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Statement for the Record

"How Primary Care Improves Health Care Efficiency"

Full Committee Hearing

United States Senate Committee on the Budget

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Chairman Whitehouse, Ranking Member Grassley, and Members of the Committee,

Thank you for the opportunity to submit a statement for the record regarding your March 6th hearing on how primary care improves health care efficiency.

The Commonwealth Fund is a nonprofit, nonpartisan foundation dedicated to affordable, quality health care for everyone. We support independent research on health care issues and make grants to promote better access, improved quality, and greater efficiency in health care, particularly for society's most vulnerable. I lead our Delivery System Reform program with a focus on strengthening primary health care, particularly for underserved populations.

Primary care is the only health service associated with improved life expectancy and reduced health care disparities. Evidence is clear that improving the capacity and quality of primary care so that it can improve the health and wellbeing of persons and whole populations is essential to successfully addressing the nation's most pressing health crises, including:

- Ending the decline in life expectancy in the U.S.;
- Reducing the cost of health care for patients and families;
- Advancing health equity;
- Addressing a burgeoning mental health crisis;
- Responding to the opioid epidemic; and
- Developing a reliable system for identifying and mitigating the next health-related emergencies, including pandemics.

But in the U.S., several indicators suggest that the sustainability and future of primary care is at risk. According to the National Scorecard on the Health of Primary Care, the percent of people that report having a usual source of care is declining, even as access to health insurance has increased, with three in ten people now reporting not having a usual source of care. Compared to other high-income countries, U.S. patients are among the least likely to have a usual source of care or a longstanding relationship with a primary care provider. This trend is only likely to worsen as the supply of primary care shrinks, particularly in communities with historically few primary care clinicians like rural areas. Between 2012 and 2020, only one in five medical residents selected primary care as their practice and we are training clinicians in hospital settings predominantly on the coasts, not in community settings, contributing to shortages across the country.

There is growing consensus that changing *how* and *how much* we pay for primary care is a critical next step for policymakers to reverse these trends and strengthen primary care in the U.S. As the National Academies for Sciences, Engineering, and Medicine (NASEM) identified in their 2021 landmark report "Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care", the growing issues facing primary care—including workforce shortages and poor access —are in large part due to financing and decades-long underinvestment. The portion of health care dollars going to primary care is low and decreasing over time across payers, with the U.S. spending an estimated 4-6% of total health expenditures on primary care. In Medicare, studies find primary care represents roughly 3% of spending despite the greater needs for care coordination and management of chronic conditions in the Medicare beneficiary population.

As recent Medicare Payment Advisory Commission (MedPAC) meetings and reports confirm, primary care clinicians are paid substantially less than specialists. Under the Medicare Physician Fee Schedule, due to how prices are determined by the specialty-dominated Relative Value Scale Update Committee, services that make up the core of primary care like evaluation and management (E&M) are undervalued and therefore not sufficiently supplied by clinicians. Moreover, almost all of the payments to primary care clinicians are fee-for-service (FFS), which experts increasingly agree discourages team-based, coordinated care – features associated with better quality and greater patient satisfaction.

As one of the largest insurers in the U.S., Medicare plays a critical role in leading the charge by increasing our nation's investment in primary care services and changing the way we pay for them, moving towards more population-based approaches. Congress now has the opportunity to implement specific changes to the Medicare Physician Fee Schedule to act on the NASEM recommendations and MedPAC discussions.

Congress could consider the following policies to strengthen primary care payment:

1. **Enable population-based payment for certain primary care services in Medicare**. Population-based payments are critical for providing clinicians with greater flexibility to innovate, budget, and more easily integrate other kinds of care, like behavioral health or telehealth, into primary care. Congress can grant the Centers for Medicare and Medicaid Services (CMS) the authority to pay population-based payments for primary care clinicians' attributed patients on top of billing for individual patient services under the fee schedule. Population-based payments could cover services which are currently not covered in the fee schedule like coordinating social services and communications with patients and caregivers, as well as services provided in high-volume which involve low resource use, like telehealth for non-behavioral health services. Fee-for-service could continue to apply for underprovided and clinically essential services, like immunizations.

2. **Encourage patient designation of a primary care provider by waiving Medicare Part B beneficiary cost-sharing**. In order to implement population-based payments, CMS will need data from patients about who they consider to be their primary care provider. Congress can direct the Secretary to establish a process for individuals to designate a primary care provider as their usual source of care on an annual basis, and as an incentive for doing so, waive any cost-sharing for services delivered by that provider.

3. **Direct CMS to create a new expert advisory panel to support development of new processes to accurately set relative value units (RVUs) in the Medicare Physician Fee Schedule.** The current process for determining RVUs relies heavily on flawed estimates of practice expenses and clinician time and work. To fix distortions in the fee schedule, Congress can direct the Secretary to establish an expert advisory panel to provide guidance for establishing a new process to more accurately and empirically determine RVUs. In addition, the group can identify strategies to simplify the fee schedule by collapsing the current 8000 service codes into a

smaller number of payment code "families" with similar time and work valuations for related services and guide CMS' development of a research agenda to inform fee schedule design.

Evidence suggests these changes would ultimately be budget neutral or even generate cost savings in the long-term, but further assessment and modeling is needed. First, the proposed RVU updates could result in savings by reducing payments for currently overpriced specialty services. Second, evidence suggests that reorienting our current health care spending towards primary care and shifting to population-based payment approaches could result in savings over the long term for the federal government, particularly by reducing high-cost forms of utilization like emergency department visits and inpatient hospitalizations. For instance, one of the characteristics most closely correlated with cost savings in the Medicare Shared Savings Program (MSSP) was having more primary care clinicians within an accountable care organization (ACO) and having higher provision of E&M services; MSSP ACOs comprised of 75% primary care clinicians or more saw $281 per capita in net savings compared to $149 for ACOs with fewer primary care clinicians. These savings have been achieved despite not using a hybrid payment model, which would better complement the risk-sharing arrangement ACOs face. If using a hybrid payment for primary care in MSSP, as has been recommended for adoption, savings would likely be far more substantial.

The largescale Comprehensive Primary Care Plus (CPC+) program, which included PMPM payments similar to those proposed above, was beginning to produce small reductions in total Medicare expenditures in its fourth year, with evaluators noting, "If this trend is sustained or becomes stronger in performance year 5, CPC+ could show cost savings even after accounting for the enhanced payments." And finally, several other analyses have found a correlation between an increased supply of primary care physicians and lower total costs of health services, including in Medicare.

While these recommendations focus on Medicare, there would naturally be broader implications for other payers. As one of the country's largest payers, Medicare is the de facto health care provider payment policymaker for other payers, with most commercial payers basing their fee schedules off of Medicare fee schedules. The proposed changes above could also impact MA, since their rates are often pegged to actual Traditional Medicare fee levels. Moreover, the Center for Medicare and Medicaid Innovation would likely consider these changes in their models to align with the rest of the Medicare program.

Changes implemented to strengthen primary care in Medicare will influence the rest of the health care payer ecosystem, help restore more balance to a health care financing system that is badly out of balance, and generate long-term efficiencies and savings. Most importantly, the stronger primary care that would result from these payment changes would result in more accessible, equitable, affordable, and comprehensive care for patients and address the large and growing shortage of the primary care workforce that is compromising essential health services.