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On

Achieving Health Efficiency through Primary Care

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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.

Recommendations

I. **Grant CMS the authority to pay primary care practices through a hybrid primary care payment model.**
II. **Address inefficiencies in the Medicare Physician Fee Schedule with independent and representative expert input.**

Context

III. **A robust primary care infrastructure is required for a cost-efficient system that produces more health for each dollar spent.**
IV. **The current fee-for-service payment system produces misalignment between provider financial incentives and patient health that leads to systematic underinvestment in primary care.**
V. **There is substantial experience with hybrid payments for primary care that indicates both benefits and feasibility.**
VI. **A hybrid primary care payment system is a linchpin for reducing federal spending on health care.**

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Mr. Chairman, Ranking Member Grassley, and members of the Committee, thank you for this opportunity to testify regarding our nation's primary care crisis. Accessing timely and high-quality primary care is a challenge for many people in the United States. Primary care practices are struggling to meet the demand despite long hours for clinicians. Physician burnout is at an all-time high with rates over 50%, and primary care clinicians are among the most affected.[1,2,3] The primary care workforce is consequently shifting away from physicians to other clinician types, such as nurse practitioners.[4,5,6,7] Moreover, the advent of new technologies such as telehealth increases administrative burden and

[1] Shanafelt TD, Boone S, Tan L, et al. Burnout and Satisfaction with Work-Life Balance Among US Physicians Relative to the General US Population. Arch Intern Med. 2012;172(18):1377–1385. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1351351

[2] West CP, Shanafelt TD, Kolars JC. Quality Of Life, Burnout, Educational Debt, and Medical Knowledge Among Internal Medicine Residents. JAMA. 2011 Sep 7;306(9):952-60. https://jamanetwork.com/journals/jama/fullarticle/1104293

[3] Berg S. These 6 Physician Specialties Have the Most Burnout. American Medical Association. 2023 Aug 29. https://www.ama-assn.org/practice-management/physician-health/these-6-physician-specialties-have-most-burnout

[4] Barnes H, Richards MR, McHugh MD, Martsolf G. Rural and Nonrural Primary Care Physician Practices Increasingly Rely on Nurse Practitioners. Health Affairs (Millwood). 2018 Jun;37(6):908-914. doi: 10.1377/hlthaff.2017.1158. https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1158

[5] March 2022 Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Commission (MedPAC). https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/

[6] Meeting Pennsylvania's Primary Care Needs: The Nurse Practitioner Workforce. Leonard Davis Institute of Health Economics, University of Pennsylvania. https://ldi.upenn.edu/wp-content/uploads/archive/Penn%20LDI%20Brief_PA%20Nurse%20Practitioners%20and%20Primary%20Care.pdf

[7] Nurse Practitioners in Primary Care. American Association of Nurse Practitioners (AANP). https://www.aanp.org/advocacy/advocacy-resource/position-statements/nurse-practitioners-in-primary-care

added complexity to practice operations.[8] Consequently, U.S. medical students are foregoing primary care in favor of other specialties. [9,10,11,12]

Why is our primary care system in crisis? This is at least in part due to the current fee-for-service (FFS) payment system, which is transactional in nature rather than comprehensive. The system currently pays for activity, not health. This leads to an unsustainable model of clinicians churning through 30 to 40 visits per day to keep practice finances stable. The ever-increasing number of billing codes, including those for telehealth services and patient portal messaging, places tremendous administrative burden on practitioners. Often, it is not worth it for a primary care practice to bill for activities that are not face-to-face because the cost to bill is higher than its resulting payment. As a result, the current system is unsustainable and cannot deliver the robust primary care infrastructure Americans and taxpayers desperately ***need*** and ***deserve***.

There is also opportunity to address inefficiencies throughout the Medicare Physician Fee Schedule (MPFS), extending beyond primary care services. The current payment rates in the MPFS, determined by Relative Value Unit (RVU) weights, create strong incentives for the delivery of procedural services. This is one factor leading to underinvestment in cognitive, diagnostic, and supportive services such as primary care. Moreover, the misaligned incentives result in higher Medicare spending without commensurate improvements in beneficiary health.

Given this backdrop, I would like to highlight how Congress can enable transformation of primary care and address inefficiencies in the MPFS. I would like to make two recommendations.

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RECOMMENDATIONS

I. Grant CMS the authority to pay primary care practices through a hybrid primary care payment model.

Shifting to a hybrid primary care payment model is imperative to strengthen primary care infrastructure in the United States and support more cost-efficient health care. In a hybrid payment model, primary care clinicians receive both monthly payments for each Medicare beneficiary, adjusted for their level of illness, as well as the usual method of FFS payments for selected services provided at visits. This type of hybrid payment is feasible because it does not disrupt cash flow to physician groups, including small,

[8] Dang S, Olsan T, Karuza J, Cai X, Gao S, Intrator O, Li J, Gillespie SM. Telehealth in Home-Based Primary Care: Factors and Challenges Associated with Integration into Veteran Care. J Am Geriatric Soc. 2019 Sep;67(9):1928-1933. doi: 10.1111/jgs.16045. https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.16045

[9] Nicholson S, and Souleles NS. 2001. Physician income expectations and specialty choice. Cambridge, MA: National Bureau of Economic Research.

[10] Pugno PA, Schmittling GT, Fetter GT, Kahn NB. Results of the 2005 National Resident Matching Program: Family Medicine. Fam Med. 2005; 37:555-64.

[11] Knight V. American Medical Students Less Likely to Choose to Become Primary Care Doctors. Kaiser Health News. 2019 Jul 3. https://kffhealthnews.org/news/american-medical-students-less-likely-to-choose-to-become-primary-care-doctors/

[12] Weida NA, Phillips Jr. RL, and Bazemore AW. 2010. Does Graduate Medical Education Also Follow Green? Archives of Internal Medicine 170(4):389–390.

independent primary care practices, while delivering greater flexibility. Practices can use the flexibility and stability created by a predictable flow of monthly payments to deliver more patient-centered care, harnessing technology such as telehealth when it is efficient and effective, and through a staffing model that better represents today's primary care workforce.

Hybrid primary care payments cannot be implemented at scale without Congressional action. Notably, the Center for Medicare and Medicaid Services (CMS) has conducted demonstration projects with hybrid payments (e.g., Comprehensive Primary Care Plus). It also has the authority to implement hybrid payments in the Medicare Shared Savings Program (MSSP),[13] which is a step it should take. However, what we need now to strengthen the nation's primary care infrastructure must be *nationwide* and *permanent*. Demonstration projects by nature are time-limited and uncertain, leading to challenges in providing sufficient technical assistance and infrastructure support, as well as a lack of investment from providers. Consequently, it has been difficult to garner multi-payer alignment. This has led to physicians receiving hybrid payment and the usual FFS method simultaneously, complicating operations for primary care practices. Yet, regardless of these limitations, there have been promising results – such as decreases in hospitalization and emergency department visits and increases in quality.

To catalyze practice transformation at scale requires changes to Medicare payment that private payers follow, such as changes to the MPFS. Simply put, until the majority of revenue to primary care practices comes from a hybrid payment system, we are unlikely to see any transformative shift in how care is delivered nationwide. This transformative shift is critical because it will enable the scaling of leading indicators into lower spending. Only through Congressional action can CMS scale hybrid payments past this 'tipping point' of transformation across the nation.

II. Address inefficiencies in the Medicare Physician Fee Schedule with independent and representative expert input.

Fee schedule inefficiencies exist throughout the MPFS, creating strong incentives to perform procedural services. This results in higher Medicare spending without commensurate improvements in beneficiary health.[14] There are many factors that contribute to inefficiencies in the fee schedule, such as the amount of time and resources needed to collect data required to perform updates, and a methodology that heavily weights time and intensity without considering medical evidence of health benefit. These methodological challenges are compounded by rapid changes in medical technology as well as experience and learning by clinicians and health systems. These two dynamics influence the input factors within the methodology but change at rates that surpass the frequency with which weights can realistically be updated. Consequently, the fee schedule systematically over-weights procedures relative to diagnostic or supportive services.

[13] https://www.commonwealthfund.org/sites/default/files/2022-08/TO ATTACH AS DOWNLOAD_Commonwealth Fund_OASH Primary Care RFI_7.29.22.pdf

[14] Chant ED, Crawford M, Yang CW, Fisher ES, Morden NE, Ganguli I. Sources of Low-Value Care Received by Medicare Beneficiaries and Associated Spending Within US Health Systems. JAMA Network Open. 2023 Sep 5;6(9): e2333505. doi:10.1001/jamanetworkopen.2023.33505

These inefficiencies in fee schedule weights across service types, as well as the current process and structure of updating the weights, leads to undervaluing services provided by primary care physicians (PCPs). Further, much of what PCPs do, such as addressing social challenges, is not included in the codes of the fee schedule itself. Together, these two factors lead to underinvestment in primary care.

Implementing a hybrid primary care model, which can in part address underinvestment in primary care, will require changes to weights of codes within the per-beneficiary-per-month component as well as those that are continued to be paid FFS. Determining which services should be folded into a monthly payment versus paid separately via FFS is an important aspect of hybrid payment model design. High-volume, low-cost tasks such as patient messaging and common lab tests are best paid via per-beneficiary-per-month payments,[15] while additional important services such as immunizations may be best targeted through FFS payments. Evaluation and management services, through which most diagnosis and counseling occurs, may be paid in part through per beneficiary per month payments and in part through FFS, to preserve access. Importantly, implementing hybrid payments will have an impact on and require adjustments to the rest of the fee schedule across services delivered by primary care and other physicians.

Regardless of the proposed implementation of a hybrid payment model for PCPs, the MPFS needs to be reweighted to address inefficiencies that lead to wasteful spending. This will require not only a re-examination of the weights themselves, but also, more importantly the methodology and process of determining weights. An independent group, free of any interest in the results itself, but having the right expertise and balanced representation across specialties, will be well situated to contribute to this task. This addition can bolster the current process in place for reviewing fee schedule weights.

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CONTEXT

There is a substantial evidence base supporting the recommendations I propose. Below I review key aspects of the evidence. I do note, however, that these topics are areas of continued research activity and consequently new evidence is likely to emerge over time.

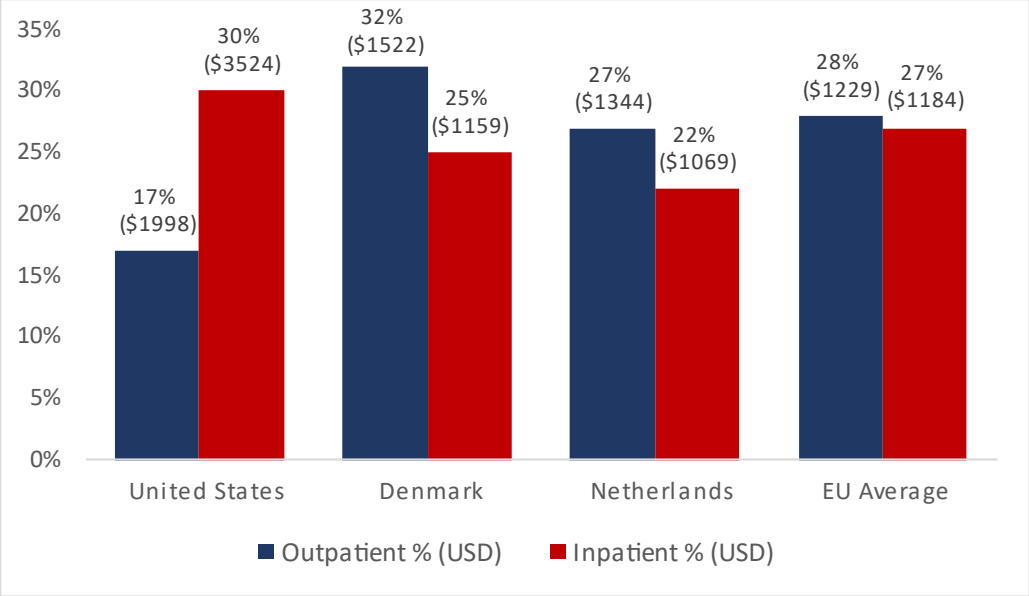
III. A robust primary care infrastructure is required for a cost-efficient system that produces more health for each dollar spent.

Medicare spends an estimated 4% of its total spending on primary care,[16,17,18] about $15 billion per year,

[15] 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, https://doi.org/10.1093/haschl/qxad024
[16] New "Scorecard" Finds Primary Care Funding and Physician Workforce Are Shrinking. AA of Family Physicians. 2023 Feb 24. https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/primary-care-scorecard.html
[17] 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
[18] 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.

which is a smaller proportion than many other developed countries.[19] This is also related to greater inpatient versus outpatient spending in the U.S. CMS spends 30% of its total spending on inpatient care ($3,524 per capita) and 17% of its total spending on outpatient care ($1,998 per capita).[20] These relative shares are the opposite of other high-income countries with robust investment in primary care, many of which have invested in hybrid payment systems.[21,22] For example, Denmark spends the highest share of its health spending on outpatient care (32% of its total spending, or $1,518 USD per person), while only 25% of its total spending is on inpatient care ($1,157 USD per person).[23] Similarly, the Netherlands spends 27% of its total spending ($1,431 USD per person) on outpatient care and only 22% ($1,067 USD per capita) on inpatient care.[24] Both of these countries are above the European Union (EU) average for outpatient spending (28% of total spending in the EU) and below its average for inpatient spending (27% of total spending in the EU) (Exhibit 1), highlighting how investment in a robust primary care infrastructure can keep patients out of the hospital and produce more health for each dollar spent.

Exhibit 1. Per capita spending on outpatient and inpatient services.



Note: Denmark and the Netherlands allocate a greater share of their total health spending to outpatient than inpatient services. They each spend above the EU average share on outpatient services and below the EU average share on inpatient services. In contrast, the United States spends a greater share on inpatient than outpatient services—above the EU average share for inpatient and below for outpatient. $ represents USD. *Source: Author's analysis of OECD Country Health Profiles, 2023.*

[19] OECD Country Health Profiles, 2023. https://www.oecd.org/els/health-systems/primary-care.htm
[20] Medicare Geographic Variation - by National, State & County. 2021. https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-geographic-comparisons/medicare-geographic-variation-by-national-state-county
[21] Marchildon GP, Brammli-Greenberg S, Dayan M, et al. Achieving Higher Performing Primary Care Through Patient Registration: A Review of Twelve High-Income Countries. Health Policy.
[22] Pedersen KM, Andersen JS, Søndergaard J. General Practice and Primary Health Care In Denmark. J Am Board Fam Med. 2012;25(Suppl 1): S34–S38. https://doi.org/10.3122/jabfm.2012.02.110216
[23] Denmark: Country Health Profile 2023. https://www.oecd-ilibrary.org/social-issues-migration-health/denmark-country-health-profile-2023_e4f0bee3-en
[24] Netherlands: Country Health Profile 2023. https://www.oecd-ilibrary.org/social-issues-migration-health/netherlands-country-health-profile-2023_3110840c-en

This relationship between primary care investment and health spending exists between areas within the United States as well. Geographic regions within the U.S. that have more primary care providers achieve greater health with lower total spending. For example, Medicare spends 25% less per beneficiary in states with many primary care providers compared to those with few.[25] There are examples of state-level investments in primary care that yielded overall savings. For example, Oregon's Primary Care Home Program produced $13 in savings for every $1 increase in primary care expenditures, saving $240 million during its first three years.[26]

IV. The current fee-for-service payment system produces misalignment between provider financial incentives and patient health that leads to systematic underinvestment in primary care.

Because of financial incentives misalignment, robust primary care infrastructure has historically been unattainable. FFS incentivizes volume of visits above all else without adequate incentives to coordinate care, keep patients happy, healthy, and out of hospitals and emergency departments.[27] Perhaps just as important, FFS traps primary care in an arcane model, hindering investment in practice transformation via technology, team-based care, or optimal staffing.[28] Adding billing code upon billing code increases administrative complexity while still failing to appropriately pay primary care practices for all the services they provide off of the fee schedule, an estimated 25% of their activities.[29] Studies show that 60% of primary care visits deliver services that are not reportable in CPT codes.[30] 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.

The payment rates for billing codes in the current MPFS undervalue diagnostic services in favor of procedural services. This leads to further underinvestment in primary care. Preliminary data from our research team comparing practice patterns of physicians who are accountable for the full financial cost of health care versus those in pure FFS supports this finding. For example, diagnostic and supportive services (including evaluation and management services; physical, occupational, and speech therapy; and vision, hearing, and speech services) are provided at higher risk-adjusted rates among physicians in full-risk contracts. In contrast, procedural services, such as chiropractic services, cardiovascular

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[25] Baicker K, Chandra A. Medicare Spending, The Physician Workforce, And Beneficiaries' Quality of Care. Health Affairs (Millwood). 2004 Jan-Jun; Suppl Web Exclusives: W4-184-97. doi: 10.1377/hlthaff.w4.184.

[26] Gelmon S, Wallace N, Sandber B, Petchel S & Bouranis N. 2016 September. Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings. https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Sept2016.pdf

[27] Zyzanski SJ, Stange KC, Langa D, Flocke SA. Trade-Offs In High-Volume Primary Care Practice. J Fam Pract. 1998;46:397-402.

[28] Goroll AH. Emerging from EHR purgatory—moving from process to outcomes. N Engl J Med. 2017;376(21):2004-2006. doi: 10.1056/NEJMp1700601

[29] 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.

[30] Ibid.

procedures, ophthalmologic, and drug administration services, occur less frequently among physicians in full-risk contracts.[31] This suggests that when providers are accountable for the cost of the health care they deliver, they are better able to prioritize diagnostic and supportive services over expensive procedures. This provides a potential guide for the incentives that a fee schedule oriented around health care value may provide.

The process for determining FFS reimbursement weights, or RVUs, may be an element driving higher volume of procedures among FFS providers. While multiple factors are inputs to determining weight, the intensity of the "effort" is weighed heavily, while the medical evidence of health benefit is not factored. Consequently, procedural services are designated as higher "intensity" work than cognitive services, undervaluing diagnostic services.[32] This may be in part because procedures are easier to quantify and measure than the complex work that goes into diagnosis in primary care and other specialties.[33] This is compounded by the methodology that is used to determine RVUs, which heavily weights both time and intensity.[34] The accuracy of RVU weights also varies by code, due to both the resource intensive nature of measuring the time and intensity of each code and changes over time related to technology and experiential learning. For example, there is evidence of large gaps between estimated and actual times for surgical services. This may play a role in overweighting procedural services as well, as the gaps are larger for surgical services than for office visits, such as those to primary care physicians.[35,36,37,38] Refining fee schedule weights may also require re-examination of representation of physician expertise, independence, and specialty mix in determining RVU methodology. For example, although half of Medicare physician visits are provided by primary care physicians, primary care physicians comprise only 15% of RVU Update Committee voting members.[39]

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. While this increased

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[31] Navathe AS, Schwartz AL, et al. Working Paper. The Parity Center. 2024.
[32] 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.
[33] 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.
[34] Berenson RA et al. 2022. Urban Institute. https://www.urban.org/sites/default/files/2022-09/Medicare%20Physician%20Fee%20Schedule%20Comment%20Letter.pdf
[35] McCall N, Cromwell J, Braun P. Validation of Physician Survey Estimates of Surgical Time Using Operating Room Logs. Med Care Res Rev. 2006 Dec;63(6):764-77. doi: 10.1177/1077558706293635..
[36] Merrell K, Schur C, Oberlander T, et al. 2014. Analysis Of Physician Time Use Patterns Under the Medicare Fee Schedule. Report prepared for the Assistant Secretary for Planning and Evaluation. Washington, DC: Social & Scientific Systems and the Urban Institute.
[37] 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
[38] 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.
[39] 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.

'investment in primary care', studies demonstrated that this change led to only a 2% decrease in the gap between average Medicare payments to primary care and specialty physicians (from a gap of $40,259.80 to one of $39,434.70).[40]

Inefficiencies exist throughout the fee schedule and exacerbate the volume incentive in FFS by shifting services toward costlier procedures. As a result, Medicare spending gets inflated without producing additional health benefits.

V. There is substantial experience with hybrid payments for primary care that indicates both benefits and feasibility.

The evidence for hybrid payments is promising. In Hawaii, the 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.[41] This included increased rates of cost-effective prevention like 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).[42] In fact, unlike other states where primary care practice finances were massively disrupted by the Covid-19 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.

[40] 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

[41] 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.

[42] 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.

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 results in certain domains. 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.[43] 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

[43] 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

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.[44] 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, 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.

Hybrid payments are feasible because they do not require any meaningful financial risk for practices or disruptions to cash flow. In fact, they can provide a more stable source of cash flow for practices that presently depend entirely on visit and procedure volume. Implementation does not face major operational, pragmatic, or technological challenges. This approach can be particularly helpful for small practices that lack the resources to participate in larger risk-based alternative payment models. For example, in Hawaii hybrid payments have been in place since 2016, including for small, independent physician practices.[45,46]

VII. A hybrid primary care payment system is a linchpin for reducing federal spending on health care.

While not every test of primary care payment reform has yielded overall savings, key leading indicators on quality and high-cost utilization are positive. For example, the significant reductions in high-cost utilization such as hospital care, ED visits, and imaging are key sources of overall savings in the MSSP. However, the limitations of demonstration projects have hindered practice transformation, which in turn has prevented key practice pattern changes from scaling into overall savings.

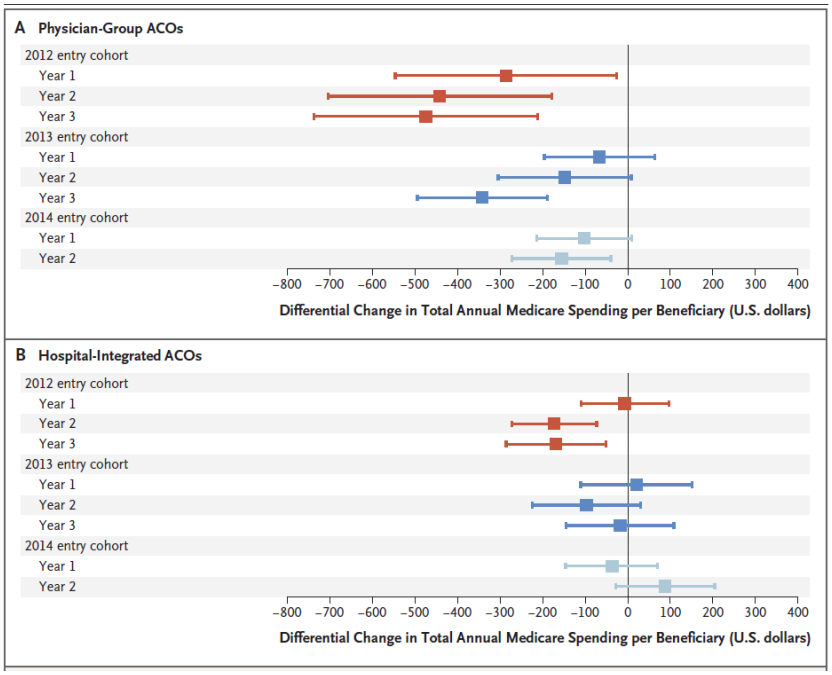
There is considerable evidence on the shift toward more cost-efficient practice patterns under hybrid payment. In Hawaii, there was a 5% reduction in spending on outpatient imaging among Medicare Advantage beneficiaries enrolled in HMSA's plan after implementation of hybrid primary care payment.[47] To give a sense of magnitude, this would translate to $368 million in savings if replicated

[44] 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
[45] Volpp KG, Navathe AS, Lee EO, et al. Redesigning Provider Payment: Opportunities and Challenges from The Hawaii Experience. Healthcare (Amst). 2018;6(3):168-174. doi: 10.1016/j.hjdsi.2018.06.004
[46] Emanuel EJ, Mostashari F, Navathe AS. Designing a Successful Primary Care Physician Capitation Model. JAMA. 2021;325(20):2043–2044. doi:10.1001/jama.2021.5133
[47] 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 Radiol. 2020 Jan;17(1 Pt B):101-109. doi: 10.1016/j.jacr.2019.08.013.

across the Medicare program. CMS demonstrations led to meaningful reductions in use of expensive hospital care and ED visits. For example, primary care practices also enrolled in shared savings programs reduced inpatient hospital expenditures by 3-4%, leading to a 1.5% overall reduction in Medicare spending or $180 of annual savings per Medicare beneficiary. If these results were replicated in Medicare FFS, they would reflect $5.4 billion in annual savings.

Primary care's ability to drive savings is also evident through the performance of primary care and physician-led Accountable Care Organizations (ACOs) in the MSSP. Physician-led ACOs are more successful than other ACOs. An evaluation studying differential changes in total Medicare spending for beneficiaries found that physician-led ACOs demonstrated significantly greater and growing savings for Medicare over a 3-year period in the MSSP. Per-beneficiary spending reductions were -$474, -$342, and -$156 for cohorts entering in 2012, 2013, and 2014, respectively. In contrast, hospital-led ACOs showed significantly lower spending reductions, with corresponding estimates of -$169, -$18, and $88 (Exhibit 3).[48] 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] These results highlight the superior performance of physician-led ACOs in achieving cost savings for Medicare.

Exhibit 3: Differential Changes in Total Medicare Spending for Patients in Physician-Group and Hospital-Integrated ACOs.



Notes: Physician-led ACOs demonstrated significantly greater and growing savings for Medicare over a 3-year period in the voluntary MSSP compared to Hospital-Integrated ACOs. *Source: 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.*

[48] 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.

In another evaluation of nearly a dozen ACOs – primarily formed and led by networks of independent physician practices – physician-led ACOs earned over twice as much savings (64%) compared to all MSSP ACOs (31%).[49] This trend held true over the years, as is evidenced by a recent analysis of ACO performance trends and drivers of successful shared savings between 2016-2020.[50] Regardless of the ACO provider type, PCP clinical staffing type played a pivotal role in influencing financial gains within ACOs. An increase of one primary care visit per 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$).[35] These findings underscore the impact of primary care providers within the ACO framework.

To date, the MSSP has saved CMS $1.8 billion by its own estimates.[51] 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.[52] This provides supportive evidence for CMS using its existing authority to implement hybrid primary care payment in MSSP.

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In summary, a robust and sustainable primary care is essential to achieve more cost-efficient health care. Implementing a hybrid payment system is a necessary step, and Congress can support this by enabling CMS to make this a reality. This will also require reform of the Medicare Physician Fee Schedule to address inefficiencies and re-align payment rates for services toward more cost-efficient delivery of high-quality health care in the U.S.

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[49] Lemaire N and Singer SJ. Do Independent Physician-Led ACOs Have a Future? NEJM Catalyst 4.1 (2018).
[50] 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.
[51] 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
[52] 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

Commission, personal fees from Catholic Health Services Long Island, and equity from Clarify Health, personal fees and board membership for The Scan Group, and non-compensated board membership for Integrated Services, Inc. outside the submitted work in the past 3 years.

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