



June 14, 2024

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Chairman Wyden and Ranking Member Crapo:

The Part B Access for Seniors and Physicians Coalition (“ASP Coalition”), representing more than 300 patient and provider organizations across the country, appreciates the Senate Finance Committee’s continued work to address Medicare Part B payment challenges impacting beneficiaries and physicians. The Coalition is greatly encouraged by the Committee’s White Paper, “Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B,” and is pleased to offer policy recommendations for your consideration. Specifically, we urge the Committee to advance legislation to improve the adequacy of Medicare Part B Average Sales Price (ASP) add-on payments, in light of ongoing reimbursement reductions that threaten the ability of physicians to continue providing high-quality and accessible medical care to seniors. We also recommend that the Committee adopt safeguards in Center for Medicare and Medicaid Innovation (CMMI) demonstrations to ensure they improve patient health and preserve access to care. Our proposals are intended to enable the Medicare program to meet “the chronic care needs of beneficiaries today,” and are aligned with your focus on Medicare Part B payment issues “that may jeopardize a clinicians’ ability to own and operate a health care practice and meet patient needs.”

Medicare Part B ASP Add-On Payment Adequacy

Rationale – We strongly believe that the Medicare Part B add-on payment must be improved to meet the Committee’s goals to “ensure that Medicare Part B reimbursement structures keep pace with the cost of providing care,” and “improve access to comprehensive care while allowing physicians to remain independent.” We appreciate your consideration of reforms to the Medicare Physician Fee Schedule (PFS) and aspects of the Quality Payment Program (QPP), and believe that the add-on payment represents an overlooked, yet critical aspect of physician reimbursement that must also be addressed. These payments are particularly relevant for Medicare beneficiaries with chronic diseases. Medicare Part B covers drug therapies for almost 60 million seniors and disabled Americans, including those with cancer and other serious and complex chronic conditions such as rheumatologic, autoimmune, and inflammatory conditions; and those living with blinding eye diseases, Crohn’s disease and ulcerative colitis, other rare chronic diseases, and serious mental illness. Given the often life-threatening complexity of their health conditions, these beneficiaries require personalized and accessible medical care from their providers; yet, physicians caring for these patients face an increasingly challenging reimbursement environment.

Background – Under Medicare Part B, physicians purchase covered drugs directly from manufacturers, and are reimbursed by Medicare based on a formula intended to address the cost of the medicine.



Providers are also paid an “add-on” fee to cover overhead costs of acquiring, storing, and administering the medication.

Unfortunately, the adequacy of ASP add-on fees is threatened in several ways. First, ASP add-on fees were reduced from 6% to 4.3% due to sequestration under the *Budget Control Act of 2011 and the Balanced Budget and Emergency Deficit Control Act of 2013*. Provisions included in the Inflation Reduction Act (IRA) will further exacerbate the reimbursement cuts that the Centers for Medicare & Medicaid Services (CMS) has been implementing for years.

Under the IRA, reimbursement, including add-on fees, for negotiated Medicare Part B drugs will no longer be based on “Average Sales Price” but rather a new rate called the “Maximum Fair Price” (MFP). A recent study analyzing the potential range of reimbursement reductions in Medicare Part B found that add-on reimbursements could fall by as much as 47.2 percent.¹ This new mechanism does not account for the overhead costs associated with acquiring and administering drugs, placing all the financial risk on physicians. Additionally, it creates further administrative burdens for medical practices faced with two different reimbursement rates – ASP and MFP – which will also affect commercial insurance contracts. Currently, a significant share of provider reimbursement by commercial insurers for provider-administered medicines is based on ASP. Under the IRA, it also appears that MFP will not be excluded from the calculation of a Medicare Part B selected drug’s ASP. Since MFP will likely be lower than ASP, its inclusion in the ASP calculation will likely lower commercial reimbursement for physician-administered medicines.²

Practices are closing, especially in rural areas, and consolidating into the more expensive hospital setting. This new round of IRA-induced reimbursement cuts will worsen pressures on physician practices by reducing Medicare add-on fees for covered drugs and influencing commercial reimbursement through the erosion of ASP. As the Committee works to address challenges facing physicians and modernize physician payment, the Coalition encourages you to consider policies to codify the ASP add-on fee as the standard reimbursement for Medicare Part B drug administration. Ultimately, providers and their patients should be removed from the middle of drug price negotiations between the government and drug companies.

Recommended Solution – Legislation that aims to protect patient access and quality for Medicare beneficiaries, by holding physicians harmless from IRA drug price negotiation, the “Protecting Patient Access to Cancer and Complex Therapies Act of 2023” (S. 2764), has been introduced by Senator Barrasso (R-WY). The legislation reverts provider reimbursement for negotiated drugs to ASP and excludes MFP from the calculation of ASP for selected drugs. Further, it would maintain Medicare beneficiary coinsurance based on MFP to ensure patients continue to pay reduced coinsurance for Medicare Part B negotiated drugs. Finally, it requires selected drug manufacturers to pay a retrospective rebate directly to Medicare for the cost difference between the MFP and ASP rates.

¹ Milena Sullivan Managing Director Amanda Tripp Associate Principal Ekemini Isaiiah Consultant II, et al. “Ira Medicare Part B Negotiation Shifts Financial Risk to Physicians.” *Avalere Health*, November 29, 2022, <https://avalere.com/insights/ira-medicare-part-b-negotiation-shifts-financial-risk-to-physicians>.

² Milena Sullivan Managing Director Amanda Tripp Associate Principal Ekemini Isaiiah Consultant II, et al. “Ira Medicare Part B Negotiation Shifts Financial Risk to Physicians.” *Avalere Health*, November 29, 2022, <https://avalere.com/insights/ira-medicare-part-b-negotiation-shifts-financial-risk-to-physicians>.



Establishing Guardrails in CMMI Demonstrations to Preserve the Provider-Patient Relationship

Rationale & Background – The ASP Coalition has long been concerned that mandatory CMMI demonstrations threaten access to medically necessary treatment for patients with life-threatening chronic conditions such as cancer and autoimmune diseases. We applaud your interest in exploring and evaluating models created by the CMMI, and urge the Committee to examine the shortfalls of the entity, including attempts to interfere in the patient-provider relationship. Our experience with multiple proposals has led us to develop a set of meaningful, clear guardrails that we believe are essential to ensure demonstrations conducted through CMMI improve patient health and preserve access to care. These guardrails include essential patient protection principles addressing transparency, patient and provider engagement, and access to care.

Recommended Solution – The Coalition recommends increasing safeguards in CMMI through principles as outlined below:

- **Support small scale, voluntary testing** – ensure that all models are small-scale, voluntary tests; test models in a limited population to minimize unintended consequences before proper testing is completed; limit the duration of all models to no more than 5 years; and ensure CMMI avoids making wholesale changes to existing law and includes a process for engaging Congress and stakeholders in broader programmatic changes.
- **Prevent overlapping models** – ensure that the same population of patients is not subject to multiple models simultaneously.
- **Improve transparency** – improve the transparency of model design and evaluation; solicit more input from providers and patient groups; and ensure an opportunity for broad solicitation of comments on proposed models.
- **Evaluate access to care** – CMMI should carefully evaluate how proposed changes will impact access to care and should not incorporate elements of an existing pilot or demonstration into new payment models before proper testing is complete; proposed models should include a strategy to monitor, assess and quickly address changes in patient outcomes and access to care; and make available the results of CMMI model tests with respect to quality, access and costs on a regular and timely basis.

Healthcare innovations tested through CMMI must be focused on protecting patient access to vital therapies and ensuring that care is not compromised as new models are tested.

In conclusion, the ASP Coalition is grateful for your leadership in seeking sustainability in physician payment. We stand ready to work with you to advance policies that protect physician practice autonomy and Medicare beneficiary access to personalized care, particularly for patients with chronic conditions who rely on Medicare for essential medical treatment. Our proposals regarding Medicare Part B ASP add-on payments and CMMI demonstrations are offered to meet these challenges. Thank you for your consideration.

Sincerely,

The Part B Access for Seniors and Physicians Coalition