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Before the
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On

Bolstering Chronic Care through Medicare Physician Payment

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**These comments reflect solely my beliefs and do not reflect the opinions of any organization I am affiliated with, including MedPAC, for which I serve as Vice Chair, and the University of Pennsylvania Health System and Perelman School of Medicine.*

"To really help address the needs of patients with chronic diseases, we need information systems and teams that can help patients in between office visits, and we need financial incentives that reward providers for adopting them."
Dr. Thomas Lee, MD, M.SC., Network President for Partners Healthcare System and Chief Executive Officer, Partners Community HealthCare, Inc.

Chairman Wyden, Ranking Member Crapo, and distinguished members of the Committee, thank you for the opportunity to testify today. My name is Dr. Amol Navathe. I am a primary care-trained internal medicine physician and a PhD-trained health economist. I would like to highlight why the Medicare program needs to better address chronic care for its beneficiaries and how changes to physician payment can support improvements. As a practicing physician, I have a front row seat in witnessing the challenges that Medicare beneficiaries face in receiving optimal care for chronic conditions.

Take for example, my patient Mr. L. He is a wonderful, elderly gentleman suffering from diabetes, heart failure, kidney disease, and a concern for kidney cancer. Most notably, he lives alone with no living spouse or children to help care for him. While I do my best to help Mr. L get his medications on time and make it to his specialist appointments, our fragmented system does not make it easy. Mr. L has to manage his chronic conditions on his own, spending up to an average of two hours a day coordinating his medications, traveling to appointments, and interacting with the health system.[1] He is an archetypal Medicare patient who would benefit from a more proactive and supportive model of care, ensuring that he gets his routine care to avoid long, avoidable, and expensive hospitalizations, like the one he had last month for acute kidney failure. In learning from Mr. L's situation, I would like to share three key points.

I. Chronic diseases may be the single most important challenge affecting Medicare beneficiaries and thus the Medicare program.

The U.S. has the highest rate of individuals with multiple chronic conditions.[2] Some of the most common conditions include heart disease, cancer, dementia, diabetes, and chronic kidney disease. More than two-thirds (69%) of the Medicare population is diagnosed with 2 or more chronic conditions, with *1 in 7* beneficiaries (15%) having 6 or more conditions.[3] These 15% alone account for $92 Billion in emergency visits, hospitalizations, and post-acute care; with

[1] Jowsey T, Yen L, W PM. Time spent on health related activities associated with chronic illness: a scoping literature review. BMC Public Health. 2012 Dec 3;12:1044. doi: 10.1186/1471-2458-12-1044.
[2] Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes (Commonwealth Fund, Jan. 2023). https://doi.org/10.26099/8ejy-yc74
[3] Centers for Medicare & Medicaid Services. Medicare Multiple Chronic Conditions 2015 data. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/MCC_Main.html

their overall care resulting in over $150 Billion dollars of Medicare spend.[4] Across the entire U.S. adult population, 27% are estimated to have multiple chronic conditions, costing the American healthcare system more than $1 trillion annually. [5,6] When incorporating the costs associated with lost economic productivity, this number balloons to $3.7 trillion.[7] The overall financial impact is likely to increase moving forward, given projections related to an aging U.S. population.

This financial impact also affects patients directly. For example, patients with chronic disease have increased adverse financial outcomes compared with healthier patients.[8] Of individuals with medical debt, those with 7 or more conditions owed an estimated $1,252 compared with $784 for those with no chronic diseases.[9] Patients experiencing chronic diseases face additional difficulties, such as the inability to work due to symptoms, managing their disease, and other health implications.[10] The experiences of beneficiaries living with chronic conditions, as well as the experiences of the clinicians caring for them, convey a compelling case for why the Medicare program must address the challenges of chronic disease care in a timely fashion.

II. Dramatic fragmentation in care makes addressing chronic disease a burden.

One of the most important challenges in managing chronic conditions is the extremely fragmented nature of the U.S. healthcare system. As an illustrative fact, over a third of Medicare beneficiaries (35%) received care from 5 or more physicians in 2019, a number likely to be higher among beneficiaries with chronic conditions.[11] That reflects not only a substantial number of physician visits, diagnostic tests, treatments, and prescriptions that beneficiaries have to keep track of, but also the many opportunities for care details to slip through the cracks. For a primary care physician (PCP) to effectively coordinate care for a single medical condition it can require upwards of 50 interactions in a three-month period (through various modes of communication)

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[4] Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chartbook, 2012 Edition. Baltimore, MD. 2012. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/chronic-conditions/downloads/2012chartbook.pdf

[5] Boersma P., Black L.I., Ward B.W. Prevalence of multiple chronic conditions among US adults, 2018. Prev Chronic Dis. 2020;17:E106.

[6] Waters H., Graf M., editors. The costs of chronic disease in the U.S. 1st ed. Milken Institute; 2018. https://milkeninstitute.org/sites/default/files/reports-pdf/ChronicDiseases-HighRes-FINAL_2.pdf

[7] *Ibid.*

[8] Becker NV, Scott JW, Moniz MH, Carlton EF, Ayanian JZ. Association of Chronic Disease With Patient Financial Outcomes Among Commercially Insured Adults. JAMA Intern Med. 2022;182(10):1044–1051. doi:10.1001/jamainternmed.2022.3687

[9] Slomski A. Chronic Disease Burden and Financial Problems Are Intertwined. JAMA. 2022;328(13):1288–1289. doi:10.1001/jama.2022.15440

[10] Boersema HJ, Hoekstra T, Abma F, Brouwer S. Inability to Work Fulltime, Prevalence and Associated Factors Among Applicants for Work Disability Benefit. J Occup Rehabil. 2021 Dec;31(4):796-806. doi: 10.1007/s10926-021-09966-7. Epub 2021 Mar 12. PMID: 33710457; PMCID: PMC8558289.

[11] Barnett ML, Bitton A, Souza J, Landon BE. Trends in Outpatient Care for Medicare Beneficiaries and Implications for Primary Care, 2000 to 2019. Ann Intern Med. 2021 Dec;174(12):1658-1665. doi: 10.7326/M21-1523. Epub 2021 Nov 2. Erratum in: Ann Intern Med. 2022 Oct;175(10):1492. PMID: 34724406; PMCID: PMC8688292.

between patient, primary care physician, and other physicians.[12] Moreover, there has been a substantial increase in the total number of other clinicians a PCP's Medicare panel of patients saw between 2000 and 2019, from a median of 52 to one of 95 physicians.[13] While having multiple physicians can tailor treatment to the needs of a patient's condition, it can also increase the likelihood of medical errors, redundant visits, preventable hospitalizations, and substandard care due to incomplete communication and differing treatment strategies. Each individual interaction adds complexity. This demonstrates the challenging role of a PCP, highlighting a structural complexity in managing care for those with chronic conditions amidst a backdrop of increasing specialization and resulting fragmentation.

A study involving patients with diabetes and chronic kidney disease revealed significant repercussions of fragmented care on emergency department (ED) utilization. Every 0.1-unit increase in the fragmentation of care (encompassing number of different providers visited, the proportion of attended visits to each of those providers, and the total number of visits) was associated with a 15% increase in the number of ED visits (incidence rate ratio, 1.15; 95% CI, 1.09-1.21).[14] Another study, specifically focused on Medicare beneficiaries with chronic conditions, similarly reported that incremental and heightened fragmentation significantly increased the risk of both ED visits and hospital admissions (by 14% for each; adjusted $P < .05$ for each comparison).[15]

Beneficiaries with chronic conditions face the burden of fragmentation across the care continuum. Among patients with 5 or more chronic conditions, patients experiencing the highest degree of care fragmentation underwent roughly twice as many radiology and other diagnostic procedures as those experiencing the lowest level of fragmentation, translating to an additional 284 tests per 100 patients, or an increase of 110% (adjusted $p <0.01$).[16] A study from the Harvard Chan School of Public Health assigned patients a fragmentation index based on their PCP's practice style, measured by the number of other physicians seen by their PCP's panel. The authors found increased departures from clinical best practice, higher rates of preventable hospitalizations, and higher healthcare spending in the highest fragmentation quartile versus the lowest fragmentation quartile ($10,396 versus $5,854, $p<0.001$) (Exhibit 1).[17]

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[12] Press MJ. Instant Replay — A Quarterback's View of Care Coordination. New England Journal of Medicine. 2014;371:489-491. doi: 10.1056/NEJMp1406033

[13] Barnett ML, Bitton A, Souza J, Landon BE. Trends in Outpatient Care for Medicare Beneficiaries and Implications for Primary Care, 2000 to 2019. Ann Intern Med. 2021 Dec;174(12):1658-1665. doi: 10.7326/M21-1523. Epub 2021 Nov 2. Erratum in: Ann Intern Med. 2022 Oct;175(10):1492. PMID: 34724406; PMCID: PMC8688292.

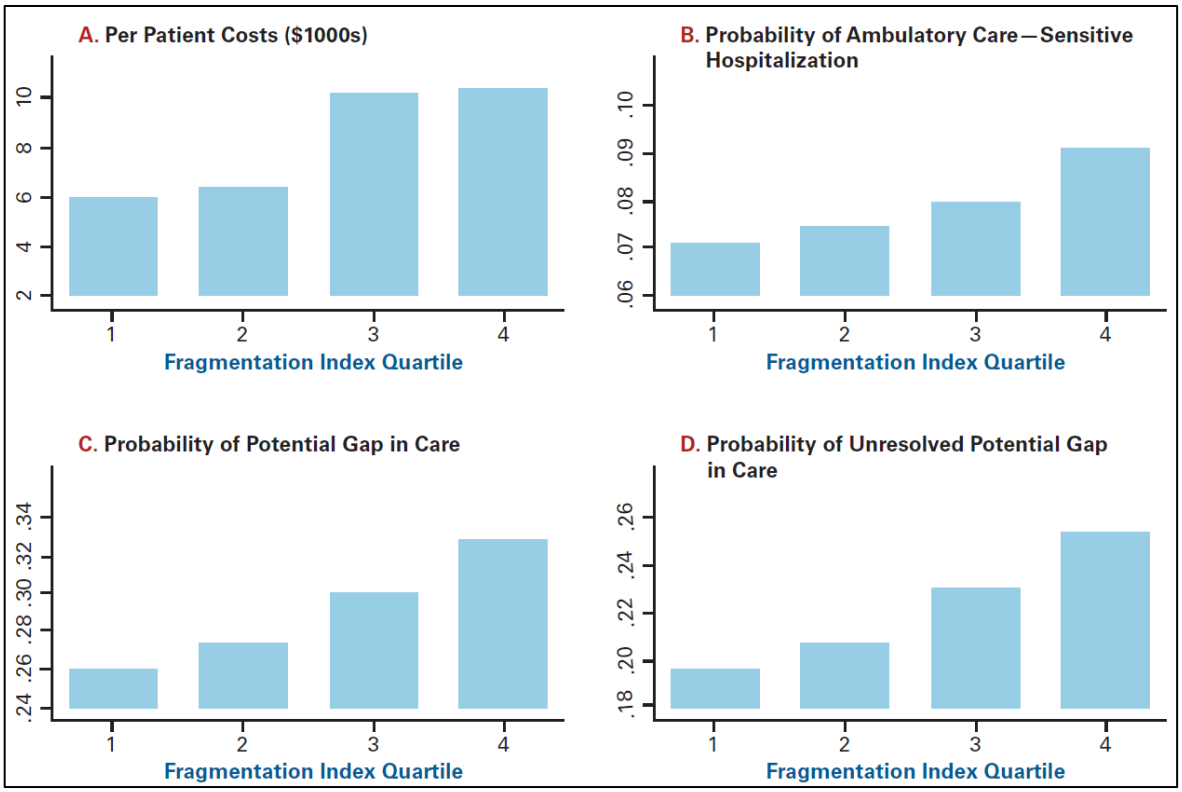
[14] Liu, CW., Einstadter, D and Cebul, RD. "Care fragmentation and emergency department use among complex patients with diabetes." The American journal of managed care 16.6 (2010): 413-420.

[15] Kern, LM., et al. "Fragmented ambulatory care and subsequent healthcare utilization among Medicare beneficiaries." Am J Manag Care 24.9 (2018): e278-e284.

[16] Kern, LM., et al. "Healthcare fragmentation and the frequency of radiology and other diagnostic tests: a cross-sectional study." Journal of general internal medicine 32 (2017): 175-181.

[17] Frandsen, BR., et al. "Care fragmentation, quality, and costs among chronically ill patients." Am J Manag Care 21.5 (2015): 355-362.

Exhibit 1. Association Between Fragmentation Quartile and Patient Outcomes.



Notes: Higher fragmentation of care for a PCP's panel was associated with poorer patient outcomes.
Source: Frandsen, BR., et al. "Care fragmentation, quality, and costs among chronically ill patients." Am J Manag Care 21.5 (2015): 355-362.

III. The American care system prioritizes producing more health *care*, rather than producing more health.

The prevailing fee-for-service (FFS) reimbursement system is a key driver in producing such a fragmented system. FFS reimbursement pays physicians and other health care providers based on volume of activities, creating a system that incentivizes each clinician to focus on increasing the number of visits and procedures.[18] The complex task of coordinating care, especially for beneficiaries with chronic conditions, is not directly reimbursed and therefore gets overlooked.[19]

With good intentions, Center for Medicare and Medicaid Services (CMS) has tried to fill this gap by adding more billing codes in an attempt to more comprehensively tie payment to effort. Unfortunately, it is a fraught effort to reduce the important work of physicians and other health care providers to a list of codes. This has resulted in an administratively burdensome system of

[18] Zyzanski SJ, Stange KC, Langa D, Flocke SA. Trade-Offs In High-Volume Primary Care Practice. J Fam Pract. 1998;46:397-402.
[19] Young RA, Burge S, Kumar KA, Wilson J. The Full Scope of Family Physicians' Work Is Not Reflected by Current Procedural Terminology Codes. J Am Board Fam Med. 2017 Nov-Dec;30(6):724-732. doi: 10.3122/jabfm.2017.06.170155.

'ticky tack' codes that get underused because the cost of submitting the bill exceeds the payment doctors receive. I sometimes call this "death by a thousand codes." For example, the billing cost for a visit has been estimated to be $20.49,[20] exceeding CMS's initially proposed $15 FFS payment for a phone call or other "virtual check-in" visit. This places PCPs in a difficult situation: shoulder substantial administrative burden to deliver and bill for these services, deliver but do not bill for these services, or do not provide these services at all. Either of the first two options is financially perverse and the third is clinically perverse. Consequently, the core issue of fragmentation does not get systematically addressed.[21]

Adding billing code upon billing code increases administrative complexity while failing to appropriately pay primary care practices for all the services they provide off of the fee schedule, an estimated 25% of their activities.[22] Studies show that 60% of primary care visits deliver services that are not reportable in CPT (Current Procedural Terminology) codes.[23] Examples of these services include checking insurance coverage for patients, addressing social determinants of health during visits, and discussing medication options. All of these are critical for effective delivery of medical care, but providers are not compensated for them.

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What can we do to fix this? Despite the challenge facing beneficiaries, doctors, and policymakers, there are some potential options we can consider.

Any effort to improve chronic disease care will require a change in the way health care is delivered, a different "model of care" to address fragmentation. It will require physician groups to be able to invest in new capabilities; use technologies like telehealth when they are safe, efficient, and effective; and expand the role of staff practices, including care coordinators and case managers. For example, there is a growing workforce of nurse practitioners in primary care who help bolster access and improve care coordination, demonstrating successful care model shifts. A crucial element to enable a new model of care, however, is substantial change to physician payment. Simply adding more dollars to the current system is unlikely to address the chronic care crisis in Medicare. Instead, thoughtful care redesign is needed.

A natural place to start is to invest more in primary care, empowering PCPs to act as the "quarterback" or "point guard" of a patient's care team. Robust primary care has consistently demonstrated an improvement in population health and reduction in health

[20] Tseng P, Kaplan RS, Richman BD, Shah MA, Schulman KA. Administrative costs associated with physician billing and insurance-related activities at an academic health care system. JAMA. 2018;319(7):691-697. doi:10.1001/jama.2017:19148
[21] Berenson R, Shartzer A. The Mismatch of Telehealth and Fee-for-Service Payment. JAMA Health Forum. 2020;1(10):e201183. doi:10.1001/jamahealthforum.2020.1183
[22] Young RA, Burge S, Kumar KA, Wilson J. The Full Scope of Family Physicians' Work Is Not Reflected by Current Procedural Terminology Codes. J Am Board Fam Med. 2017 Nov-Dec;30(6):724-732. doi: 10.3122/jabfm.2017.06.170155.
[23] *Ibid.*

disparities.[24] Despite this, the United States systemically underinvests in primary care. Expenditure on primary care in the U.S. has declined over the past decade, ranging from 6.2% in 2013 to 4.6% in 2020 across all insurance types. Medicare spends an estimated 4% of its total spending on primary care,[25,26,27] about $15 billion per year, which is half that of many other developed countries.[28] In contrast, we spend more on inpatient care and hospitalizations than other nations. Within the U.S., primary care is systematically underinvested relative to other specialties,[29,30] despite the fact that PCPs play the central role in a patient's health and face the cognitively and logistically complex task of care coordination and integration. Procedural specialties are compensated significantly more than primary care and other office-based specialties.[31,3233] Changing fee schedule weights alone will not fix this; studies demonstrated that a recent upweighting of reimbursement for office visits led to only a 2% decrease in the Medicare payment gap between primary care and specialty physicians (from a gap of $40,259.80 to one of $39,434.70).[34]

Beyond mobilizing more dollars into primary care, we need to enable PCPs to invest in new capabilities and grant them more flexibility. One potential path would be to provide PCPs with consistent per-beneficiary, per-month (PBPM) payments in addition to certain fee-for-service payments.[35] These PBPM payments would be designed to cover the estimated 25% of PCP activities that are not currently captured in the Medicare Physician Fee Schedule, such as care coordination, communication with other providers, addressing social determinants of health, and improving patient and caregiver health literacy. Consequently, a benefit of such an approach is that it would unshackle PCPs from a system that tries to capture every activity across thousands of codes, since the litany of codes would no longer be necessary (since the associated clinical

[24] Jabbarpour Y, Petterson S, Jetty A, Byun H, Robert Graham Center. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care. Milbank Quarterly. 2023 Feb. https://www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard_final_V2.pdf
[25] New "Scorecard" Finds Primary Care Funding and Physician Workforce Are Shrinking. AA of Family Physicians. February 24, 2023. https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/primary-care-scorecard.html
[26] Jabbarpour Y, Petterson S, Jetty A, Byun H, Robert Graham Center. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care. Milbank Quarterly. 2023 Feb. https://www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard_final_V2.pdf
[27] Reid R, Damberg C, Friedberg MW. Primary Care Spending in the Fee-for-Service Medicare Population. JAMA Intern Med. 2019 Jul 1;179(7):977-980. doi: 10.1001/jamainternmed.2018.8747.
[28] OECD Country Health Profiles, 2023. https://www.oecd.org/els/health-systems/primary-care.htm
[29] Reid R, Damberg C, Friedberg MW. Primary Care Spending in the Fee-for-Service Medicare Population. JAMA Intern Med. 2019;179(7):977–980. doi:10.1001/jamainternmed.2018.8747v
[30] Zuckerman S, Merrell K, Berenson RA, Cafarella Lallemand N, and Sunshine J. 2015. Realign Physician Payment Incentives in Medicare to Achieve Payment Equity Among Specialties, Expand the Supply of Primary Care Physicians, and Improve the Value Of Care For Beneficiaries. Washington, DC: Urban Institute, Social & Scientific Systems Inc.
[31] Hsiao WC, Braun P, Yntema D, Becker ER. Estimating Physicians' Work for A Resource-Based Relative-Value Scale. N Engl J Med. 1988; 319:835-41.
[32] Katz S, Melmed G. How Relative Value Units Undervalue the Cognitive Physician Visit: A Focus on Inflammatory Bowel Disease. Gastroenterol Hepatol (N Y). 2016 Apr;12(4):240-4.
[33] Bodenheimer T, Berenson RA, Rudolf P. The Primary Care-Specialty Income Gap: Why It Matters. Ann Intern Med. 2007 Feb 20;146(4):301-6. doi: 10.7326/0003-4819-146-4-200702200-00011.
[34] Neprash HT, Golberstein E, Ganguli I, Chernew ME. Association of Evaluation and Management Payment Policy Changes with Medicare Payment to Physicians by Specialty. JAMA. 2023;329(8):662–669. doi:10.1001/jama.2023.0879
[35] Berenson RA, Shartzer A, Pham HH. Beyond demonstrations: implementing a primary care hybrid payment model in Medicare. Health Affairs Scholar. 2023 Aug;1(2):qxad024.

activities would be included in the monthly payment). This would also balance the goals of preserving access through FFS payments while enabling PCPs to practice more patient-centered, rather than visit-centered, care. The PBPM payments would allow PCPs to invest in sustainable practice infrastructure transformation such as hiring case managers and care coordinators or integrating technology and team-based care. Such care model redesign is of particular importance for improving the health of patients with multiple chronic conditions while reducing wasteful administrative complexity.

Hybrid primary care payments cannot be implemented at scale without Congressional action. The Center for Medicare and Medicaid Services (CMS) has conducted several demonstration projects implementing hybrid payments (e.g., Comprehensive Primary Care Plus). It also has the authority to—and should—implement hybrid payments in the Medicare Shared Savings Program (MSSP),[36] the largest accountable care program in Medicare. The ACO Primary Care Flex Model is a step in that direction.[37] However, moving past demonstrations to impact Medicare beneficiaries nationwide will require Congressional action to grant CMS the appropriate authority.

The evidence for hybrid payments is promising. Blue Cross Blue Shield of Hawaii, or Hawaii Medical Services Association (HMSA), has conducted what is perhaps the most rigorous test of hybrid payments for primary care to date in its Population-based Payments for Primary Care (3PC) model. The 3PC model is a hybrid model that shifted the majority of payments to PCPs to a risk-adjusted per-member-per-month payment, while continuing to pay some services as FFS.

The transformative elements of HMSA's 3PC model relate to its large market share; across its commercial, Medicare Advantage, and Managed Medicaid lines of business, HMSA retains large shares of patients and revenue for most of its PCPs. The model led to marked improvements in quality, greater use of telehealth that predated the COVID-19 pandemic, and fewer low-value imaging tests.[38] This included increased rates of cost-effective prevention such as blood pressure control among patients with diabetes (2.7% differential increase), as well as greater cost-saving care such as a 5.5% differential increase in advance care planning (Exhibit 2).[39] In fact, unlike other states where primary care practice finances were massively disrupted by the COVID-19

[36] Commonwealth Fund. Response to Request for Information on HHS Initiative to Strengthen Primary Health Care from the Office of the Assistant Secretary for Health, Department of Health and Human Services. https://www.commonwealthfund.org/sites/default/files/2022-08/TO ATTACH AS DOWNLOAD_Commonwealth Fund_OASH Primary Care RFI_7.29.22.pdf

[37] https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model

[38] Dinh CT, Linn KA, Isidro U, Emanuel EJ, Volpp KG, Bond AM, Caldarella K, Troxel AB, Zhu J, Yang L, Matloubieh SE, Drye E, Bernheim S, Lee EO, Mugiishi M, Endo KT, Yoshimoto J, Yuen I, Okamura S, Tom J, Navathe AS. Changes in Outpatient Imaging Utilization and Spending Under a New Population-Based Primary Care Payment Model. J Am Coll Radiology. 2020 Jan;17(1 Pt B):101-109. doi: 10.1016/j.jacr.2019.08.013. PMID: 31918865.

[39] Navathe AS, Emanuel EJ, Bond A, Linn K, Caldarella K, Troxel A, Zhu J, Yang L, Matloubieh SE, Drye E, Bernheim S, Lee EO, Mugiishi M, Endo KT, Yoshimoto J, Yuen I, Okamura S, Stollar M, Tom J, Gold M, Volpp KG. Association Between the Implementation of a Population-Based Primary Care Payment System and Achievement on Quality Measures in Hawaii. JAMA. 2019 Jul 2;322(1):57-68. doi: 10.1001/jama.2019.8113.

pandemic, practices in Hawaii were protected financially, as PCPs were well-equipped to care for patients effectively in a remote fashion because they had already made such infrastructure investments. The experience and transformative successes in Hawaii underscore the stability and ability to invest that hybrid payments can impart to primary care practices.

Exhibit 2. Changes in Quality Measures in the Population-Based Payments for Primary Care—Hawaii Medical Services Association.

	3PC, %			Non-3PC, %			Unadjusted		Adjusted	
	2012-2015	2016	Difference	2012-2015	2016	Difference	Differential Change, Percentage Points	*P* Value	Differential Change, Percentage Points (95% CI)	*P* Value[a]
Quality										
No. of unique patients	74 371	58 270	NA	207 159	140 772	NA	NA	NA	NA	NA
No. of PCPs	107	107	NA	312	312	NA	NA	NA	NA	NA
Composite measure score (n = 284 544)[b]	76.4	84.6	8.2	76.8	83.4	6.7	1.5	<.001	2.3 (2.1 to 2.6)	<.001
Advance care planning (n = 42 102)	40.9	75.7	34.8	37.0	67.2	30.1	4.7	<.001	5.5 (4.3 to 6.7)[c]	<.001
Body mass index assessment (n = 245 415)	72.1	88.1	16.0	74.9	85.5	10.6	5.4	<.001	4.5 (4.1 to 5.0)[d]	<.001
Breast cancer screening (n = 62 230)	82.8	85.7	2.9	84.7	86.7	2.0	0.9	.03	0.9 (0.2 to 1.5)	.07
Cervical cancer screening (n = 74 426)	82.2	82.2	0.0	81.1	82.0	0.9	−0.9	.02	−1.1 (−1.8 to −0.5)[e]	.01
Diabetes care										
Blood pressure control (<140/90 mm Hg) (n = 31 683)	63.7	87.2	23.5	64.2	84.6	20.5	3.0	<.001	2.7 (1.6 to 3.8)[f]	<.001
Eye examination (n = 32 072)	74.8	79.3	4.6	73.8	76.8	3.0	1.6	.02	1.4 (0.2 to 2.6)	.14
HbA_{1c} in control (≤9.0%) (n = 29 581)	77.1	84.9	7.8	76.6	84.4	7.8	0.1	.92	0.0 (−1.1 to 1.1)[g]	>.99
Medical attention for nephropathy (n = 32 072)	92.4	96.0	3.6	91.1	95.3	4.2	−0.6	.13	−0.5 (−1.2 to 0.2)	.73
Childhood immunization status (n = 12 636)	87.2	94.2	6.9	84.7	89.0	4.3	2.6	.45	0.31 (−4.8 to 5.4)[h]	>.99
Colorectal cancer screening (n = 106 150)	79.4	83.3	3.8	77.8	81.6	3.7	0.2	.62	0.2 (−0.3 to 0.7)	>.99
Immunizations for adolescents (n = 16 380)	73.2	84.3	11.1	71.6	78.5	6.9	4.1	.07	1.3 (−2.5 to 5.2)[i]	>.99
Well-child visits										
First 15 mo of life (n = 9757)	92.8	NA	NA	88.8	NA	NA	NA	NA	NA[j]	NA
Third, fourth, fifth, and sixth years of life (n = 29 743)	90.7	91.4	0.8	87.9	90.2	2.3	−1.6	.05	−2.9 (−4.4 to −1.5)[k]	<.001

Abbreviations: HbA_{1c}, glycated hemoglobin; NA, not applicable; PCP, primary care practitioner.

[a] Reported *P* values are adjusted for Holm-Bonferroni correction except for the primary outcome of the Composite Measure Score.

[b] The composite measure score indicates the probability of achieving a quality measure for which a patient was eligible in a given year, with a range between 0% and 100% (with higher percentages indicating higher quality achievement). The score was computed by taking the mean of the number of measures achieved divided by the number of eligible measures by patient, weighted by a patient's number of eligible measures. It included the 13 pooled individual Healthcare Effectiveness Data and Information Set–based quality measures in this table that were also incentivized in the prior pay-for-quality program and thus had preintervention and postintervention data available. An improvement in quality would require the mean probability of achievement to increase across all eligible measures, not just a single measure.

[c] Data only available for 2014-2016.

[d] Data only available for 2014-2016.

[e] Data only available for 2013-2016.

[f] Data only available for 2013-2016.

[g] Data only available for 2014-2016.

[h] Status only available for 2013-2016.

[i] Data only available for 2013-2016.

[j] Data only available for 2013-2015 and therefore cannot be represented in this data set.

[k] Data only available in 2013-2016. Of the pediatric members who did not meet the well-child visit measure, 72.8% in the 3PC group had at least 1 PCP visit, with a mean of 2.4 visits, and 73.2% in the non-3PC group had at least 1 PCP visit, with a mean of 2.5 visits. This likely suggests that the differences in access or follow-up were quite small between the groups.

Notes: Significant differential improvement in blood pressure control among patients with diabetes and advance care planning in hybrid payment group versus control group. *Source: Navathe AS et al. Association Between the Implementation of a Population-Based Primary Care Payment System and Achievement on Quality Measures in Hawaii. JAMA. 2019 Jul 2;322(1):57-68.*

Beyond private payers in Hawaii, CMS has been testing 'advanced primary care models' at a national level using hybrid payments in Medicare for over a decade with promising 'leading indicator' results. These models led to fewer emergency department visits and hospitalizations, while producing modest gains in chronic disease management and prevention. In Comprehensive Primary Care (CPC, 2012-2016), hospitalizations and emergency department visits increased by 2% less among participating practices.[40] This represented a statistically significant relative reduction of 8,150 hospitalizations and 15,472 outpatient emergency department (ED) visits over the four years of the program. Importantly, practices with greater access to resources or more experience with care delivery transformation were more likely to reduce growth in expenditures (~2%). This highlights the importance of providing practices with resources for successful and sustainable transformation.

Comprehensive Primary Care Plus (CPC+, 2017-2021) similarly saw a 2% reduction in ED visits that emerged early and persisted across the five program years.[41] A 2% reduction in hospitalizations emerged in program years 3 and 4 and was driven by reductions in medical admissions, suggesting that these admissions were prevented by improved outpatient care. Furthermore, over the five years of the program, the percentages of beneficiaries who received all recommended services for diabetes increased by about 1 percentage point and of females who received breast cancer screening increased by about 1 percentage point. CPC+ had more favorable effects among concurrent MSSP participants, again suggesting that practices can build experience with care transformation with time and proper investment. These demonstrations suggest that transforming primary care payment can have important implications for beneficiaries with multiple chronic conditions, such as decreasing emergency department visits and hospitalizations while improving the delivery of robust well-integrated and well-coordinated primary care.

Another approach would be to continue expansion of alternative payment models (APMs), which increase accountability for cost and quality outcomes onto providers, shifting provider focus to value. This will require continued support for the CMS Innovation Center. There is some evidence that APMs can improve care for beneficiaries with both high and low burdens of chronic disease. A great example has been the accountable care organization (ACO) model.

40 Evaluation of the Comprehensive Primary Care Initiative: Fourth Evaluation Report. Mathematica. 2018 May. https://downloads.cms.gov/files/cmmi/CPC-initiative-fourth-annual-report.pdf
41 Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Final Evaluation Report. Mathematica. 2023 Dec. https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fifth-annual-eval-report

The ability of ACOs to improve quality measures and drive savings is particularly evident through their performance in the MSSP. Notably, physician-led ACOs are more successful than other ACOs. An evaluation studying differential changes in annual per-beneficiary utilization and total Medicare spending found that physician-led ACOs demonstrated significant improvements and growing savings for Medicare over a 3-year period in the MSSP.[42] Among the physician-group led ACOs, the study reported statistically significant reductions (differential change) for annual per-beneficiary any-cause hospitalization (-0.008), ED visits (-0.018), and post-acute facility stays. In contrast, hospital-led ACOs showed statistically significant reductions in ED visits (-0.009) only. Per-beneficiary spending reductions were significant in both ACO types, but larger for physician-led ACOs.[43] The spending reductions observed in ACOs led by physicians resulted in a net savings of $256.4 million for Medicare in 2015, while the corresponding spending reductions in ACOs integrated with hospitals were offset by bonus payments.[47] The integration facilitated by ACOs, particularly those led by physicians, can be important among beneficiaries with chronic conditions, as fragmented management of these conditions is known to drive a significant portion of overall Medicare spending.

Another evaluation analyzed outcomes of ACOs entering MSSP in 2012 through 2014, stratifying beneficiaries as either low-risk or high-risk based on the number of chronic conditions. The authors identified improvements in quality measures such as a reduction in annual hospitalizations, with statistically significant reductions among the high-risk patients in 2012 only and reductions for low-risk patients in both 2012 and 2013. Among hospitalizations for ambulatory care-sensitive conditions in the 2012 cohort, participation in MSSP was linked with a decrease in the proportion of patients hospitalized for chronic obstructive pulmonary disease or asthma (−0.05 percentage points, or 4.8% of the precontract mean). However, there were significant increases in the proportion hospitalized for congestive heart failure (0.05 percentage points, or 3.6%) and cardiovascular disease or diabetes (0.07 percentage points, or 3.5%).[44] High-risk patients experienced a substantially greater absolute decrease in spending (-$686 versus -$207), while relative reductions were similar between the two groups (-3.0 percent versus -2.9 percent). The notable decrease in spending and admissions observed in the 2013 cohort predominantly stemmed from reductions among patients classified as low-risk.

In another evaluation of nearly a dozen ACOs, PCP clinical staffing type played a pivotal role in influencing financial gains within ACOs.[45,46] An increase of one primary care visit per

[42] McWilliams JM et al. Medicare Spending After 3 Years of The Medicare Shared Savings Program. New England Journal of Medicine 379.12 (2018): 1139-1149.
43 *Ibid.*
[44] McWilliams, JM, Chernew ME, and Landon BE. Medicare ACO program savings not tied to preventable hospitalizations or concentrated among high-risk patients. Health Affairs 36.12 (2017): 2085-2093.
[45] Lemaire N and Singer SJ. Do Independent Physician-Led ACOs Have a Future? NEJM Catalyst 4.1 (2018).
[46] Coyne J et al. Financial Performance of Accountable Care Organizations: A 5-Year National Empirical Analysis. Journal of Healthcare Management 69.1 (2024): 74-86.

beneficiary-year administered by PCPs resulted in significant average gains of $49.65, $40.84, and $27.31 in earned shared savings per beneficiary for hybrid, hospital-led, and physician-led ACOs, respectively ($p < 0.001$). These findings underscore the impact of primary care providers within the ACO framework, especially for managing chronic conditions.

To date, the MSSP has saved CMS $1.8 billion by its own estimates.[47] When advanced primary care models have overlapped with ACOs, the synergies have yielded even larger savings, up to 3% lower Medicare spending per beneficiary or about $300 in annual savings per beneficiary.[48] This provides supportive evidence for CMS using its existing authority to implement hybrid primary care payment in MSSP.

ACOs are an exemplar of the positive shifts in care that APMs can create for Medicare beneficiaries. Other APMs have also been successful in changing practice patterns toward greater quality and cost-efficiency. However, we should also note that most, if not all, APMs still rely on the Medicare Physician Fee Schedule. This can create complexities and conflicts in the financial incentives for many physicians.

This leads me to point out that CMS needs additional tools to manage the FFS program more effectively. The FFS system is only getting more complicated as new technologies and drugs emerge and as clinical care becomes increasingly specialized and sub-specialized.[49] There are many factors to consider in improving physician payment, and no single entity has all of the required expertise. Payment changes will require multi-disciplinary experts to provide input to CMS who could be convened as a panel.[50] Ultimately, CMS needs the ability to catalyze a new care model and that will require adapting the fee schedule to accommodate approaches like a PBPM payment.

A recent effort to address the undervaluation of primary and outpatient care led to evaluation and management (office visit) weights being increased in 2021 by up to 20%. This also resulted in a corresponding decrease in weights to other services to maintain budget neutrality. However, this was a refinement in the current payment structure rather than enablement of a shift. Looking forward, it will be important to give CMS the ability to scale payment approaches that support better care for beneficiaries with chronic diseases.

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[47] Medicare Shared Savings Program Saves Medicare More Than $1.8 Billion in 2022 and Continues to Deliver High-quality Care. CMS. 2023 Aug 24. https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high

[48] Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Final Evaluation Report. Mathematica. 2023 Dec. https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fifth-annual-eval-report

[49] Hunter K, Kendall D, Ahmadi L. "The Case Against Fee-for Service Health Care. September 9, 2021. https://thirdway.imgix.net/pdfs/the-case-against-fee-for-service-health-care.pdf

[50] National Academy of Medicine; Finkelman EM, McGinnis JM, McClellan MB, et al., editors. Vital Directions for Health & Health Care: An Initiative of the National Academy of Medicine. Washington (DC): National Academies Press (US); 2017. 9, Payment Reform For Better Value And Medical Innovation. Available from: https://www.ncbi.nlm.nih.gov/books/NBK595162/

Telehealth represents one example of an opportunity for improved care management of patients with multiple chronic conditions. When so much of patients' time is spent traveling to and from office visits, capitalizing on technological advancements could offer one means by which this burden can be reduced, and health outcomes can be improved. For example, one care coordination approach using telehealth for chronically ill Medicare beneficiaries demonstrated significant savings of approximately 7.7-13.3% ($312-$542) per person per quarter.[51] Reforms to primary care payment, which enable investment in practice-transforming programs such as telehealth in this study, can improve the care of beneficiaries with multiple chronic conditions. While telehealth is a great potential area of opportunity, implications of accessibility and feasibility must be taken into consideration given the nuances of supporting an aging population. Furthermore, telehealth, like other services, may be susceptible to overuse if paid for in the usual FFS structure.

Primary care practices can also improve the health of patients with multiple chronic conditions by hiring community health workers (CHWs). A CHW is a "frontline public health worker who is a trusted member of the community served, which enables the worker to serve as a liaison between health/social services and the community to facilitate access and improve the quality and cultural competence of service delivery."[52] CHW visits can help patients improve their self-efficacy and health literacy in managing multiple chronic conditions. Randomized controlled trials of CHWs have demonstrated improvements in hospital admissions, hospital length of stay, chronic disease control, and mental health for patients with chronic conditions.[53] These programs have also improved measurable health outcomes such as hemoglobin A1C, Body Mass Index, cigarettes per day, and blood pressure.[54] In Medicaid, CHWs have been estimated to return an annual $2.47 for every dollar invested.[55] Hospital-based health systems across the country have begun to incorporate CHW programs, such as the IMPaCT (Individualized Management for Patient-Centered Targets) program at the University of Pennsylvania. Reforming primary care payment can enable practices to invest in CHW programs, one such innovation in care management to improve the care of patients with chronic disease.

Acting now is paramount to improve the landscape of chronic condition care management and payment. Unlike in Medicare Advantage, where we have seen substantial innovation to meet

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[51] Baker LC, Johnson SJ, Macaulay D, Birnbaum H. Integrated telehealth and care management program for Medicare beneficiaries with chronic disease linked to savings. Health Aff (Millwood). 2011 Sep;30(9):1689-97. doi: 10.1377/hlthaff.2011.0216. PMID: 21900660.

[52] "Community Health Workers." American Public Health Association. https://www.apha.org/apha-communities/member-sections/community-health-workers/

[53] Kangovi S, Mitra N, Grande D, et al. Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial. *JAMA Intern Med.* 2014;174(4):535–543. doi:10.1001/jamainternmed.2013.14327

[54] Kangovi S, Mitra N, Grande D, Huo H, Smith RA, Long JA. Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial. Am J Public Health. 2017 Oct;107(10):1660-1667. doi: 10.2105/AJPH.2017.303985.

[55] Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment. Health Aff (Millwood). 2020 Feb;39(2):207-213. doi: 10.1377/hlthaff.2019.00981.

beneficiary needs on a near real-time basis, traditional Medicare requires Congressional action to stay up to date. It is imperative to give CMS the tools and authorities it requires to address chronic diseases among Medicare beneficiaries. Thank you for the opportunity to share my testimony with you today.

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