

Invited Commentary

The Future of Primary Care in the United States Depends on Payment Reform

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In this issue of *JAMA Internal Medicine*, Basu and colleagues¹ report that greater density of primary care physicians is associated with better population health in the United States. Their findings are consistent with an extensive body of literature linking

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access to primary care with better individual- and population-level health outcomes. Unfortunately, their study also confirms that the primary care workforce is maldistributed, with many rural communities having no primary care physicians. To increase access to primary care, especially in underserved areas, we must align incentives to attract individuals into primary care practice, innovate primary care training, and greatly improve the primary care practice model. Physician payment reform is a key to making all of this happen.

Successful models for attracting primary care physicians to underserved settings exist, and positive exposures to primary care during medical school lead to an increase in physicians who are practicing primary care. For the past 30 years, the Health Resources and Service Administration has been the primary source of federal funding for primary care workforce development, including training programs for medical students, residents, and fellows; for faculty development; and more recently for primary care practice transformation education. This funding was essential because during the same period, academic health centers have prioritized building networks of subspecialty providers for their quaternary hospitals. Even with some positive changes, graduate medical education programs continue to focus on training physicians for acute and specialty care. Ultimately, this government support has fostered primary care training program innovation, which has allowed many programs to attract highly competitive candidates to primary care residency and to satisfying careers.²

Despite successful training programs, there has been a steady decline in interest in primary care among US medical students. Those who choose primary care physician disciplines are not being attracted to practice in underserved rural or urban areas in large enough numbers. This decline has been attributed to factors such as the desired income, level of debt, type of patients cared for, and perceived work hours and workload of a primary care physician.³ Factors that favor the choice to practice primary care medicine in these communities include early clinical training experiences in underserved areas and loan forgiveness for practicing in those areas.⁴ However, these strategies alone are not common or powerful enough. Current low reimbursement levels for primary care and high burden reporting of quality and performance measures that monopolize many patient encounters make it difficult to support sustainable, satisfying, and impactful careers.

The practice environment is becoming increasingly inhospitable for physicians who want to make a career in primary care. Practice model innovations—patient-centered medical homes, use of interprofessional teams, physician extenders such as scribes, care managers, and community health workers—attempt to improve the primary care environment. However, even with a differential payment to fund patient-centered medical homes, the payment is not enough to cover costs. In contrast, in a well-run subspecialty practice, a team consisting of a physician and a physician assistant can care for 7 patients in 1 hour. The physician assistant completes all of the documentation and patient education, with the physician conducting the clinical assessment and, together with the patient, formulating a plan. Reimbursement for this clinical activity covers all the costs and leaves enough time for the subspecialist to have a satisfying professional and personal life. Most primary care physicians work with minimal support and can see only 2 to 3 patients per hour, and they are likely to receive lower payment than the subspecialty physician for each of those patients. What if primary care physicians had resources similar to those of subspecialty physicians? Primary care physicians need enough resources to build teams with all members practicing at the top of their licenses and time and space for teaching and building rapport with staff, patients, and families, thereby creating a satisfying work life for the physicians and the best possible patient outcomes.

Our reimbursement system needs to incentivize a realignment in the ratio between primary care and nonprimary care that is associated with the best population health, such that primary care physicians no longer shoulder a disproportionate share of administrative work such as medication refills and prior authorizations. Time spent on important activities such as arranging for a patient to be seen by a specialist for a potentially serious abnormal finding or communicating with patients and their families should be compensated. Underlying the current incentive structures is a devaluing of cognitive work and interpersonal interactions compared with performance of procedures.⁵

The American Medical Association (AMA) Relative Value Scale Update Committee (RUC) reviews resource costs for physician services as described by *Current Procedural Terminology* codes and recommends how many relative value units should be associated with each of the more than 8000 billable procedures.⁶ The committee's recommendations have generally been implemented by the Centers for Medicare & Medicaid Services (CMS) in its annual updates to the physician fee schedule, which determines physician services compensation for Medicare beneficiaries and heavily influences Medicaid and commercial insurance rates. The RUC's recommendations have led to the growing compensation gap be-

tween cognitive and proceduralist physicians owing to inequities in how evaluation and management codes are valued, even in alternative practice models such as patient-centered medical homes, accountable care organizations, and bundled care.⁷ The Medicare Payment Advisory Commission and CMS's growing recognition of the problem is heartening, and as a result of relentless advocacy, there is less reliance on the AMA RUC for relative value unit expertise. New *Current Procedural Terminology* codes have also been added to increase compensation for annual wellness visits, transitions of care services, and caring for patients with multiple chronic diseases. Continuing advocacy by the Cognitive Care Alliance and other entities such as the American College of Physicians, Society of General Internal Medicine, and American Academy of Family Physicians can help keep the issue of undervalued evaluation and management codes and the need for innovative payment policy solutions front and center for CMS and US Congress. The Medicare Payment Advisory Commission has proposed changes in reimbursement, such as primary care bonuses and other changes, to help narrow the compensation gap, which is essential to rebalance the physician workforce to align with the country's health needs.

High levels of medical student debt have further eroded the primary care pipeline. Medical students graduating with debt burdens greater than \$100 000 may eschew primary care

for better salaries in specialty care. For this reason, debt forgiveness programs have been successful in recruiting medical students to serve as primary care physicians in underserved areas. Innovative medical school curricula that allow primary care-oriented students to begin residency after 3 years of medical school may also help by decreasing debt and adding a year of earnings.

Payment reform is key to attracting more US physicians into primary care training and practice. Higher pay and lifestyle preferences lead most students to choose non-primary care fields, even when their hearts say primary care.⁸ We must reverse this trend with substantive changes in physician payment policy; no amount of superb primary care training or innovative practice reform will prevent further declines in primary care physician density, which will lead to worsening health for the United States. As Basu et al¹ have shown, an increase of 10 primary care physicians per 100 000 population was associated with an increase in life expectancy that was more than 2.5 times that associated with a similar increase in non-primary care physicians.¹ The inverse is also true and starker: as the density of primary care physician decreases (11% decline across 10 years), there is a predictable increase in the number of deaths due to preventable causes and an average loss in life expectancy of 51.5 days. The cost of inaction will be increased morbidity and higher premature mortality in the US population.

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REFERENCES

1. Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of primary care physician supply with population mortality in the United States, 2005-2015 [published online February 18, 2019]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2018.7624
2. Lipkin M, Zabar SR, Kalet AL, et al. Two decades of Title VII support of a primary care residency: process and outcomes. *Acad Med*. 2008;83(11):1064-1070. doi:10.1097/ACM.0b013e31818928ab
3. Schwartz MD, Durning S, Linzer M, Hauer KE. Changes in medical students' views of internal medicine careers from 1990 to 2007. *Arch Intern Med*. 2011;171(8):744-749. doi:10.1001/archinternmed.2011.139
4. Raymond Guilbault RW, Vinson JA. Clinical medical education in rural and underserved areas and eventual practice outcomes: a systematic review and meta-analysis. *Educ Health (Abingdon)*. 2017;30(2):146-155. doi:10.4103/efh.Efh_226_16
5. Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. 2018. http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirerreport_sec.pdf. Accessed December 7, 2018.
6. RVS Update Committee. <https://www.ama-assn.org/about/rvs-update-committee-ruc/rvs-update-committee-ruc>. Accessed November 19, 2018.
7. Ginsburg PB, Patel KK. Physician payment reform—progress to date. *N Engl J Med*. 2017;377(3):285-292. doi:10.1056/NEJMhpr1606353
8. National Resident Matching Program. Main residency match results and data. <https://mkOnrmpcikgb8jxyd19h.kinstacdn.com/wp-content/uploads/2018/04/Main-Match-Result-and-Data-2018.pdf>. Published April 2018. Accessed December 7, 2018.