficulty navigating the health care system in order to support their care recipients and also showed they had a desire for integration with the formal care team. **We are pleased to see the proposed rule establish new coding and payment for caregiver training for direct care service services and supports, effectively recognizing them as members of the care team.** This aligns with the 2022 National Strategy to Support Family Caregivers and will likely disproportionately benefit Medicare beneficiaries of color, who are more likely to rely on unpaid, informal caregivers for home health than white beneficiaries.

**We also support language in the proposed rule that allows these critical caregiving training services (CTS) to be furnished by telehealth.** Allowing CTS to be furnished via telehealth will increase access to these services for informal caregivers (and in turn, uptake of

these services) by providing interventions in convenient locations, reducing transportation costs, and allowing employed caregivers to access services without having to take time off. Additionally, telehealth may enable caregivers in rural areas, who are disproportionately informal caregivers compared to their urban counterparts, greater opportunities to access support.

**Extending Telehealth Flexibilities**

Expanding access to virtual health services allows for more people to receive timely, personalized, and understandable care. Even before the COVID-19 pandemic, virtual care was changing how health services are delivered, especially in communities disproportionately facing barriers to care. Through our listening work, we learned that people appreciate the convenience provided by virtual care, which has repeatedly been shown to be as effective as in-person care where appropriate. When constructed with careful attention to people-centered strategies and solutions, telehealth access can overcome, rather than exacerbate, existing disparities that often plague health care access.

Many people have come to appreciate the convenience, comfort, and sometimes necessity of accessing telehealth services through audio-only technology from home. **We are pleased to see CMS propose that this critical form of telehealth become permanent so that people who have come to rely on this form of care can maintain access to needed services.** While the percentage of overall evaluation and management (E&M) visits delivered via telehealth decreased between 2020 – the height of the pandemic – to 2022, audio-only visits still represented a quarter of all telehealth visits in 2022. This population is more likely to have complex conditions, be Black, and/or live in a rural area.

Unfortunately, the proposed rule plans to repeal other existing telehealth flexibilities ahead of their scheduled legislative repeal at the end of 2024. Unless Congress acts, many telehealth flexibilities, such as allowing providers to treat patients remotely without seeing them in person first or various scope expansions, will expire and revert back to how things were prior to the pandemic. **Because of the potential disruption to patients' care plans, we are hopeful Congress will pass legislation to ensure that these flexibilities are extended prior to their expiration at the end of the year.** If they are extended through legislation after the proposed rule is finalized later this year, we believe CMS has the authority to issue an interim final rule to ensure there are no disruptions or gaps in coverage for people who have come to depend on this form of care.

**Preserving No-Cost Access to Preventive Care**

The *Braidwood Management, Inc. v. Becerra* court case threatens to unravel more than could allow insurers to reintroduce cost-sharing for more than 100 preventive services, including cancer screenings, vaccinations, and contraception, for more than 150 million people with private insurance coverage. Research has shown that even nominal amounts of cost-sharing could impede people's access to needed health care, and nearly half of all Americans say they would skip common preventive care procedures if cost-sharing were reintroduced.

USofCare appreciates efforts taken by the Departments of Labor, Health and Human Services (HHS), and the Treasury to clarify for insurers, providers, and patients that for a majority of people, these no-cost protections remain in place for the time being. **Similarly, we appreciate CMS's efforts to preserve access to needed preventive care services through this proposed rule, including hepatitis B vaccines, colorectal cancer (CRC) screenings, and HIV prevention medication.** CMS continues to prioritize providing

access to preventive services to address conditions that disproportionately affect underserved communities, including communities of color and the LGBTQ+ community.

**Lowering the Cost of Prescription Drugs**

USofCare strongly supported the passage of the Inflation Reduction Act (IRA), which has not only lowered prescription drug costs for Medicare beneficiaries – including most recently, securing more than an estimated $6 billion in savings for seniors – but also extended and expanded critical advanced premium tax credits for families looking to purchase health insurance on the exchanges. Since enactment, USofCare has strongly supported CMS's implementation of the IRA's provisions that lower out-of-pocket costs for Medicare beneficiaries, including capping the cost of insulin at no more than $35 per month and ensuring that seniors pay no more than $2,000 per year in out-of-pocket prescription drug costs. **Looking ahead, we are strongly supportive of language found in the proposed rule codifying the Medicare Prescription Drug Inflation Rebate Program to encourage pharmaceutical manufacturers to limit any drug price increases to below the rate of inflation.** We stand ready to work with both CMS and Congress to identify additional ways to lower the cost of prescription drugs for beneficiaries enrolled in either public and/or private insurance coverage.

**Conclusion**

Thank you for the opportunity to respond to this proposed rule, which builds towards USofCare's mission to ensure that everyone has high-quality, affordable, personalizable, and understandable access to care. Please reach out to 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