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Before the

U.S. Senate Committee on the Budget

on

How Primary Care Improves Health Care Efficiency

March 6, 2024

I. We spend more on health care than any other country and get poorer results for it
II. Our unbalanced delivery system is the reason why
III. How much and how Medicare pays for physician services has created this unbalanced delivery system
IV. Medicare's own performance is poorer as a result – but reforms have shown change is possible
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I. We spend more on health care than any other country and get poorer results for it

In 2022, the U.S. spent 16.6% of its GDP on health-related expenditures, approximately 50 percent more than peer countries. On a per capita basis we spend almost twice as much on health care as our peers.[1]

What do we get for all that money? In 2022, the U.S. life expectancy at birth was 77.5 years. The life expectancy at birth in comparable countries was 82.2 years.[2] Our life expectancy, depending on the source, is somewhere between 45th and 50th best in the world.

Not all premature deaths are the result of poor health care – public health spending and social conditions such as income, education, and access to housing and food also contribute. However, it is possible to measure mortality amenable to care, or mortality from medical conditions that can be prevented by recognized health care interventions. Data from 2014 shows the U.S. had 112 deaths that could have been prevented with medical care per 100,000 population, over one-third more deaths than in comparable countries.[3]

II. Our unbalanced delivery system is the reason why our spending is higher and our outcomes are poorer

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[1] Wagner E, McGough M, Rakshit S, Amin K, Cox C. How does health spending in the U.S. compare to other countries? Peterson-Kaiser Health System Tracker. https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-pricesgrown-in-the-u-s-over-time/#item-start. Published January 23, 2024. Accessed February 16. 2024.
[2] Rakshit S, McGough M, Amin K. How does U.S. life expectancy compare to other countries? Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/brief/the-state-of-the-u-s-health-system-in-2022-and-the-outlook-for-2023/#Total%20deaths%20in%20the%20United%20States%20from%20COVID-19%20and%20other%20leading%20causes,%202020-2022. Published January 30, 2024. Accessed February 16, 2024.
[3] Sawyer B, McDermott D. How do mortality rates in the U.S. compare to other countries? Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/chart-collection/mortality-rates-u-s-compare-countries/. Published January 14, 2019. Accessed February 16, 2024.

Numerous studies have demonstrated that higher health care spending in the U.S. compared to other countries is due to a difference in prices paid, not in utilization of services.[4,5,6,7]

The higher prices can be attributed in part to the mix of clinicians in the U.S. In spite of how much we spend on health care, according to the Organisation for Economic Co-operation and Development (OECD), in 2021, the U.S. had fewer physicians per capita than almost all OECD countries at 2.7 per 1,000 people.[8] However, our ratio of specialists to generalists was over seven to one, compared to ratios of about two to one in the other countries.[9]

This unbalanced delivery system is the basis for our higher costs and poorer outcomes. Twenty years' worth of studies have shown that generalist- or primary care–oriented health care systems produce better health outcomes, longer life expectancies, and fewer disparities in health outcomes between groups of different races or ethnicities.[10] Increased primary care clinician supply has been shown to be associated with longer life expectancy, fewer hospital visits, fewer emergency department visits, and fewer surgeries.[11]

In the U.S., we have ignored this evidence and cultivated a specialist-oriented health system. We have reaped what we have sown, with higher expenses, poorer outcomes and more disparities in those outcomes as a result. This specialist-oriented delivery system also left the U.S. poorly prepared for the COVID-19 pandemic and may be in part responsible for our higher mortality rates and slower post-pandemic rebound in both economic activity and life expectancy compared to other countries.[12]

III. How much and how Medicare pays for physician services has created this unbalanced delivery system

Medicare's physician fee schedule (PFS) is primarily responsible for the problems cited here. Not only does Medicare comprise about one-fifth of health care spending in the country, but it

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[4] Anderson GF, Hussey P, Petrosyan V. It's still the prices, stupid: why the US spends so much on health care, and a tribute to Uwe Reinhardt. Health Aff (Millwood). 2019;38(1):87–95.
[5] Schneider EC, Shah A, Doty MM, Tikkanen R, Fields K, Williams II RD. Mirror, Mirror: Comparing Health Systems Across Countries. Commonwealth Fund; 2021. https://www.commonwealthfund.org/series/mirror-mirror-comparing-health-systems-across-countries. Accessed February 19, 2024.
[6] Claxton G, Rae M, Levitt L, Cox C. How Have Healthcare Prices Grown in the U.S. Over Time?, Peterson-Kaiser Health System Tracker. https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-prices-grown-in-the-u-s-over-time/. Published May 8, 2018. Accessed February 19, 2024.
[7] Laugesen M, Glied S. Higher fees paid to US physicians drive higher spending for physician services compared to other countries. *Health Affairs.* 2011; 30(9):1647–56. https://doi.org/10.1377/hlthaff.2010.0204.
[8] https://www.oecd-ilibrary.org/sites/9f24c36f-en/index.html?itemId=/content/component/9f24c36f-en
[9] Healthcare Resources: Physicians by categories. Organisation for Economic Co-operation and Development. https://stats.oecd.org/Index.aspx?QueryId=30173. Accessed January 16, 2024.
[10] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. *Milbank Q*. 2005;83(3):457-502.doi: 10.1111/j.1468-0009.2005.00409.x.
[11] Kravet SJ, Shore AD, Miller R, Green GB, Kolodner K, Wright SM. Health care utilization and the proportion of primary care physicians. *Am J Med.* 2008;121(2):142-8.doi:10.1016/j.amjmed.2007.10.021.
[12] Ku BS, Druss BG. Associations Between Primary Care Provider Shortage Areas and County-Level COVID-19 Infection and Mortality Rates in the USA. *J Gen Intern Med*. 2020;35(11):3404-3405.doi:10.1007/s11606-020-06130-4.

also serves as the reference point for the payment amounts and methods for the remaining four-fifths of spending. State Medicaid agencies set their prices for health care services in reference to Medicare, and it also is the starting point for all commercial insurer negotiations. In short, Medicare, to quote baseball star Reggie Jackson, "is the straw that stirs the [health care] drink."

The Medicare PFS assigns relative value units (RVUs) for each identified health care service, based on recommendations from the Center for Medicare Services' Relative Value Scale Update Committee (RUC). The RUC is a standing committee of the American Medical Association, comprising 31 physicians. The ratio of specialists to generalists on the RUC is almost five to one. The RUC selects physician procedures for review and determines the value of services relative to other physician services for three categories of activity: physician work, practice expense, and malpractice risk. The RUC passes the resulting numerical assessments on to the Center for Medicare and Medicaid Services (CMS), which can accept or modify recommendations. Historically, CMS has deferred to nearly all the RUC's recommendations, accepting them unaltered almost 90 percent of the time between 1994 and 2010.[13]

In 2021, a committee of the National Academies of Sciences Engineering and Medicine (NASEM) conducted a comprehensive study of published research and issued a report on implementing high quality primary care. The report, in studying Medicare's method of health care services valuation, concluded:

- *The relative prices set by the Medicare PFS have profound effects on prices paid by Medicaid, commercial payers, and others. The RUC exerts significant influence on the relative prices assigned by CMS.*

- *The RUC, together with the structure of the PFS, have resulted in systematically devaluing primary care services relative to other services and its population health benefit, reflected in large and widening gaps between primary care and specialty compensation.*

- *The widening compensation gap between primary care and other physician specialties is associated with reductions in medical trainees' likelihood of choosing primary care careers and with hospitals' graduate medical education training priorities.*[14]

Given the composition of the RUC and the extent to which CMS accepts its recommendations, these findings are not entirely surprising. The Government Accountability Office and numerous commentators have pointed out the conflicts of interest present in this arrangement.[15]

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[13] National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press; 2021.p 91.
[14] National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press; 2021.p 295.
[15] Berenson RA, Ginsburg P, Hayes KJ, Kay T, Pham HH, Terrell G. Comment Letter on the CY 2023 Medicare Physician Fee Schedule Proposed Rule. The Urban Institute. 2022. https://www.urban.org/sites/default/files/2022-09/Medicare%20Physician%20Fee%20Schedule%20Comment%20Letter.pdf. Accessed February 19, 2024.

In addition *to how much* Medicare pays*, how* it pays perpetuates a poor performing health care system. Paying for each service rendered by a clinician on a fee for service (FFS) basis encourages the provision of care that is more highly valued by the RUC – such as technically oriented surgical procedures and testing – and discourages the lower priced services and those with no fee valuation at all often used by generalists, such as patient education, telephone consultations, email messaging, care planning and services delivered by non-licensed clinicians. The FFS payment system also discourages investments by the provider team to improve care and leaves providers financially vulnerable in times of reduced demand for in-person services, such as during the pandemic.

Last week the Milbank Memorial Fund released its annual primary care scorecard documenting the impact of the Medicare fee schedule.[16] The portion of U.S. health care spending on primary care is dropping and the number of primary care physicians per capita continues to decline. Fewer Americans report access to a usual source of care — which when established has been associated with fewer inpatient admissions, lower rates of ER use, better self-reported health, and reduced disparities between populations. With fewer physicians pursuing primary care residencies, the cycle is continuing and the prospects for reversing cost and health trends in the U.S. look bleak.

IV. Medicare's own performance is poorer as a result – but reforms have shown change is possible

By virtue of the delivery system produced by its fee schedule, Medicare is not getting a good return for its spending. It is spending more on specialty services than it needs to because it encourages them, as well as the production of clinicians who perform them.

This has become a self-perpetuating cycle. A committee dominated by specialists systematically values specialty care over generalist care, leading to higher Medicare payments for technically oriented services. Commercial payers follow suit. Specialists' incomes increase, attracting a greater share of debt-burdened, status-conscious medical school students and further unbalancing our delivery system. Overall, health system and Medicare-specific performance for cost and health outcomes diminishes as a result.

Burdened by rising numbers of Medicare enrollees and increasing program costs, Congress and CMS have understandably focused on ways to obtain immediate reductions in the increasing costs per enrollee. Strategies pursued include adjusting prices for pharmaceuticals, Medicare Advantage benchmarks, overall Medicare fee schedule adjustments, and adjusting specific specialty services identified as overpriced. These efforts, however, have not taken into account their long-term impacts on the overall balance of the delivery system or resulting health outcomes.

[16] Jabbarpour Y, Jetty A, Byun H, Siddiqi A, Petterson S. No One Can See You Now: Five Reasons Why Access to Primary Care Is Getting Worse (and What Needs to Change). New York. The Milbank Memorial Fund; 2024.Accessed February 18, 2024.

Medicare payment reforms conducted by the Centers for Medicare and Medicaid Innovation (CMMI) have shown, however, that it is possible to shift this dynamic and encourage more balanced systems of health care.

- In the Medicare Shared Savings Program, CMMI reports that that accountable care organizations comprising 75% or more primary care clinicians saw twice as much savings per capita as groups with a smaller proportion of primary care physicians.

- Studying CMMI's Comprehensive Primary Care Plus initiative- which focused mostly on clinicians not employed by a health system - and other models paying primary care practices with a hybrid methodology — a blend of fee-for-service and per enrollee — NASEM concluded:
    - *Hybrid payment models in support of advanced primary care mitigate FFS incentives for increased use and provide resources for team-based care and non-PFS services, though this produces modest to no reductions in spending and use in the short term.*
    - *With adequate time, hybrid reimbursement models show improvements in care and reductions in use, particularly for people with multiple complex chronic conditions.*[17]

In Medicaid, a program in Maryland similar to Comprehensive Primary Care Plus – the Maryland Primary Care Program (MDPCP) – found that practices enrolled in MDPCP had a 20 percent lower risk-adjusted mortality rate from COVID-19 than practices not enrolled in the program.[18] Encouraged by these and other findings, Medicaid programs in Oregon and Massachusetts are now moving primary care payment models away from fee-for-service to hybrid methodologies.

Measuring the portion of health care spending that is going to primary care is a good way to assess the balance of a health care system. In California, where a sizable number of physician groups are paid similar to Medicare's ACO program, researchers found that physician groups that spent a higher proportion of their spending on primary care were associated with lower overall levels of risk-adjusted costs. Twenty-two states have now passed laws or issued executive orders to measure or increase the portion of health care spending going to primary care.[19] The pioneers in Rhode Island, Delaware, and Oregon are seeing payments to primary care clinicians increase as a result of these requirements.

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[17] National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press; 2021.p. 301.
[18] Perman C, Adashi E, Gruber E, Haft H. Improving COVID-19 Outcomes for Medicare Beneficiaries: A Public Health-Supported Advanced Primary Care Paradigm. New York, New York: The Milbank Memorial Fund, 2021. https://www.milbank.org/publications/improving-covid-19-outcomes-for-medicare-beneficiaries-a-public-health-supported-advanced-primary-care-paradigm/. Accessed February 19, 2024.
[19] Primary Care Collaborative. State primary care investment initiatives. https://thepcc.org/primary-care-investment/legislation. Published 2024. Accessed February 19, 2024.

In studying this work, NASEM found that:

- *At a national level, primary care–oriented health care systems are associated with better population health and lower spending.*
- *The portion of total health care expenses going to primary care is a way to measure primary care orientation.*
- *By this measure, the United States is at or below the proportion in other developed countries.*
- *State-level policies to increase primary care spending rates have been politically sustainable, resulted in significant additional resources for primary care through non-FFS mechanisms, and supported statewide efforts to build primary care capacity. When coupled in Rhode Island with hospital price inflation caps to pay for increasing funds to primary care, there were attributable spending reductions.*[20]

Finally, using the principles of Value-Based Insurance Design, payers are learning how to use insurance benefits to engage enrollees in demanding a more balanced delivery system. Studies in employer groups that made services to a primary care clinician designated by the enrollee free to that enrollee have found greater use of those preventive and routine services — in some cases with reductions in inpatient admissions and emergency room visits — and no increase in overall expenses.[21,22]

V. Recommendations

Based on this analysis, I offer four recommendations for Congress to improve the efficiency and effectiveness of the Medicare Physician Fee Schedule (FPS).

1. **Revise the Medicare PFS valuation process and the role of the RUC consistent with the recommendations in the NASEM report on primary care.**

   According to the NASEM report:

   > *The Centers for Medicare & Medicaid Services should increase the overall portion of spending going to primary care by:*
   > *a. accelerating efforts to improve the accuracy of the Medicare physician fee schedule by developing better data collection and valuation tools to identify overpriced services, with the goal of increasing payment rates for primary*

[20] National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press; 2021.p 307.
[21] Zhang H, Cowling DW. Association of Participation in a Value-Based Insurance Design Program with Health Care Spending and Utilization. JAMA Netw Open. 2023;6(3). doi:10.1001/jamanetworkopen.2023.2666
[22] Ma Q, Sylwestrzak G, Oza M, Garneau L, DeVries AR. Evaluation of value-based insurance design for primary care. Am J Manag Care. 2019;25(5):221-227.

care evaluation and management services by 50 percent and reducing other service rates to maintain budget neutrality; and

b. *restoring the Relative Value Scale Update Committee to the advisory nature as originally intended by developing and relying on additional independent expert panels and evidence derived directly from practices.*[23]

2. **Direct CMS to annually report primary care spending levels across all its programs and models.**

   We improve what we measure. Monitoring how Medicare and Medicaid policies are promoting or discouraging a more balanced delivery system and better outcomes for the programs will lead to more public attention and Medicare accountability,

3. **Implement a hybrid payment methodology in the Medicare fee schedule for primary care clinicians and services.**

   This recommendation mirrors that made by NASEM:

   > *Payers — Medicaid, Medicare, commercial insurers, and self-insured employers —using a fee-for-service (FFS) payment model for primary care should shift primary care payment toward hybrid (part FFS, part capitated) models, making them the default method for paying for primary care teams over time…. Hybrid reimbursement models should:*
   >
   > a. *pay prospectively for interprofessional, integrated, team-based care, including incentives for incorporating non-clinician team members and for partnerships with community-based organizations;*
   > b. *be risk-adjusted for medical and social complexity;*
   > c. *allow for investment in team development, practice transformation, and the infrastructure to design, use, and maintain necessary digital health technology; and*
   > d. *align with incentives for measuring and improving outcomes for attributed populations.*[24]

4. **Direct CMS to waive Part B cost sharing for all services provided by whomever the beneficiary has designated as their usual source of care.**

   The NASEM report recommended that "all individuals should have the opportunity to have a usual source of primary care" and that "Payers—Medicaid, Medicare, commercial insurers, and self-insured employers—should ask all covered individuals to declare a usual source of primary care annually and should assign non-responding

[23] National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press; 2021.p 372-373.
[24] National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press; 2021.p 372.

enrollees using established methods, track this information, and use it for payment and accountability measures."[25]

Private sector benefit design has found that financial incentives to patients to use their usual source of care results in more beneficial use of services at no additional cost. Medicare can waive part B cost sharing similarly, consistent with these findings and the no-cost annual preventive visit benefit currently place.

Together these four recommendations are critical steps will address flaws that have emerged in the Medicare Physician Fee Schedule, making it more effective and efficient and producing a more balanced health care delivery system for Medicare beneficiaries and the country.

[25] National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press; 2021.p 374-375.