Testimony Given By

Christina Taylor, M.D.

Chief Medical Officer, Value Based Care, Clover Health

President-Elect, Iowa Medical Society

West Des Moines, Iowa

In A Hearing Before

Committee on the Budget

U.S. Senate

On “How Primary Care Improves Health Care Efficiency”

March 6, 2024

Dirksen Senate Office Building

Thank you, Chairman Whitehouse and Ranking Member Grassley for convening this hearing and allowing me the opportunity to testify.[1]

I'm an internal medicine physician from Iowa and I've practiced for nearly 20 years. I'm a proud Iowa physician. I graduated from the University of Iowa Carver College of Medicine and completed my internal medicine residency in Des Moines, Iowa at what is now Unity Point. I started in a physician owned multi-specialty group, The Iowa Clinic, and I was their first Chief Quality Officer; I was then Chief Medical Officer (CMO) at McFarland Clinic, where we served both urban and rural patients in Iowa. I've further served as the medical director of a multi-state accountable care organization (ACO) of which The Iowa Clinic and McFarland were both part. In my career I've been deeply involved in transitioning my organizations from Fee-For-Service to Value-Based Care and directing those efforts.

I've been blessed to work in clinics who historically delivered exceptional care, but even we still had to change our focus from volume to that of patient access and coordination, to delivering the right care, to the right patient, at the right time.
I'm now the CMO of the Value Division for Clover Health, a company which brings support and actionable patient information, to Primary Care Providers (PCPs) to improve care.

In all of these settings, a fundamental aspect we focused on, which I emphasize today, **is the critical role of Primary Care Providers who are crucial to Coordinating Care.**

Patients who see Primary Care Providers have a lower overall cost of care. A recent study found, "On average, each additional in-person primary care visit was associated with a total cost reduction of $721 (per patient per year…Among the top 10% of high-risk patients, the first PC in-person visit was associated with a reduction of $16 406 (19%)."[2]

In my clinics, we transformed patient access and engagement. We actually improved quality of care and cost and were successful in value contracts. We received shared savings every year. As an example: for the 2022 performance year, the Stratum ACO (102,391 members) generated $36 million in savings, and at a 75% savings rate. The ACO received $27M in shared savings, which was then distributed back to the

[1] The views expressed in this testimony are mine alone and do not necessarily represent the views of any organization referenced in my testimony.
[2] The Effect of Primary Care Visits on Total Patient Care Cost: Evidence From the Veterans Health Administration. J Prim Care Community Health. 2022 Jan-Dec; Published online 2022 Dec 23. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9793026/.

participating provider organizations. This is a 3.5% savings compared to their benchmark. With a focus on proper utilization, the admits per thousand patients was 229 with the national weighted average at 253. Emergency room visits per thousand were 593 with the national weighted average at 611.[3]

The most meaningful results, however, were our patients' outcomes: both prevention and disease management. The great majority of this work was done by primary care providers.

Then through the American Medical Group Association, we collaborated with others around the country to share best practices and challenge ourselves further. Our preventative care increased, such as childhood and adult vaccines and cancer screenings. With actionable data and additional personnel, we better managed chronic patients, such as our high blood pressure and diabetic patients to help them get, and stay, in good control. This resulted in healthier patients with fewer ER and hospital admissions.

Along the journey to value, many investments were necessary. We added additional personnel (self-funded, without additional reimbursement), such as nurse care managers, plus technological and analytical resources to make data actionable. These "extra" initiatives were outside the scope of a typical or traditional medical practice. For example, we put people and processes in place to get real time hospital discharge information so we could reach out to our patients in these vulnerable times of their health. Having both timely data and care managers in place resulted in true care coordination to ensure there was good follow up, reduced medical error, and readmissions prevented.

Across multiple organizations, I've seen the positive impact that PCPs who focus on value have made. With the right resources, PCPs provide safer, better care and at a lower cost. But despite these successes, significant challenges remain. Namely: investment, administrative burden and unpredictability.

Transforming care does require significant investment, which small or rural practices cannot afford or practically accomplish at a smaller scale. There is a base cost to the personnel and the patient outreach & analytics tools, often unaffordable for small practices. But without the additional data and care solutions, we don't have crucial information and people we need to best care for patients and avoid duplicate services. Thankfully there are now companies like Clover Health, who work with small

[3] Centers for Medicare and Medicaid Services. Performance Year Financial and Quality Results. https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results.

practices to bring solutions at their scale. This is what drew me to Clover, to bring capability and resources to providers. To explain, Clover and similar organizations bring timely patient information to the PCPs at the point of care. Much of this relevant patient data is external to what a provider would have in their electronic medical record. Important details include gaps in clinical care, missing diagnoses, recent emergency room or hospitalizations and medications the patient is taking which the provider may not be aware. This type of information is needed to more safely and efficiently care for patients, and I used by the primary care providers when they see patients at office visits.

Administrative burden: We've experienced a drastic uptick in federal administrative requirements and burden, beyond good medical record documentation you'd expect. There is extra tracking, recording and reporting of information not impactful to patient care. This burden is more heavily weighed on primary care physicians. We take precious time away from patient-facing, clinical duties intentionally or not, we have added time and strain to a shrinking PCP workforce. We must decrease reporting and other administrative burdens that do not directly impact care.

Finally, there needs to be predictability. Too frequent changes in federal requirements and unstable payment arrangements are challenging for all providers, more so for smaller practices. In order for practices to be able to move to value and provide coordination beyond traditional care, which I've only detailed a few today, they need predictable and sustainable reimbursement models.

In summary, Primary Care Providers are the front line for coordinating care. Patients who see a PCP are healthier and their costs decrease. We need to assist primary care physicians to enter and remain in Value Based Care programs.

Thank you.

Christina Taylor, M.D.
Chief Medical Officer, Value Based Care, Clover Health
President-Elect, Iowa Medical Society