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Testimony
of
Visiting Research Professor
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for the
Committee on the Budget
of the
U.S. Senate
"How Primary Care Improves Health Care Efficiency"
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Chairman Whitehouse, Ranking Member Grassley, and members of the Committee, I am Lisa Grabert, a Visiting Research Professor in the College of Nursing at Marquette University in Milwaukee, WI. I am a former Congressional staffer for the U.S. House of Representative Ways and Means Committee and I am honored to testify before the committee today on the Medicare program, a policy area where I have worked for over twenty years. I applaud the committee for addressing the important topic of primary care.

My testimony focuses on: 1) Medicare and primary care, 2) analysis of primary care reforms, 3) recommendations.

Status of the Medicare program

The Medicare program is the largest purchaser of health care services in the US—covering 20 percent of the US population.[1] Over the next decade, Medicare is projected to cost US taxpayers nearly $2 trillion.[1] One factor driving this cost is the 13 million new beneficiaries that will be added to Medicare over the next ten years.[1] These new beneficiaries are selecting coverage via Medicare Advantage "MA" at a faster rate than traditional or fee-for-service "FFS" Medicare and last year enrollment in MA surpassed FFS for the first time in the history of the Medicare program.[2] Over the next decade MA is projected to grow 42 percent while FFS is projected to shrink.[3]

These demographic changes are taking a toll on the financial health of the Medicare program. The Medicare Trustees' project the Hospital Insurance trust fund will run out of funds to cover benefits before 2028.[4] In addition, the Medicare Payment Advisory Commission (MedPAC) has sounded the alarm on the impact of the Supplemental Medical Insurance trust fund, which continues to see year-over-year increases in costs to beneficiaries, and consumption of general revenue tax dollars.[1] Given this stark reality, the Committee's focus on efficiency is the exact conversation the Medicare program needs.

Status of primary care in the Medicare program

Medicare beneficiaries have adequate access to primary care services.[5] Specifically, approximately 96 percent of beneficiaries have a primary care provider.[5] The supply of primary care clinicians is growing, with the greatest growth as advanced practice nurse practitioners or "APRNs."[5] Particularly in rural areas, APRNs are a consistent and reliable source of primary

care.[6] During the COVID-19 pandemic, APRNs expanded telehealth capacity to ensure Medicare beneficiaries still had adequate access to primary care.[7]

Examples of primary care reform in Medicare

Telehealth

In March 2020, Medicare in-person office visits dramatically dropped, and telehealth visits spiked.[8,9,10,11] MedPAC found nearly half of all telehealth services delivered in April 2020 were for primary care.[12] In total 45 percent of Medicare beneficiaries used telehealth in 2020.[13] There were two policies that were primarily responsible for these changes in the delivery of primary care services—one in FFS and one in MA.

Prior to the pandemic, FFS reimbursement of telehealth services was limited to rural areas, restricted to delivery within a health care facility, and only allowed with two-way interactive video.[14] When Congress enacted the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020, FFS telehealth reimbursement was expanded to cover urban areas, originate within a beneficiary's home, and included audio-only services.[15,16] MedPAC found spending on FFS telehealth visits in 2020 totaled $4.2 billion.[10] After President Biden officially ended the public health emergency, Congress enacted two additional extensions of the FFS telehealth policy, which cost an additional $3 billion.[17,18,19,20]

Unlike FFS, the telehealth changes signed into law for MA, saved money. The Bipartisan Budget Act of 2018 included a policy that permits MA plans to offer telehealth as a basic benefit.[21] The Medicare program establishes an annual benchmark system for MA plans. A different benchmark is set for each county in the US based on a statutory formula.[22] If an MA plan submits a bid that is lower than the benchmark, the plan receives a rebate. MA plans are

required to reinvest a portion of the rebate, and plans typically elect to reinvest in premium reductions, reduced cost-sharing, and supplemental benefits.[23] By allowing plans to move telehealth services out of the supplemental benefit, and into the basic benefit, the policy achieved two things. The first achievment was "freeing" up capital to expand supplemental benefits. This means MA plans are able to offer new benefits, such as enhanced vision, dental, and hearing. The second achievement was less taxpayer spending, in the form of lower annual bids.[24] The Congressional Budget Office "CBO" estimated this policy would save taxpayers $80 million and the Centers for Medicare & Medicaid Services "CMS" estimated the policy will save beneficiaries $557 million.[21-22]

In a peer-reviewed study that I led, along with my co-authors Dr. Grace McCormack and Dr. Erin Trish from USC-Schaffer and Dr. Kathryn Wagner from Marquette University, we found the MA policy was related to telehealth offered as a basic benefit for 71 percent of enrollment in 2020 and grew to 95 percent in 2021.[25] Our study concluded that the MA telehealth policy afforded plans two years of strategizing, negotiating, and investing, which may have allowed FFS to leverage the infrastructure that ultimately enabled the virtual primary care safety-net during the COVID-19 pandemic.

Like telehealth, there are other primary care services that may be appropriate to transition to the basic benefit. Specifically, services that are offered under Value-Based Insurance Design "VBID" should be considered. There are a number of VBID primary care "adjacent" services CMS currently allows, such as:

- Cost sharing reductions for medications;
- Non-emergency medical transport;
- Healthy food and grocery options;

- Annual wellness and routine physicals;
- Smartphones;
- Broadband/internet support;
- Roadside assistance; and
- Minor home repairs.[26]

Today these benefits are allowed in limited capacity. The MA telehealth policy is a novel pathway that can be extended to these services. Such an extension would allow for much greater access to primary care services.

Affordable Care Act Reforms

In addition to telehealth, there are three more reforms related to primary care that bear discussion. The Affordable Care Act (ACA) of 2010 included three programs that, unfortunately, have not been as successful as the telehealth example. With the best of intentions to build upon a framework of primary care, the Medicare Shared Savings program, commonly referred to as Accountable Care Organizations or "ACOs," has failed to meet its intent. ACOs are groups of providers that agree to be held accountable for the cost and and quality of Medicare beneficiaries.[27] An annual budget is set, in advance, and ACOs are expected to keep total annual cost below the budget. If ACOs are able to beat the budget projection, they are able to share in savings with the Federal government. CBO estimated ACOs would save approximately $5 billion from 2010 through 2019.[28] A recent study published by *JAMA* found the ACO program contributed between $584 million and $1.4 billion in additional cost for FFS Medicare from 2013 to 2021.[29]

There have also been several FFS primary care projects tested under the Center for Medicare & Medicaid Innovation or the "CMMI," such as the Multi-Payer Advanced Primary Care Practice, Comprehensive Primary Care Initiative, and Comprehensive Primary Care Plus. None of these primary care programs have produced savings.[30,31] Despite the 87 CMMI projects listed on CMS' web site, only 4 projects or less than 5 percent have yielded savings.[27-28] In 2011, CBO estimated the CMMI would save approximately $1.3 billion from 2010 through 2019. An important factor in this score is the projected savings was net of the $10 billion in implementation money afforded to CMS, meaning the CMMI was projected to save roughly $11.3 billion.[25] In fall 2023, CBO changed its underlying baseline assumptions regarding the CMMI because it concluded the CMMI cost $5.4 billion in its first decade of implementation.[28]

The third ACA program that has not manifested its projected savings is the Independent Payment Advisory Board or "IPAB." Envisioned as a 15-member mini-government agency, the IPAB was charged with recommending programmatic savings upon enactment of an annual budgetary "trigger." Projected, by the CBO, to save $28 billion, such savings never manifested due to an overwhelming bipartisan vote to repeal the IPAB.[19,25] The idea that a board of unelected bureaucrats unaccountable to the American people—and perhaps more importantly Medicare beneficiaries—can successfully make major modifications to the Medicare program has not worked in the past and is unlikely to achieve success in the future.

Recommendations

FFS reforms such as ACOs and CMMI have increased programmatic administrative costs in the Medicare program. Incidentally, the MA reforms have saved the program money. Moving forward policymakers should target reforms within the highest growth area of the Medicare

program, MA. The successful example of MA telehealth prompts consideration of additional flexibility beyond the standard basic benefit package. Ths idea of "decoupling" the MA FFS benefit packages holds great promise of achieving efficiency in the Medicare program.

The MA program is not perfect and MedPAC has identified some areas in need of reform, such as risk-adjustment, benchmarking, and quality bonuses.[32] As you consider these reforms, it is essential you reinvest any savings back into the Medicare program. Though these are important reforms, they are outside of the scope of today's focus. Given that MA now constitutes over half of Medicare enrollment, you should consider allowing plans flexibility in the provision of primary care services, such as those highlighted in my VBID example.

Though the failed Affordable Care Act examples I cited in my testimony do not align with driving efficiency in FFS, there are other FFS policies you should consider that show great promise. Perhaps the biggest threat to the promise of primary care efficiency is consolidation by large hospital-based systems.[33,34,35,36] Due to odd peculiarities of Medicare FFS reimbursement, office-based clinicians are unable to compete with outpatient-based providers. Equalizing payment or "site of service neutrality," such as the solutions offered in Senator Braun's Site-Based Invoicing and Transparency Enhancement Act and Senator Sander's Bipartisan Primary Care and Health Workforce Act are very worthy of your consideration.[37,38]

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