Testimony of G. Alan Kurose, MD MBA FACP

Before the United States Senate
Committee on the Budget

October 18, 2023

Chair Whitehouse, Ranking Member Grassley, and members of the Committee, thank you for inviting me to address the topic of managing patient care and population health to reduce healthcare costs. Happily, when done correctly, such efforts also typically improve the patient's experience of care and their health outcomes. But this work is far from simple.

My name is Dr. Al Kurose. In my first career as a primary care internist, I saw patients every Monday through Friday in the same suburban community office practice for almost twenty years. Fifteen years ago, I transitioned to a second career as CEO of Coastal Medical, a large primary care practice in Rhode Island that transformed itself into a nationally recognized, tech-enabled, data-driven Accountable Care Organization (ACO) with consistently high performance on cost, quality, and patient experience of care. For the last two and a half years, Coastal has been a part of the Lifespan Health System. I served as Senior VP of Primary Care and Population Health for the system for most of that time. I am grateful for the many innovative federal programs, such as Meaningful Use, the Medicare Shared Savings Program (MSSP), CPC+, and others that have been crucial enablers of much of this rewarding and complex work.

I also served for the last five years as a co-chair of the RI Health Care Cost Trends Steering Committee, a publicly convened group of payers, providers, employers, patient advocates, and regulators collectively committed to controlling the growth of healthcare costs in Rhode Island. I currently serve as Board Chair of the Rhode Island Foundation, one of the twenty largest community foundations in the country. The opinions expressed here are my own.

I will make three main points.

1. Despite the daunting complexities we face and our track record to date, as a healthcare industry, I believe **we *can* transform how care is delivered and paid for in ways that will reduce costs and make things better for patients.** In many cases, we already know what to do. Executing sustainably and at scale is challenging.

2. **Primary care is the foundation of any high performing healthcare delivery system and right now, primary care is in crisis**. Access to primary care is a problem in many if not most communities, and provider burnout is rampant. Help is needed in the form of workforce development, enhanced compensation, robust team-based care, and primary care capitation.

3. P**rimary care is *necessary but not sufficie**nt*** to sustainably achieve the Triple Aim of better care and better health at a lower cost. The efforts of primary care driven models of

> accountable care, by themselves, to control total cost of care can be overwhelmed by the effects of pricing and the economic behavior of other providers. I believe **continued incremental movement away from fee-for-service payment and toward prospective payment and value-based payment models - for hospitals, specialists, and primary care - will be needed** to sustainably mitigate unrelenting increases in U.S. healthcare costs.

Have ACO's been effective, and which models have performed best? What has Coastal's experience been?

The 2021 National Academy of Sciences Engineering and Medicine (NASEM) Report "Implementing High Quality Primary Care" summarizes the available evidence on effectiveness of ACO's as follows:

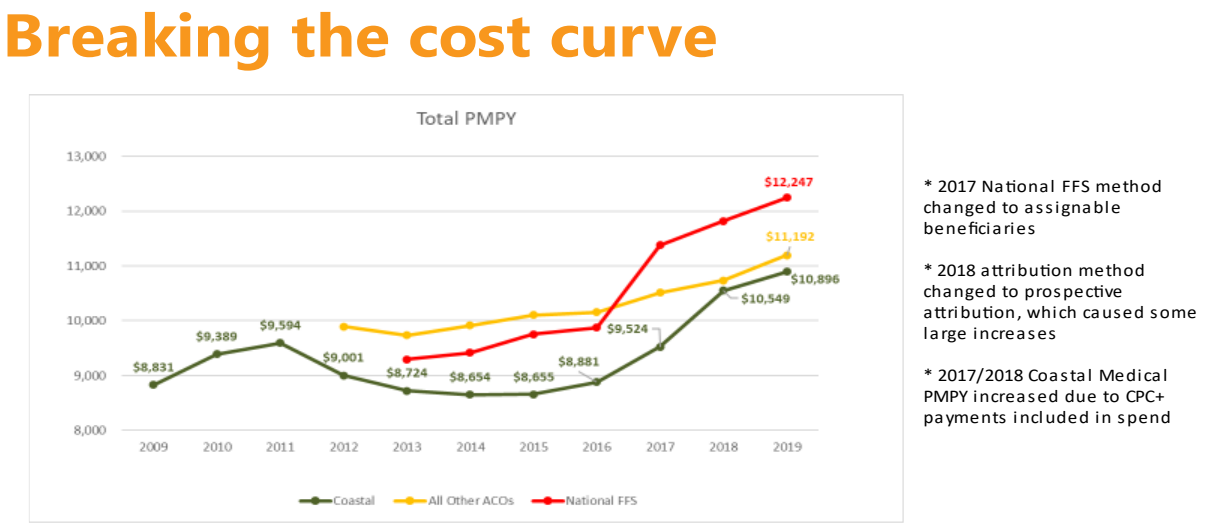
> "In general, research on the impact of ACO's shows modest savings in total spending alongside quality and patient satisfaction improvements…Research has demonstrated that ACO's with a higher share of PCMH (Patient Centered Medical Home) practices and a greater percentage of PCP's (Primary Care Physicians) perform better on cost and quality outcomes. Similarly, physician-led ACO's, compared to hospital-integrated ACO's, produce greater savings."

Dranove and Burns in their 2021 book *Big Med* add the observation that in the Medicare Shared Savings Program "Smaller ACO's (with a mean number of beneficiaries less than ten thousand) achieved greater net savings per beneficiary than larger ACO's." This finding highlights the challenge of managing the total cost of care of populations at scale. They also make a salient observation echoed by many ACO's:

> "What none of these analyses (of CMS ACO savings) addressed was how much money, time, and energy providers had to invest up front to reap these savings."

The issue of new costs for ACO's - both one-time and recurring - was highly relevant at Coastal, which early on built out new human and technological infrastructure to an extent disproportionate to its relatively small MSSP ACO population size of 10,000 beneficiaries at the time. One advantage was that Coastal took an all-payer approach early in its journey of accountable care. The second was that Coastal's ACO experience was fortunately significantly more positive than the MSSP average. Early on, Coastal was able to reinvest 85% of value-based revenue to support value-based care, with the remaining 15% allocated to physician and staff incentive compensation. In terms of impact on total cost of care, Coastal not only "bent" it's cost curve for population total cost of care starting in 2012, it "broke" it (see green line in the graph below).

Fig. 1. ***Breaking the Cost Curve*****, 2019**

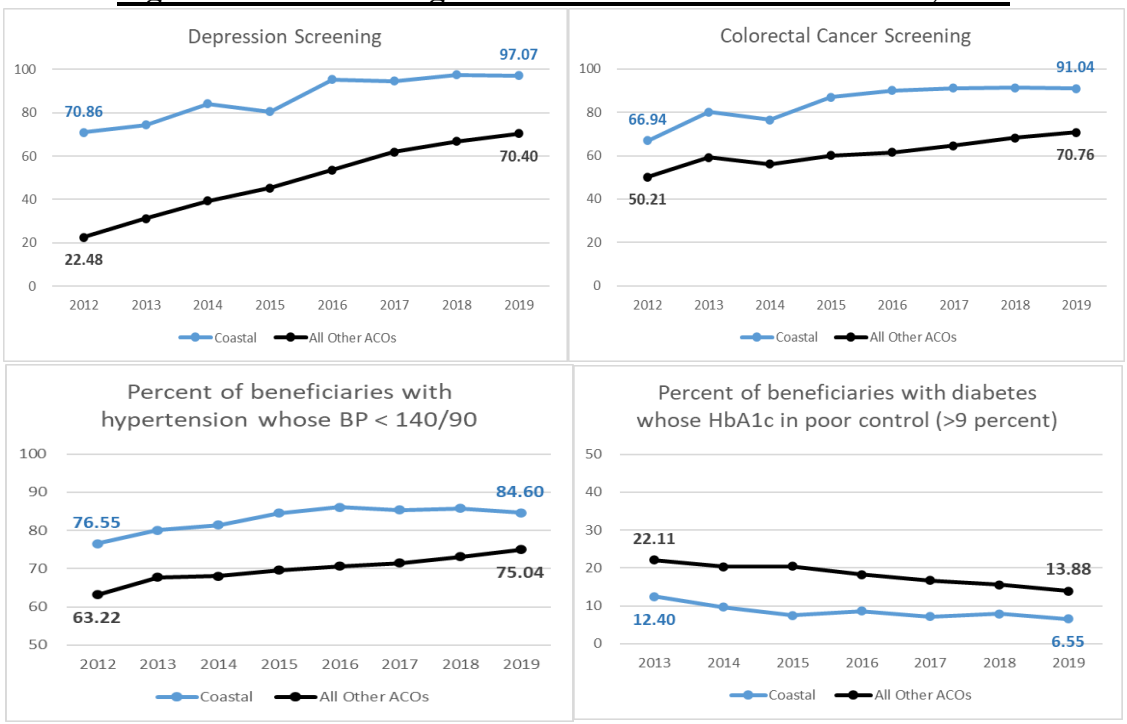


Courtesy of Coastal Medical

At Coastal, some of the largest cost savings were related to observed reductions in visits to hospital emergency departments, admissions to hospitals, and readmissions to hospitals. Coastal's hospital admissions in the MSSP were reduced by 25% in the first three years.

From 2012 to 2019, Coastal also achieved steady improvements in health screening and control of chronic conditions, as exemplified in the graphs below.

Fig. 2. Health Screening and Control of Chronic Conditions, 2019



courtesy of Coastal Medical

The data presented above ends with 2019, by design. Beginning in 2020, the pandemic created significant volatility in utilization of services and cost performance and impacted patient and provider behavior in numerous complex ways for ACO's and the entire delivery system. In Rhode Island, COVID-19 restrictions caused an abrupt reduction in the use of in-person health care in 2020, which in turn caused a sharp drop in per capita spending on healthcare. Utilization rebounded in 2021, with large year over year increases in commercial and Medicare spending. Labor shortages, diminished clinical revenue, wage increases for staff, and fluctuating demand for services were commonly voiced challenges across a broad range of provider types. I've chosen to largely exclude pandemic-related issues from this testimony, in favor of pattern recognition and lessons learned over a longer period of less turbulent times. But I would be remiss not to mention that it is well accepted that the pandemic exposed longstanding inequities in access to care and health outcomes and revealed the economic fragility of many types of providers, including primary care. It also drove large numbers of healthcare workers at every level from the profession.

How Have Coastal and Similar ACO's Been Able to Impact Costs, Patient Experience and Outcomes?

There is an oft-repeated truism that when it comes to managing total cost of care for populations, that "there is no silver bullet." What then is the solution? Part of the answer, based on the experience of Coastal and other physician led ACO's, seems to be an extensive portfolio of centralized clinical programs that go beyond what most small traditional primary care offices can offer. At Coastal, that portfolio includes:

- "Coastal 365" urgent primary care clinics open weeknights, weekends, and holidays
- Disease management programs for patients with congestive heart failure, COPD, diabetes, and hypertension
- Nurse care managers who manage panels of high-risk patients and round on patients in hospitals and nursing homes, as well as patient navigators and social workers
- A Transitions of Care team that reaches out to patients after discharge from a hospital, emergency department, or nursing home to reconcile medications, ensure appropriate primary care and specialty follow-up, and solve any problems with access to care
- Pharmacy programs that include a prescription refill program and antibiotic and narcotic stewardship, as well as participation in disease management and home visit programs
- Integrated behavioral health program
- Non-operative orthopedic/musculoskeletal health program
- Multidisciplinary home visit program
- Strong affiliation with HopeHealth, a high performing palliative care and hospice provider

Each ACO customizes their portfolio of programs based on available resources and patient needs. Benefits of such programs go well beyond controlling utilization and costs to improve experience of care and health outcomes for patients, especially those with chronic illnesses.

ACO's also need new specialized business capabilities that again go beyond what would be in scope for a more traditional primary care practice. At Coastal these include:

- Extensive capacity to measure and report quality measures
- New patient facing technologies for communication and clinical monitoring
- Analytics based on claims and the electronic medical record (EMR) to generate actionable reports
- A centralized team to manage and track referrals to specialty care
- A centralized team to answer patient calls and schedule appointments across all open offices to optimize care in the outpatient setting
- Actuarial support to inform the viability of contracted payment models specific to each covered population of patients.

Again, each ACO builds out such capabilities differently, based on available resources and needs.

At the Highest Level, How Does the Experience of Physician-led ACO's Speak to the Challenge of Managing Care to Control Costs?

The answer here goes to my first main point which is that as a healthcare industry, **we *can* transform how care is delivered and paid for in ways that will reduce costs and make things better for patients,** and in many cases, we already know what to do. The MSSP experience tells us that executing at scale is challenging, but that smaller physician-led ACO's *have* developed capabilities and implemented programs that have moved the needle on managing total cost of care. We can apply the lessons learned from that experience more broadly – to both different types of provider organizations – and to different payer populations. At Coastal, many (not all) of the lessons from the MSSP experience were transferable to Medicare Advantage, Medicaid, and commercial ACO care models and payment models, and the converse was also sometimes true as value-based care lessons from experience with Blue Cross Blue Shield of RI and other payers helped inform Coastal's work under the MSSP.

The portfolio of clinical services that Coastal offers today goes well beyond what I could ever have imagined when I was practicing primary care physician there in the early 2000's. Management of chronic illness at Coastal today truly improves quality of life for patients, and all patients benefit from more timely and convenient access to care that now also includes telemedicine. The right care in the right place at the right time helps patients get better sooner, more safely, and with less expense. Under value-based payment, this offers a classic opportunity to do well by doing good.

A particularly cogent example of the value of providing the right care in the right place at the right time is found in Coastal's Diabetes Management Program. That program utilizes a team-based care model with pharmacists, nurses, and specially trained medical assistants; and remote patient monitoring featuring glucose meters that use cellular networks to automatically transmit blood sugar results and make them available to the care team in near to real time. This allows the team to reach out and interact with a diabetic patient in a timely manner if their sugar is getting too high or too low. By identifying this type of problem early, and speaking to the patient by phone or videoconference, the clinical team can explore the cause of the problem, and in many cases recommend immediate action to remedy the issue. In this way, the team can often help a patient to resolve a situation that might otherwise worsen and require an emergency department visit or hospital stay without such timely intervention. In the old model of primary care, more than a few patients in this circumstance might have simply entered the high or low blood sugar reading in their log book to be reviewed at the time their next visit in a few months, losing the opportunity to prevent a potentially significant health episode before that time.

Why has Primary Care Access Become So Problematic, and What Can We Do About It?

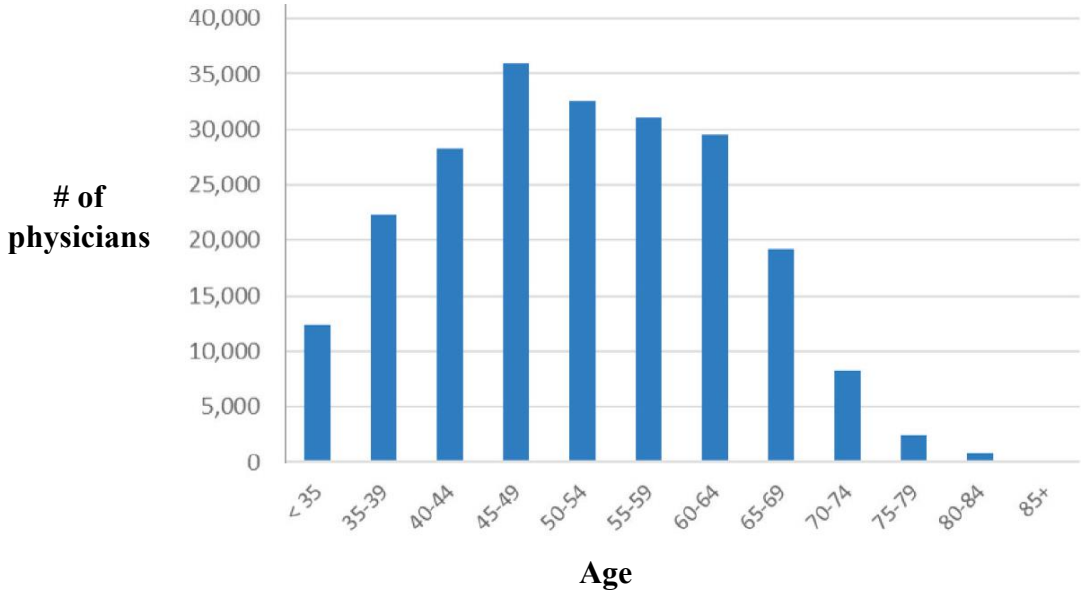
The 2021 NASEM report referenced above convincingly asserts that "high quality primary care is the *foundation* of a high-functioning health care system…and people in countries and health systems with high quality primary care enjoy better health outcomes and more health equity". The authors go on to assert that this foundation is crumbling in the U.S.:

> "Visits to primary care are declining, and the workforce pipeline is shrinking, with clinicians opting to specialize in more lucrative health care fields."

Chairman Sanders, in the Senate HELP Committee Hearing on September 21st, addressed the current crisis of access to primary care by stating "Everybody here knows we have a crisis. When you go home, your constituents will tell you, "I can't find a doctor."" He referenced an opinion piece by Elizabeth Rosenthal in *The Washington Post* in which she stated that more than 100 million Americans don't have usual access to primary care. That number has doubled since 2014.

A look at the age distribution of primary care physicians (PCP's) in the US in 2017, taken from the 2021 NASEM report referenced earlier, shows that PCP workforce demographics are clearly skewed to middle age and older, with 25 percent of PCP's being 60 years and older.

Fig. 3. Age distribution of US primary care physicians



Source: Peterson, et al., 2018 as cited in 2021 NASEM Report

These PCP workforce demographics are of particular concern given the demographic "bulge" in the US population of baby boomers that began turning 65 in 2011. In addition, the "great resignation" in healthcare associated with the pandemic only exacerbated workforce shortages since the time this data was collected. These factors appear to have created a perfect storm to precipitate the crisis of access in primary care that is now squarely upon us.

As to what can be done to address this crisis of access, workforce development initiatives such as those supported by the legislation coming out of the HELP Committee and enhancements to PCP compensation as recommended in the NASEM report both resonate strongly as requisite immediate next steps.

I will add two more. First, given the magnitude of the mismatch between current and future primary care supply and demand addressed above, we will need to experiment further with disruptive innovations in primary care delivery. Strengthening and expanding the care team so that clinicians other than the physician can deliver more patient care will take some of the pressure off of PCP's, and current leadership at Coastal has already moved forward on this work. Looking ahead as an industry, scope of practice regulations in some states may need to be modified to enable such changes in practice. Patient expectations may also need to change as some of the more routine interactions of patients with their PCP may become a thing of the past.

Requisite in this care transformation work will be listening carefully to PCP's, many of whom are experiencing significant burnout. Restoring professional satisfaction and a sense of personal agency amongst practicing PCP's is a "must have". In that context, care redesign must be collaborative, and driven by insights from the doctors and the rest of the clinical team.

Implementing primary care capitation as a substitute for fee-for-service payment can also improve the professional experience of PCP's by relieving the pressure of a schedule packed with back-to-back visits, all day long. Under primary care capitation, provider organizations are paid a risk adjusted fixed amount by the insurer "per member per month" (PMPM) for each patient receiving primary care, regardless of whether or not they receive in person care or other services during that time period. When providers are compensated for caring for a panel of patients instead of for each visit they provide, they are then empowered to spend more time on the care of the patients who need them the most, whether that be to call a patient or a family member or a consulting physician, or to see the patient for what would have been a billable visit under fee for service. The pressure to maintain a full schedule of visits to maintain a satisfactory income is relieved, and physicians can use their judgment about how to best spend their time in caring for the patients they serve.

Nesting a primary care capitation payment model within a larger contract structure with accountability for total cost of care and quality (such as the MSSP) preserves a complete set of Triple Aim incentives. A related point worth making is that value-based payment models at the organization level, with their built-in incentives intended to influence physician behavior, are not always translated into how physicians are compensated. And if those incentives aren't translated into physician compensation, they aren't as likely to be effective. This potential disconnect is increasingly relevant for primary care physicians given the observed consolidation in primary care, with one study referenced in the 2021 NASEM report indicating that 44% of PCP's were working in a practice owned by a hospital or health system as of 2017.

What Else Can Be Done in Terms of Care Delivery to Mitigate the Unrelenting Increases in U.S. Healthcare Costs?

In the preceding sections of this testimony, the focus has been largely on primary care and physician led ACO's. But it is important to remember that primary care only receives about 5% of total revenue in U.S. healthcare, and Coastal's positive experience notwithstanding, many ACO's of all types have learned the hard way that going at risk for total cost of care can be hazardous if your scope of influence over the care of your covered population of patients is limited. And the influence of primary care as a stand-alone *is* limited.

Early in my administrative career I heard about the balloon analogy for healthcare costs, which says if you squeeze one part of the cost balloon, it will bulge out somewhere else. In the work of the RI Cost Trend Steering Committee, we have seen this play out. One year, pharmaceutical costs are a big driver of cost trend, with utilization stable but prices rising. The next year, outpatient hospital services are a big cost driver. And as noted above, the pandemic was highly disruptive to management of cost and utilization performance. Providers and payers had to absorb those impacts on value-based payments and adapt accordingly.

Advocacy for aligned financial incentives across as many parts of the healthcare ecosystem as possible seems to be a logical approach to moving forward on containing costs. In practical terms, this translates to a recommendation for **continued incremental movement away from fee-for-service payment and toward prospective payment and value-based payment models - for hospitals, specialists, and primary care.** Thank you again for the opportunity to offer this testimony for your consideration.