

The Cost of Neglect

How Chronic Underinvestment in Primary Care
Is Failing US Patients



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DEFINITIONS AND ACRONYMS

ABFM – American Board of Family Medicine

ACO – Accountable care organization

AHRQ – Agency for Healthcare Research and Quality

ASTP – Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology

CHC – Community health center; also called a federally qualified health center (FQHC)

CMS – Centers for Medicare and Medicaid Services

Community-based training broad – Any primary care resident who completed their training in a program that, according to the American Medical Association's FRIEDA database, primarily trained outside of a hospital or a large academic center

Community-based training narrow – Any primary care resident who trained in a teaching health center or rural training track

EHR – Electronic health record

FFS – Fee-for-service

Graduate Medical Education (GME) – Commonly referred to as residency or fellowship training for physicians. Typically, a three- to nine-year training track for residents to specialize and practice independently after completing medical school!

HITECH Act – 2010 Health Information Technology for Economic and Clinical Health Act

HCPLAN – Health Care Payment Learning and Action Network

HHS – US Department of Health and Human Services

High-quality primary care – The provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and needs across settings and through sustained relationships with patients, families, and communities. (As defined by the 2021 NASEM report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*.)

Hospitalist – Physician who primarily focuses on providing general medical care to hospitalized patients. They are “most commonly trained as family physicians, pediatricians, or internal medicine physicians.”²

HRSA – Health Resources and Services Administration

Medicare Shared Savings Program (MSSP) ACOs – Groups of doctors, hospitals, and other health care providers who collaborate to give coordinated high-quality care to people with Medicare, focusing on delivering the right care at the right time, while avoiding unnecessary services and medical errors. (As defined by CMS.)³

MEPS – Medical Expenditure Panel Survey

NASEM – National Academies of Sciences, Engineering, and Medicine

NIH – National Institutes of Health

Nurse practitioner (NP) – Nurse with an advanced graduate degree and clinical training from a nationally accredited nurse practitioner program

ONC – Office of the National Coordinator for Health Information Technology (now ASTP)

PFS – Medicare Physician Fee Schedule

Physician associate and assistant (PA) – Individual with an accredited graduate degree, clinician training hours, and certification from the PA-accrediting body

Primary care clinician (PCC) – Clinicians practicing in the field of primary care

Primary care physician (PCP) – Physicians practicing in the field of primary care. These include family physicians, general internists, general pediatricians, and geriatricians.

Primary care (PC) spend – The proportion of total health care expenditures going to primary care

PC spend broad – Spending for office-based care from NPs, PAs, behavioral health clinicians, and obstetricians/gynecologists. Includes the narrow definition of primary care spend.

PC spend narrow – Restricted to outpatient and office-based expenditures to PCPs only

RBRVS – Resource-based relative value scale

REC – Regional Extension Center

RVU – Relative value unit

RUC – Relative Value Scale Update Committee

Social Deprivation Index (SDI) – A composite measure of area-level deprivation based on seven demographic characteristics collected in the American Community Survey and used to quantify the socioeconomic variation in health outcomes

THC – Teaching Health Center

Title VII – Public Health Service Act, Title VII – Health Professions Education

Title VIII – Public Health Service Act, Title VIII – Nursing Workforce Development

Usual source of care (USC) – A specific person (clinician) or place (doctor’s office, clinic, health center, or other place) that an individual goes to with a health issue or concern

VA – US Department of Veterans Affairs

EXECUTIVE SUMMARY

Patients in the United States are frustrated with their health care, despite living in a nation with the highest GDP investment in health care in the world. Primary care, when achieving its full potential, has the capacity to enhance life expectancy, improve health outcomes, and lower health care costs.^{4,5} However, years of neglect and chronic underinvestment by the health care system have left US primary care in a position where it is increasingly unable to meet patients' needs, particularly in rural and other underserved communities. Today, life expectancy in the United States is lower than in most developed nations that spend much less on health care, and rates of uncontrolled chronic disease are rising.

This combination of worsening primary care access and sicker patients has created a vicious cycle. Patients are driven to use more expensive services like emergency rooms, which raises health care costs and premiums, further reducing affordability and access. At the same time, overall health care spending continues to rise faster than economic indicators, while the crumbling primary care infrastructure receives only a small portion of these dollars.

It is clear that improving the health of patients in the United States depends on repairing primary care. In 2021, the National Academies of Sciences, Engineering, and Medicine (NASEM) released a landmark report, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*,⁶ which presented a comprehensive, evidence-based, and actionable plan to do just that: strengthen primary care. Shortly thereafter, the Health of US Primary Care Scorecard was created to track progress on achieving this goal. In its first year, the Scorecard reported baseline performance on primary care metrics in financing, workforce/access, training, and research and showed that primary care was in peril. In its second year, the Scorecard report, *No One Can See You Now*, used the same metrics to outline the reasons why access to primary care was deteriorating.⁷

This year, the Scorecard spotlights the downward cycle of financing for primary care, describing how persistent challenges in primary care arise from insufficient investment (or in the case of training, misplaced investment) and a fee-for-service (FFS) payment model that rewards volume rather than continuous, whole-person care. This report highlights how these systemic financial issues not only undermine the effectiveness of primary care delivery but, more importantly, jeopardize the overall health of our communities in the following ways.

I. Financing: Declining investment and fee-for-service payment are hindering primary care clinicians' ability to meet growing patient needs

- Spending on primary care was under 5% in 2022 and continued its decline across all payers, with primary care spending in Medicare and Medicaid decreasing the most since the last Scorecard, down to 3.4% and 4.3% in 2022, respectively.
- Reimbursement rates for physician visits illustrate the way the US payment system rewards procedures over the comprehensive care of patients, undervaluing primary care. In 2022, primary care physicians' reimbursement per visit averaged \$259, compared to \$1,092 for gastroenterology. This relative lack of revenue limits practice capacity to provide high-quality primary care and hinders the field's ability to draw in new clinicians.

II. Workforce/Access: Insufficient funding is diminishing the primary care workforce and access to care

- The number of primary care clinicians (PCCs), including physicians, physician associates (PAs), and nurse practitioners (NPs), dropped from 105.7 per 100,000 in 2021 to 103.8 per 100,000 in 2022. The number of primary care physicians (PCPs) per 100,000 population remained flat at around 67 while the number of advanced practice providers per 100,000 population in primary care fell slightly (from 38 in 2021 to 37 in 2022).
- The percentage of NPs and PAs in primary care dropped to new lows of 30% and 24.3% in 2022, respectively, compared with 34% and 29.7% in 2021, respectively. More than 30% of US adults lacked a usual source of care (USC) in 2022 — the highest level in a decade, despite historically high rates of insurance coverage during this period. The percentage of children without a USC dropped from 13.6% in 2021 to 12.4% in 2022.

III. Training: Misdirected graduate medical education funding is not producing enough new primary care physicians, exacerbating access issues for patients

- The disparity in growth in medical residents per capita between primary care and all other specialties continued to widen, with the rate of primary care residents remaining stagnant at 17 per capita between 2020 and 2022, while the rate for all other specialties increased from 29 to 30 per capita.
- In 2022, the percentage of new physicians entering primary care dropped to 24.4% (or 19.8% when excluding hospitalists), marking its lowest rate in a decade. While the percentage has been steadily decreasing over the past decade, 2022 marked a steeper decline from 2021 compared to previous years.
- There was an inverse relationship between Medicare graduate medical education (GME) funding at the state level and the percentage of new PCPs entering the physician workforce; the more GME funding into the state, the fewer new PCPs in that state.
- There was a marginal increase in the percentage of primary care residents training in community-based settings. Still, only 15.9% of primary care residents spent most of their training in a community-based setting in 2022 (compared with 15.2% in 2021). Only 5.1% of primary care residents were enrolled in either the Teaching Health Center program or a Rural Training Track — programs designed to provide training specifically in medically underserved communities. In addition, the FFS payment system does not provide for physician time to mentor trainees in community settings.

IV. Technology: The lack of investment in EHRs has led to burdensome systems that drain clinicians' time, thereby reducing patient access to care

- Almost half of family physicians rated electronic health record (EHR) usability as poor or fair in 2023. Specifically, more than half found the usefulness of EHRs to be poor or fair, a growth of 4% since 2022. The ease of finding information remained stagnant in 2023, at 41%.
- Similarly, over one-quarter of family physicians remained “very dissatisfied” or “somewhat dissatisfied” overall with their EHR in 2023, with a slight increase in “very dissatisfied” respondents compared with 2022.
- While progress has been made throughout the realm of health information technology, primary care still seems to fall behind as progress is made in other sectors.^{8,9}

V. Research: The lack of research dollars to study the practice of primary care is limiting evidence-based improvements in care

- The federal research investment in primary care remains well below 1%, although spending increased marginally from 0.31% of total federal health care research budget in 2022 to 0.34% in 2023.

The fragility of primary care remains rooted in the lack of tangible progress on financing — specifically, how and how much primary care practices are paid. Yet, policy shifts at both federal and state levels have the potential to drive significant change in the years ahead. Recognizing the importance of these developments, this year's report introduces key enhancements:

- **New measures:** We've added a measure that captures Medicare and Medicaid GME funding and primary care workforce production by state, providing critical insights into funding and capacity trends.
- **Enhanced dashboard:** Our improved [Health of US Primary Care Scorecard Dashboard](#) features interactive maps, state profiles, and now the ability to compare data across states. Users can also export data in various formats for deeper analysis.

Additionally, this report tracks progress on the policy recommendations outlined in the 2021 NASEM report. It also sheds light on issues affecting primary care that are not captured in the Scorecard, like the rise of private equity, as well as examples of strategic investments or state policies that are driving meaningful improvements. These enhancements illuminate a path forward toward a stronger, more sustainable primary care system that better serves communities.

INTRODUCTION

In 2021, the National Academies of Sciences, Engineering, and Medicine (NASEM) released a landmark report, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*,⁶ which presented a comprehensive, evidence-based, and actionable plan to do just that: strengthen primary care. Shortly thereafter, the Health of US Primary Care Scorecard was created to track progress on achieving this goal. In its first year, the Scorecard reported baseline performance on primary care metrics in financing, workforce/access, training, and research and showed that primary care was in peril. In its second year, the Scorecard report, *No One Can See You Now*, used these metrics along with some new ones to outline the reasons why access to primary care was deteriorating.⁷ In both years, we also published a Health of US Primary Care Scorecard Dashboard displaying metric performance by state (where the data was available).

This year, the Scorecard spotlights the poor financing of primary care, describing how persistent challenges in primary care arise from insufficient investment (or in the case of training, misplaced investment) and a FFS payment model that rewards volume rather than the value of care. While providing updates on performance on the measures in each dimension, we analyze the impact of primary care financing, or the lack thereof, on primary care workforce/access, training, information technology, and research.

This report highlights how systemic financial issues not only undermine the effectiveness of primary care delivery but, more importantly, jeopardize the overall health of our communities.

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FINDINGS

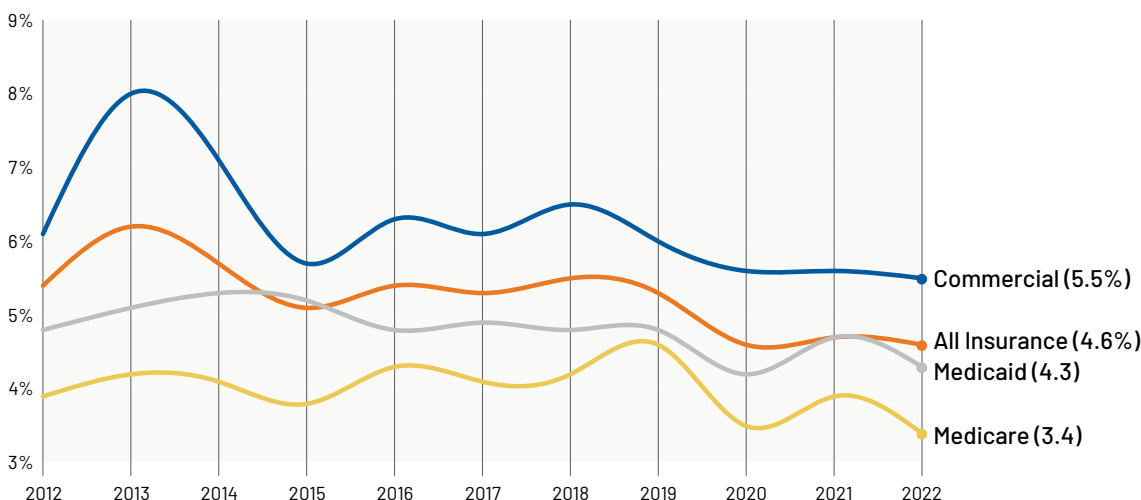
I. Financing: Declining investment and fee-for-service payment are hindering primary care clinicians' ability to meet growing patient needs

Primary care is the foundation of any health care system that delivers timely, high-quality, and equitable care. Yet, in the United States, we have decades of evidence demonstrating that our primary care foundation is fractured and that the health of US residents is suffering as a result. Despite spending more on health care than any other developed nation,^{10,11} the US has lower life expectancy than that of peer nations.^{12,13} Many people in the US do not have timely access to primary care,^{7,14} and even when patients do get an appointment, they are often dissatisfied with rushed visits and lack of attention to their needs.¹⁵ Why is the wealthiest nation in the world seeing the poorest health outcomes? It all boils down to money: where we invest it, how we invest it, and who we spend it on.

It is probably no surprise that nations that spend more on primary care have better health outcomes.^{5,16} In the US, states that invest more in primary care have fewer emergency room visits and avoidable hospitalizations.¹⁷ Unfortunately, as a nation, we invest on average only 5 cents of every health care dollar on primary care.¹⁸ Besides the underinvestment in primary care, there is also a lack of transparency about whether funds designated for primary care are actually reaching these practices, especially as they are increasingly owned by large health systems.

The last two years of tracking primary care spend in the Scorecard report have demonstrated not only historically low levels of investment, but also ongoing low investment in primary care regardless of payer.⁷ The year 2022 was no different. Using the Medical Expenditure Panel Survey (MEPS), we once again found that investment dropped when using the narrow definition of PC spend (primary care physicians only) ([Figure 1](#)).

Figure 1. Primary Care Spending (on Physicians) Continues to Decline for All Payers (2012–2022)



Data Sources: Analyses of Medical Expenditure Panel Survey data, 2012–2022.

Notes: The primary care narrow definition is restricted to primary care physicians only. Primary care specialties included family medicine, general practices, internal medicine, geriatrics, pediatrics, and osteopathy.

This underinvestment in primary care continues despite rising health care burden and evidence that primary care leads to better overall health, fewer hospital visits, and lower rates of chronic disease. Over the past decade, the average number of chronic diseases per person in the US has been rising,^{19,20} as is the incidence of mental health conditions.²¹ As a patient's first stop in the health system, primary care can prevent or identify chronic disease and mental health conditions early,^{4,22,23} as well as provide comprehensive, coordinated care.²⁴

Although primary care spend has dropped for all payers, a particular concern is the drop in Medicare and Medicaid primary care spending, which have had the steepest decline over the past year. Given that the swelling Medicare population experiences higher rates of chronic disease,²⁵ and that more than half of US children are covered by Medicaid,²⁶ it is troubling that a smaller share of these public program dollars are being directed toward primary care. Moreover, Medicare sets the benchmark for all other payers in its physician fee schedule, so when Medicare primary care investment falls, other payers may see that as permission to follow suit. As a result, the decreasing federal investment in primary care is alarming and demands immediate correction. As we note later in this report, the payment system also detracts from physicians' ability to spend time with community-based training.

Undervalued primary care services mean insufficient revenue generation for practices and lower salaries for clinicians

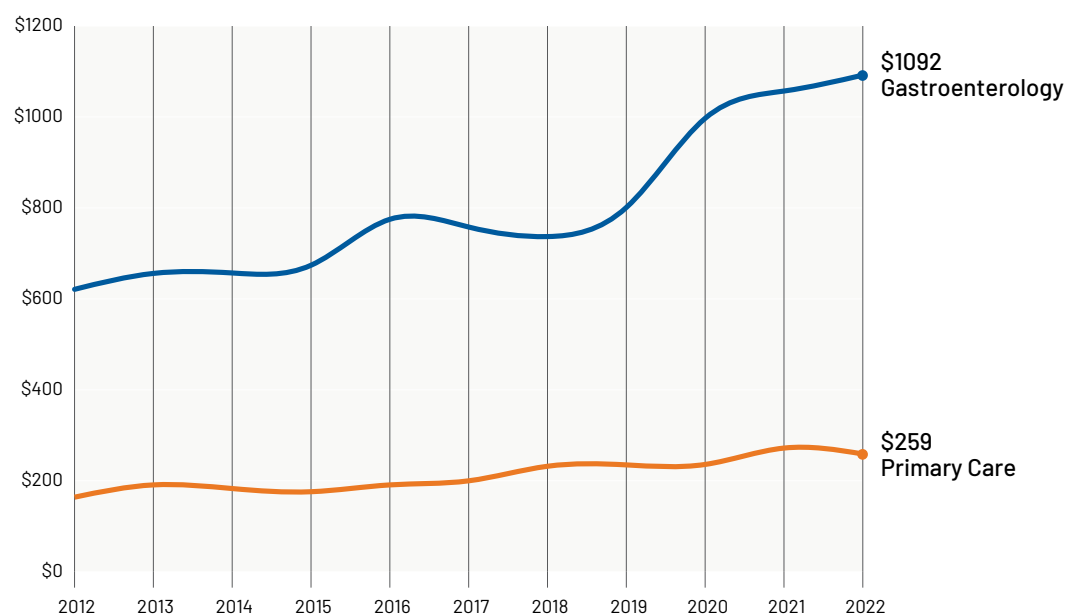
Low primary care spend is rooted, in part, in the Medicare Physician Fee Schedule (PFS), which disproportionately rewards procedural care rather than cognitive care — the history taking, clinical assessment, care coordination, and management of multiple chronic conditions.²⁷ The fee schedule is based on relative value units (RVUs), which are a valuation of every service a physician provides. An RVU is assigned to each service using the Resource-Based Relative Value Scale, which draws, in part, on a survey of physicians developed in the 1980s. Although a committee of physicians known as the Relative Value Scale Update Committee (RUC) updates this scale annually, its recommendations rely, partially, on surveys of physicians, who may inflate the complexity and time demands of their work to protect their interests. This in turn raises questions about whether the RUC's assessments reflect the true value of services.^{27-29,30} To illustrate this point, a study in 2013 concluded that cognitive care generates an hourly revenue of \$87, whereas a screening colonoscopy, a relatively routine and low-risk outpatient procedure, generates an hourly revenue of \$320.²⁷

Our analysis of per visit revenue for the five specialties with the highest volume of ambulatory visits in MEPS further illustrates this discrepancy in valuation between cognitive and procedural specialties ([Figure 2](#)). When comparing one of the most procedure-intensive internal medicine subspecialties, gastroenterology, to general primary care, we find that, in 2022, average per-visit revenue for primary care (\$259) was one-fifth of that for gastroenterology (\$1,092). Since commercial and Medicaid payers use Medicare rates as a reference, this stark disparity is multiplied.³¹ It underscores the structural problems with the current Medicare PFS, which prioritizes and financially incentivizes procedural care over the cognitive, relationship-based care central to primary care practice ([Figure 2](#)).

State Standout: Financing

Based on the rolling 10-year average from 2012 through 2022, Oregon is the top state for overall primary care spend (narrow definition), with 7.1% of all health care spending going to primary care. The national average is 4.6% ([Figure 1](#)). The state is also the highest ranked or shares that position in primary care spending for Medicaid (8.2% versus 4.3% nationally) and Medicare spending (6.4% versus 3.4% nationally). Oregon's commercial primary care spending, at 8.5%, is second to Wisconsin (9.5%), but still well above the national average of 5.5%. See the [data dashboard](#) for more state data.

Figure 2. Per Visit Revenue for Primary Care Is One-Fifth of Revenue for Procedure-Heavy Specialties (2012–2022)



Data Sources: Analyses of Medical Expenditure Panel Survey data, 2012–2022.

Notes: The primary care narrow definition is restricted to primary care physicians only. Primary care specialties included family medicine, general practices, internal medicine, geriatrics, pediatrics, and osteopathy.

Because of this undervaluing of cognitive services, primary care physicians are underpaid compared to their specialty physician counterparts.³² Since the 1980s, when services were first valued by the RUC, primary care has become increasingly complex. An aging population with more chronic disease means more conditions and medications that need to be managed – and more time spent coordinating care. Adding to this complexity in the past decade is the omnipresence of personalized digital technology. PCPs now spend a disproportionate amount of time, relative to subspecialists, answering patient emails and portal messages and integrating data from wearable devices.³³ Additionally, the administrative burdens of insurance prior authorizations, quality reporting, and patient paperwork – including medical leave, disability, and other forms – disproportionately fall on PCPs, increasing their workloads to unsustainable levels. Finally, while essential to the care of patients, attention to screening for health-related social needs and coordinating with social services has added more complexity to the primary care visit.

Health systems and payers continue to ask PCPs to accomplish more within a more complex environment but do not compensate them appropriately. Despite this increased responsibility, PCP salaries have failed to catch up to those of subspecialists due largely to this outdated payment system that makes it challenging to bill procedures and, at times, receive any reimbursement at all for these essential primary care services.³⁴ The latest Medscape survey of physician salaries shows that PCPs are among the lowest-paid physicians, earning, on average, 30% less than all other specialists.³⁴ Similar findings are seen in the nonphysician workforce, with a 20% salary gap reported between PAs in primary care and those in subspecialty fields.³⁵ While this wage gap is lower for NPs, the most recent study from 2018 shows a 7.1% difference in hourly wages for nurse practitioners who work in primary care settings and those in subspecialty settings.³⁶



Ecler Jaqua, MD

I think we are not compensated well, and we work very hard. So that's why a lot of [primary care] physicians are going part-time or are retiring early, because the amount of work that is requested for the compensation just doesn't match. I'm seeing 12 patients per half day. I need to finish all the notes, I need to finish all the patient forms. I wish the system gave us fewer patients, so we could give comprehensive care, and get reimbursed like other specialties, because we are the ones who do the root work.

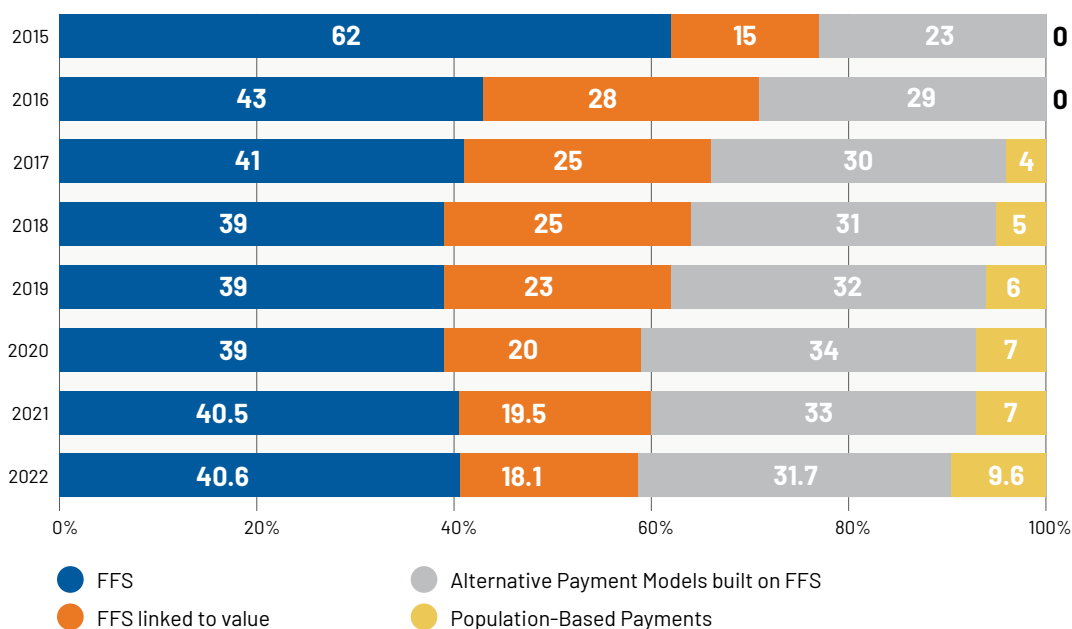
— Ecler Jaqua, MD, MBA,, geriatrician, Loma Linda University Medical Center, and residency associate program director, Family Medicine Residency Program, Loma Linda University Health Education Consortium

Fee-for-service undermines primary care's ability to provide high-quality care

In addition to undervaluing primary care services, the US is not yet broadly implementing payment models conducive to building and maintaining a high-quality primary care system. The current FFS paradigm that health care is built on is incompatible with the nature of primary care. By definition FFS rewards discrete services rather than complex, comprehensive, and coordinated care that is difficult to capture with individual visit codes. As highlighted in the NASEM report, high-quality primary care requires a payment model that enables practices to pay for an entire team to deliver care and not just a clinician who delivers services. The idea is that primary care practices are responsible for the health of their patient population, and to fulfill this responsibility, they need teams and infrastructure that allow for timely, comprehensive, continuous, and coordinated care.⁵ Team members like front-desk staff, medical assistants, nurses, community health workers, behavioralists, social workers, pharmacists, and others are all essential to providing high-quality primary care, but their services are not reimbursed sufficiently or at all in a fee-for-service system.

Providing primary care practices with sufficient resources requires moving toward a payment system with prospective payments and financial rewards for provision of high-quality care. The shift away from FFS-only payments has been tracked by organizations such as the Health Care Payment Learning and Action Network (HCPLAN). The organization's latest survey of health plans in 2023 showed that 40.6% of all health care payments were purely FFS (Figure 3). Mirroring the HCPLAN findings for primary care specifically, a survey of primary care physicians conducted by the Commonwealth Fund found that over 75% report FFS payments while less than half receive any revenue from value-based payment models.³⁷ Although there has been modest movement away from FFS-only models over time, progress has been slow.³⁸ The absence of all-payer alternative payment models to ease reporting burdens and streamline processes for primary care practices, along with the overall lack of investment in primary care, have further hindered the pace and effectiveness of payment model changes.

Figure 3. Slow Progress on Increasing Percent of Health Care Payments from Fee for Service (2015–2022)



Data Sources: Figure created from data found in the HCP-LAN Alternative Payment Model Measurement Effort Report from 2017–2024.
<https://hcp-lan.org/apm-measurement-effort>

There have been some policy shifts that may impact primary care spending in the next several years. In this section we list the NASEM committee recommendations for payers and highlight recent progress. Although progress has been made in payment policy, the vast number of models proposed by the Centers for Medicare and Medicaid Services (CMS), as outlined here, underscores the fragmented nature of these efforts.

ACTION 1.1: Payers should evaluate and disseminate payment models based on their ability to promote the delivery of high-quality primary care, not short-term cost savings.

- ✓ Making Care Primary — Announced in June 2023, this model from the Center for Medicare and Medicaid Innovation (CMMI) offers three tracks (Building Infrastructure, Implementing Advanced Primary Care, and Optimizing Care and Partnerships), which move payment to primary care from purely FFS with some financial support to build infrastructure and financial rewards for quality in track 1, to a hybrid model in track 2, to fully prospective population-based payment in track 3. This is a 10.5-year model focused on long-term savings.

ACTION 1.2: Payers using FFS models for primary care should shift toward hybrid reimbursement models, making them the default over time. For risk-bearing contracts, payers should ensure that sufficient resources and incentives flow to primary care.

- ✓ The CMMI has announced multiple payment models to support the delivery of high-quality primary care, including:
 - Accountable Care Organization (ACO) Primary Care Flex Model — Announced in March 2024, this CMMI model aims to implement prospective primary care payment into the Medicare Shared Savings Program to support innovations in care delivery through implementation of team-based care.
 - Continuation of Primary Care First — Launched in 2021, this multipayer model alters the payment structure for primary care clinicians from traditional FFS to prospective payments with a potential bonus for quality.
 - Continuation of ACO Realizing Equity, Access and Community Health (ACO REACH) — This model, which began in April 2021, offers two voluntary risk-sharing options in which participating providers agree to Medicare claims reductions and receive at least part of their compensation through their ACO.
 - States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model — Started in September 2023, this total cost of care model requires states to make explicit commitments to increasing the portion of health care spending going to primary care.
- ✓ Blue Shield of California's Primary Care Pay-for-Value Hybrid Payment Model, a value-based model launched in 2021, provides participating practices with prospective per member, per month payment while limiting FFS payments for services such as immunizations and wellness visits.

ACTION 1.3: CMS should increase the overall portion of health care spending for primary care by improving the Medicare fee schedule and restoring the RUC to its advisory nature.

- ✓ The 2024 Medicare Physician Fee Schedule includes a separate add-on payment via the G2211 code for longitudinal care, a cornerstone of high-quality primary care. For the 2025 fee schedule, CMS has introduced three new codes (G0556, G0557, G0558) for Advanced Primary Care Management (APCM) services that have the potential to both pay primary care clinicians more and pay them differently. These codes will consolidate elements of existing care management codes like chronic care management (CCM), transitional care management (TCM), and principal care management (PCM) alongside virtual communication services. Unlike traditional codes, these are not time-based and eliminate time frame restrictions, easing administrative burdens. While significant, widespread implementation of these codes alone is unlikely to bridge the reimbursement gap between primary care and subspecialists.
- ✓ The Pay Primary Care Physicians Act (S. 4338), introduced by Senators Sheldon Whitehouse (D-RI) and Bill Cassidy (R-LA) in 2024, aims to reform Medicare payments to better support primary care. The proposed legislation encourages a shift to “hybrid payments” that combine steady, up-front value-based payments with some FFS elements. Additionally, the bill proposes reducing patient cost-sharing for select primary care services and establishing a technical advisory committee to help CMS set more accurate fee schedule rates, thereby making primary care more sustainable and attractive for providers while also reducing reliance on emergency and specialty care.
- ✓ The ACO Primary Care Flex Model’s Request for Applications asks respondents to answer how they would better value primary care.
- ✓ The relaunch of the bipartisan Congressional Primary Care Caucus in 2024 signals policymaker interest in the valuation of primary care.

ACTION 1.4: States should facilitate multipayer collaboration and increase the portion of health care spending for primary care

- ✓ Currently 22 states are reporting or have committed to reporting on primary care spending, ranging from creating multipayer collaboratives to define and measure primary care spend to setting targets for primary care spend in their states.³⁹
- ✓ Since the last report, New Mexico, Rhode Island, and Utah have enacted legislation related to primary care spend, and New York has legislation pending to increase spend by all payers to at least 12.5%. In October 2024, California set its first primary care target of 15% of total health spending.
- ✓ The AHEAD model also requires states to facilitate multi-payer participation in efforts to increase spending for primary care.

How Massachusetts Is Supporting Primary Care Practices in Medicaid

By Christine Haran

To help primary care practices get the dollars and flexibility they need to deliver team-based, comprehensive care, MassHealth, Massachusetts' Medicaid agency, launched a value-based payment model for primary care providers participating in its ACO program in 2023.

The program is supported through a five-year CMS 1115 demonstration. The demonstration shifts practice reimbursement for primary care services from fee-for-service to a per-member, per-month, or capitated, payment. Practices also receive additional funding via their capitation payments to support new care delivery expectations.

This consistent revenue allows practices to break out of their 15-minute physician visit model and build teams of NPs and PAs, as well as nurse care managers, community health workers, social workers, and behavioral health care providers. "We are reorienting our practice-level leadership toward what capitation means in primary care," said Ryan Schwarz, MD, chief of the Office of Accountable Care and Behavioral Health at MassHealth. "It is a substantial change from medicine's historical culture of fee for service. And that's why we expect it to be a five-to-ten-year journey."

MassHealth is seeing practice change already, however. The program groups practices into three tiers, from Tier 1 practices that offer foundational excellent primary care to Tier 3 practices, which offer integrated behavioral health care, reproductive care, and the capacity to care for moderately complex patients and screen for and address health-related social needs. About 70 practices out of 950 moved to a higher tier in the second year of the program.

One challenge, and opportunity, is getting more payers to participate in value-based care. If most of the practices' payer mix is paying fee-for-service, that is how the practice is fundamentally going to operate, Schwarz explains.

"We're having exciting conversations with other payers, all of whom are saying the fee-for-service model is not serving our patients and our members in the way that we want it to, and asking 'How can we think differently?'" said Martha Farlow, senior director of policy for the Office of Accountable Care and Behavioral Health.

The new payment models, and the higher quality of care for patients and quality of life for clinicians, may also help draw new physicians, NPs, and PAs to primary care. "Primary care will not support a viable or joyful or gratifying career until we can really start to leverage a much more team-based approach," Schwarz said. "And capitation helps with that."

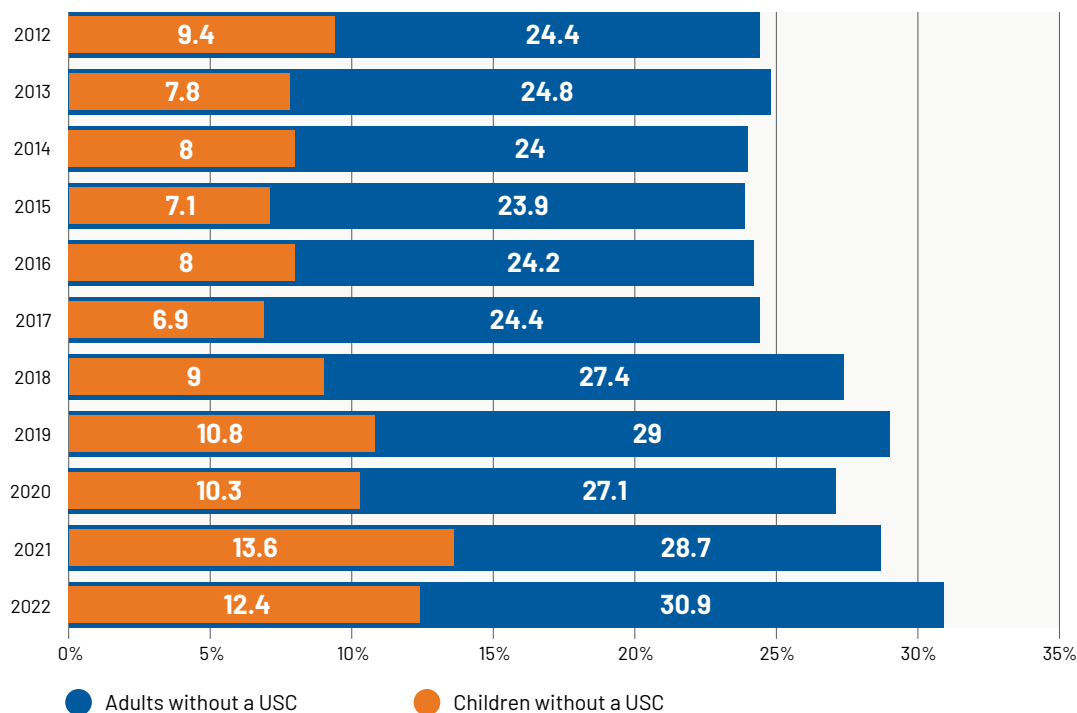
II. Workforce/Access: Insufficient funding is diminishing the primary care workforce and access to care

Underinvestment and fee-for-service payment leads to practice inefficiencies and decreased capacity

The ongoing lack of investment in primary care, combined with payment models that fail to support a strong primary care infrastructure, is one explanation for decreasing access to primary care in the US. Last year, we found that the percentage of Americans who report not having a usual source of care (USC) that they can turn to for their health care needs has been increasing over time. This year, despite the increase in insurance coverage rates, we found that the percentage of American adults who do not have a USC is the highest it has been in a decade of measurement, with nearly 31% reporting that they had no USC in 2022. For children there has been modest improvement since 2021, but still 12% do not have a usual source of care ([Figure 4](#)).

Demand for services that outpaces the number of visits available is at the core of this diminishing primary care access.¹⁹ The FFS payment system also creates inefficiencies in primary care delivery that contribute to poor access. FFS encourages clinicians to see more patients at a faster pace, which can lead to lower-quality care and repeated visits for unresolved issues. This churn not only impacts the clinician and patient experience, but also limits access for others because there are only so many appointments available each day. This can result in longer wait times, delays in receiving care, and an overall decrease in access.

Figure 4. Percentage of US Population Without a USC Rises to Highest Level in Decade (2012–2022)



Data Sources: Analyses of Medical Expenditure Panel Survey data, 2012–2022.

Notes: Usual source of care (USC) ascertained whether that is a particular doctor's office, clinic, health center, or other place where the individual usually goes when sick or in need of health advice. No usual source of care includes those who reported no usual source of care and those who indicated the emergency department as their usual source of care.



Over the last 15 years, the requirements for each primary care visit have exploded.... Every one of the insurer metrics pretty much falls on primary care. Even if the patient is seeing an endocrinologist at another health system, their A1c number is tied to me. Or the patient can't afford the \$300 copay for their diabetes medication, or they are unhoused and don't have fridge to store the insulin. So, there is a lot that we don't have control over. I'm not saying we shouldn't be evaluated for diabetes measures, but they throw out requirements without any support. We have three nurses for our entire health system and no social worker. The way primary care is right now, with employed primary care physicians, is 100% not sustainable.

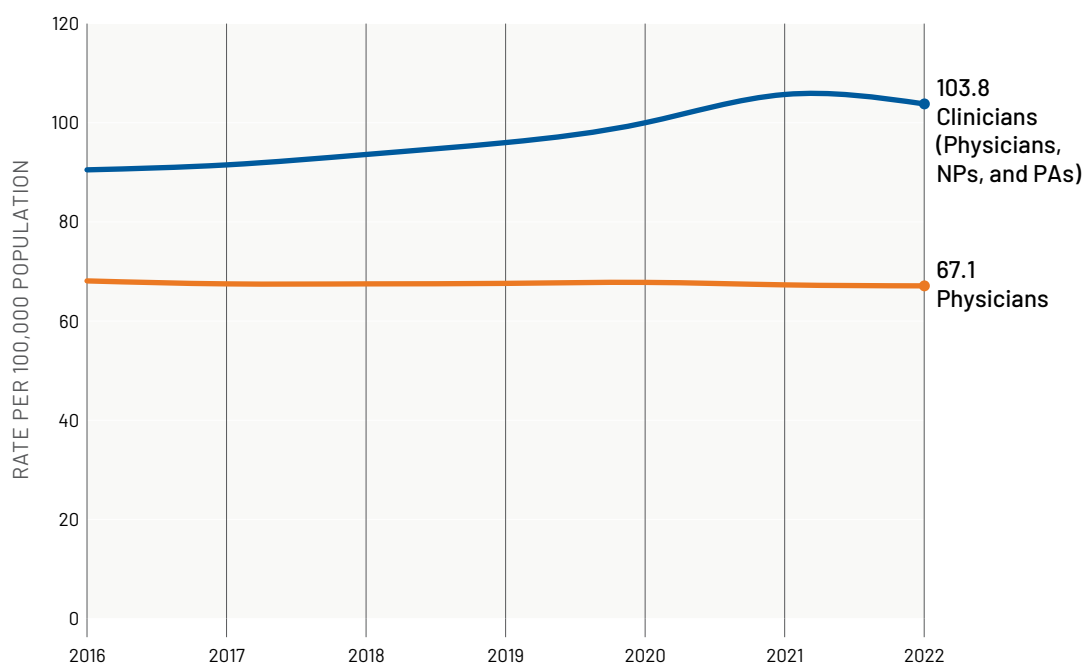
— Lauren Herrmann, MD, family medicine physician, University of Louisville Health, and assistant professor, University of Louisville School of Medicine

Increasing workloads and lower relative pay undercut growth in the primary care workforce

Primary care practices are underfunded and swamped with work. In addition to creating inefficiencies in resource utilization, the FFS payment system does not support all the members of the team that are required to provide comprehensive primary care.⁴⁰ Without a team, we see increased clinician burnout and turnover.^{41–44}

Along with having heavy workloads and few resources, primary care physicians are underpaid compared to their specialty physician counterparts.³² Why does it matter that PCPs are relatively underpaid and overworked? It directly impacts the workforce available to see patients. Studies have repeatedly shown that the workload and comparatively lower pay directly dissuade trainees from choosing primary care as a specialty.^{45–48} Furthermore, these conditions factor into PCPs' decisions to move to nonclinical careers or retire early.⁴⁹ As a result, we are not seeing growth in the primary care physician workforce, but rather a continued decline over time ([Figure 5](#)). Over the past several years, the total primary care clinician (PCC) workforce, which includes NPs and PAs, has been rising. However, in 2022, we saw a marginal drop in total PCCs ([Figure 5](#)).

Figures 5. Rate of Primary Care Physicians Continues to Decline as the Rate of Primary Care Clinicians Remains High (2016–2022)

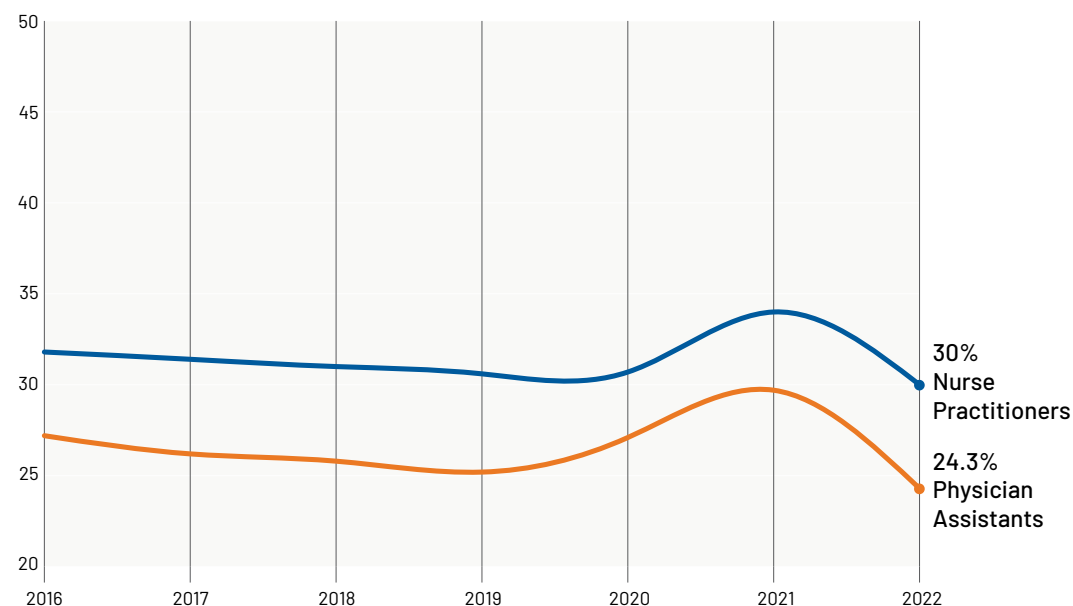


Data Sources: Analyses of American Medical Association Masterfile (2016–2022), Centers for Medicare and Medicaid Services Medicare Provider Enrollment, Chain, and Ownership System data (2016–2022), National Plan and Provider Enumeration System data (2016–2022), Centers for Medicare and Medicaid Services Physician and Other Practitioners data (2016–2022), and the American Community Survey Five-Year Summary Files (2016–2022).

Notes: Primary care specialties included family medicine, general practices, internal medicine, geriatrics, pediatrics, and osteopathy. Estimates of nurse practitioners and physician assistants working in primary care were calculated and are included in this figure. (See Appendix for detailed methodology.)

This drop in total clinicians in primary care is likely driven by more NPs and PAs leaving primary care for specialty care^{50–53} (Figure 6). Although it is too early to know for sure if the one-year decline in NPs and PAs in primary care is a new trend, or why this pattern may be emerging, it is reasonable to imagine that the same financial and workload pressures that physicians face are pushing NPs and PAs away from primary care.^{36, 54, 55} Altogether these workforce declines are resulting in a system where patients are unable to see their primary care clinicians in a timely manner or, for the 30% of Americans without a usual source of care, at all. Consequently, patients present with more advanced or preventable diseases and end up in higher-cost settings, such as the emergency room or hospital.

Figure 6. Percentage of NPs and PAs in Primary Care Drops to New Low (2016–2022)



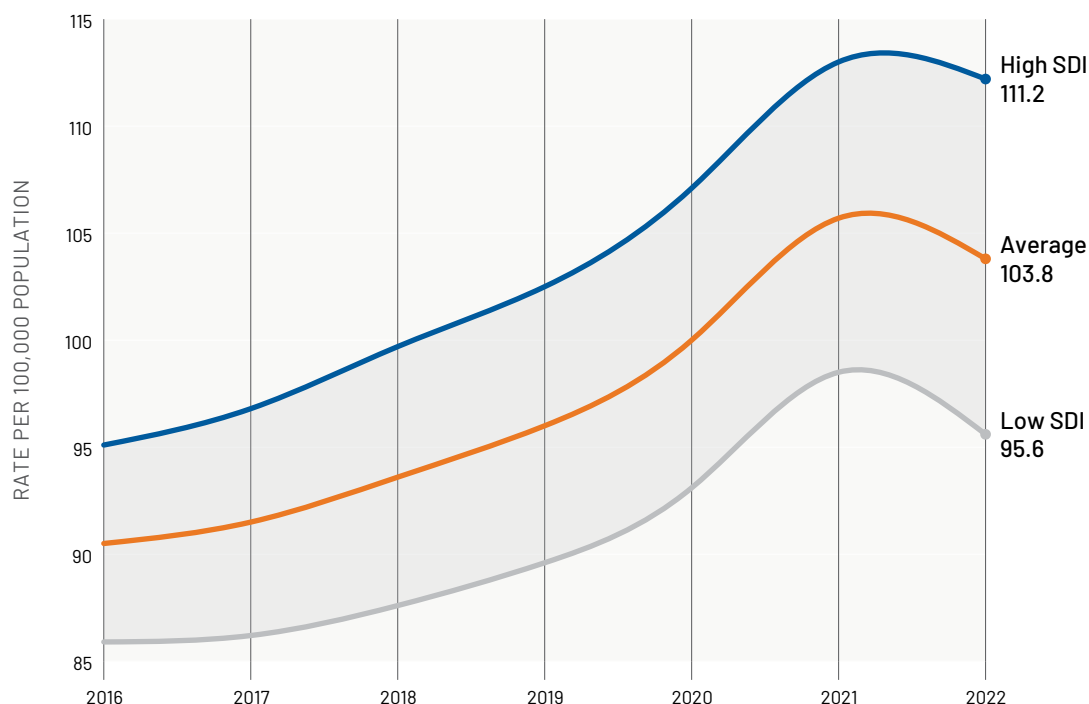
Data Sources: Analyses of Centers for Medicare and Medicaid Services Medicare Provider Enrollment, Chain, and Ownership System data, National Plan and Provider Enumeration System data, and Centers for Medicare and Medicaid Services Physician and Other Practitioners data, 2016–2022.

Notes: Primary care specialties included family medicine, general practice, internal medicine, geriatrics, pediatrics, and osteopathy. Estimates of nurse practitioners and physician assistants working in primary care were derived and are included in this figure. (See Appendix for detailed methodology.)

Community health centers: how investment can improve access

Although the decline in PCCs overall is concerning, we once again see greater primary care workforce density in areas of higher social disadvantage than in areas of lower social disadvantage (Figure 7). PCC density in high social deprivation index (SDI) regions, or highly disadvantaged areas, saw less of a decrease in workforce density in 2022 than did low SDI regions, or less socially disadvantaged areas. This could be because community health centers (CHCs) are working hard to mitigate gaps in primary care services for the medically underserved, including gaps in behavioral health care.^{58–59} Previous data show that CHCs significantly expanded access to medical care for uninsured patients, reducing the percentage of those reporting an inability to access care by nearly half, from 37% in 2009 to 20% in 2014.⁶⁰ Medicaid has historically been the largest source of CHC revenue, reaching a high of \$18.1 billion in 2022. Federal grants and COVID-19-related funding have also provided significant funding, which has enabled CHCs to expand their clinician workforce and provide care to more than 30 million people, or approximately 10% of the US population.^{59–61}

Figure 7. Smaller Decline in PCCs per Capita in More Disadvantaged Areas Than in Less Disadvantaged Regions (2016–2022)



Data Sources: Analyses of American Medical Association Masterfile (2016–2022), Centers for Medicare and Medicaid Services Medicare Provider Enrollment, Chain, and Ownership System data (2016–2022), National Plan and Provider Enumeration System data (2016–2022), Centers for Medicare and Medicaid Services Physician and Other Practitioners data (2016–2022), and the American Community Survey Five-Year Summary Files (2016–2022).

Progress on Policy Solutions: Workforce/Access

There has been some recent progress on policies that address access to care, particularly for the most vulnerable populations.

ACTION 2.1: HHS should create new health centers, rural health clinics, and Indian Health Service facilities in shortage areas.

- ✓ No new health centers were created in the last year, but HHS has expanded funding for rural health clinics and Indian Health Services facilities in shortage areas to expand substance use disorder treatment and expand access to maternal health services.⁶² They also provided \$12 million to three medical schools to help develop a primary care physician workforce in medically underserved rural and tribal communities.⁶³

ACTION 2.2: CMS should revise access requirements for primary care for Medicaid beneficiaries and provide resources to state Medicaid agencies for these changes.

- ✓ There has been significant movement in Medicaid for primary care but most of the important developments are not effective until 2025 and beyond. The changes are driven chiefly by two new rules on access that will affect transparency on payment rates, appointment wait-time standards, and quality rating of Medicaid managed care plans.⁶⁴

State Standout: Workforce/Access

As of 2022, Vermont is the top state for primary care workforce density. With 216 primary care clinicians (PCPs, NPs, PAs) per 100,000 people, Vermont has the highest density of primary care clinicians of any state; the rate is more than double the national average of 103.8 (Figure 6). Vermont ranks third for primary care clinician density in the most disadvantaged areas (222 primary care clinicians per 100,000 people) and first for primary care clinicians per 100,000 population in the least disadvantaged areas (147); both density rates are higher than the national average (Figure 8). See the [data dashboard](#) for more state data.

Managing Private Equity's Risks to Primary Care

By Christine Haran

Over the past 15 years, private equity (PE) firms have been investing in physician practices, recently expanding from hospital-based specialty practices to primary care practices. For physicians, being a part of a larger entity can bring more stable revenue, administrative help, and better leverage in insurer negotiations. However, private equity-owned physician practices are associated with higher prices for consumers, threaten health care quality, and result in loss of professional autonomy and clinician burnout!

"The other thing to be concerned about is a pressure to 'upcode' the Medicare Advantage patients' diagnoses [to make them appear sicker] to draw a higher risk-adjusted payment," said Erin C. Fuse Brown, JD, MPH, professor of health services, policy, and practice at Brown University School of Public Health. "Clinicians feel pressured to make money . . . as opposed to provide the care they think is needed," Brown said. "They end up asking themselves: 'Who am I working for? Am I caring for my patient or the investors?'"

Policymakers are starting to address the risk to patients and clinicians that the PE investment model,ⁱ which incrementally adds practices and often evades regulatory review, appears to pose. "The Biden administration was heavily focused on the issue of corporatization of health care, and I don't know if that is going to be a similar priority agenda [in the Trump administration]," Brown said. She notes that in fall 2024, the Federal Trade Commission established new transaction reporting thresholds under the Hart-Scott-Rodino Act (HSR) that subjects PE transactions to more disclosure,ⁱⁱⁱ but the new administration and Congress could choose to reverse those new rules.

Some states are taking action to improve oversight of health care market transactions involving PE. For example, the Massachusetts legislature passed a bill in December that requires changes in ownership or control that involve a "significant investor" be reported to and reviewed by its Health Policy Commission.^{iv} The bill was partially a response to the PE-backed Steward Health System purchase and mismanagement of a number of the state's hospitals and physician practices.

Other states are considering bills to strengthen their long-standing corporate practice of medicine laws designed to protect physicians from corporate interests. These laws, which have been on the books for more than 75 years in some cases, state that a physician must control the majority of a physician practice. But PE "has been exploiting loopholes to comply with the law on paper, but not in spirit," said Oregon state Representative Benjamin Bowman, who is planning to reintroduce Oregon's HB 4130 in the 2025 legislative session to close these loopholes and ban some contractual practices that can limit physicians' ability to speak out or leave a corporate-owned practice.^v

"The law will reestablish physician independence and decision making, so a patient can be sure decisions are made by the provider and not by people exclusively focused on the bottom line," Representative Bowman said.

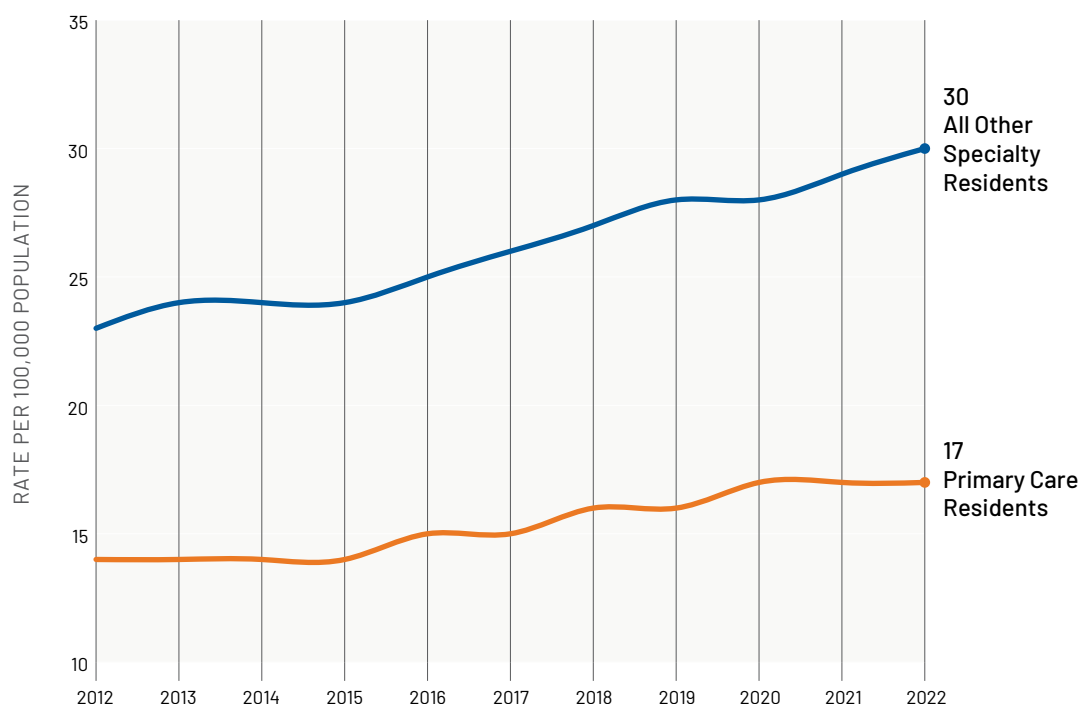
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- i Bursa A, Bejarano G, Moriah E, Doc Bruch J. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. *BMJ* 2023;382:e075244.
 - ii Fuse Brown EC, Hall MA. Private equity and the corporatization of health care. *Stanford Law Review*. March 2026;76:528-596. <https://review.law.stanford.edu/wp-content/uploads/sites/3/2024/03/Fuse-Brown-Hall-76-Stan.-L.-Rev.-527.pdf>.
 - iii Hart-Scott-Rodino Act (HSR). Federal Trade Commission. <https://www.ftc.gov/terms/hart-scott-rodino-act-hsr>. Accessed January 13, 2025.
 - iv Massachusetts legislature passes bill expanding healthcare industry oversight. JDSupra. <https://www.jdsupra.com/legalnews/massachusetts-legislature-passes-bill-7118810>. Published January 2, 2025. Accessed January 13, 2025.
 - v Legislators convene workgroup to address impact of corporate influence on healthcare in Oregon. Office of Representative Ben Bowman. <https://www.oregonlegislature.gov/bowman/PressReleases/Legislators%20Convene%20Workgroup%20to%20Address%20Impact%20of%20Corporate%20Influence%20on%20Healthcare%20in%20Oregon...pdf>. Published May 7, 2024. Accessed January 13, 2025.

III. Training: Misdirected graduate medical education funding is failing to produce new primary care physicians, exacerbating patient access issues

Financially strained primary care practices discourage students from choosing primary care careers

Rebuilding the primary care workforce will require training the workforce of the future. Unfortunately, over the past decade, we have not seen a proportionate rise in the number of students choosing a primary care specialty compared to the number choosing non-primary care specialties ([Figure 8](#)). This has led to a widening of the gap between the density of primary care residents and residents in all other specialties and further exacerbation of the primary care workforce crisis.

Figure 8. Disparity Widens in Residents Per Capita Growth Between Primary Care and All Other Specialties (2012–2022)



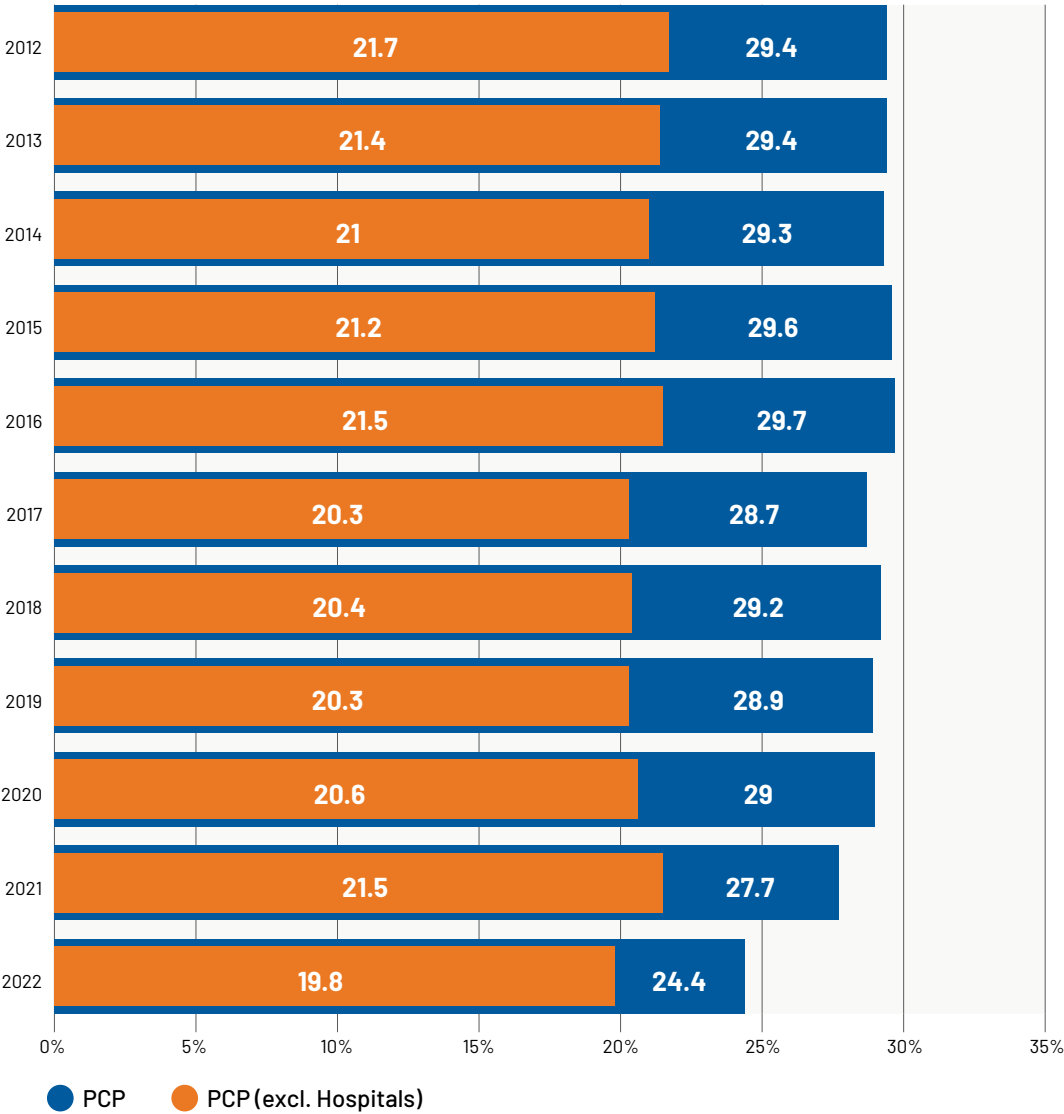
Data Sources: Analyses of American Medical Association Masterfile (2016–2022), Centers for Medicare and Medicaid Services Medicare Provider Enrollment, Chain, and Ownership System data (2016–2022), National Plan and Provider Enumeration System data (2016–2022), Centers for Medicare and Medicaid Services Physician and Other Practitioners data (2016–2022), and the American Community Survey Five-Year Summary Files (2016–2022).

Medical students rotating through outpatient primary care are likely to see dysfunctional outpatient settings with underresourced practices and stressed clinicians.⁶⁵ This experience, coupled with the fact that PCPs are relatively underpaid compared to their subspecialty colleagues, is a well-documented reason that medical students do not choose primary care careers.^{46, 65}

Underinvesting in community-based training while prioritizing hospital-based programs drives trainees away from primary care

Even students who do enter primary care residencies do not end up staying in the primary care workforce.^{7,66,67} Many of the primary care residents represented in [Figure 8](#) will end up going into subspecialty fellowships after residency, or working in an inpatient, hospital-only setting as hospitalists. In fact, only 19.8% of all physician residents (excluding hospitalists in 2022) end up working in primary care, whereas 24.4% of all residents (including hospitalists in 2022) are in primary care residencies ([Figure 9](#)).

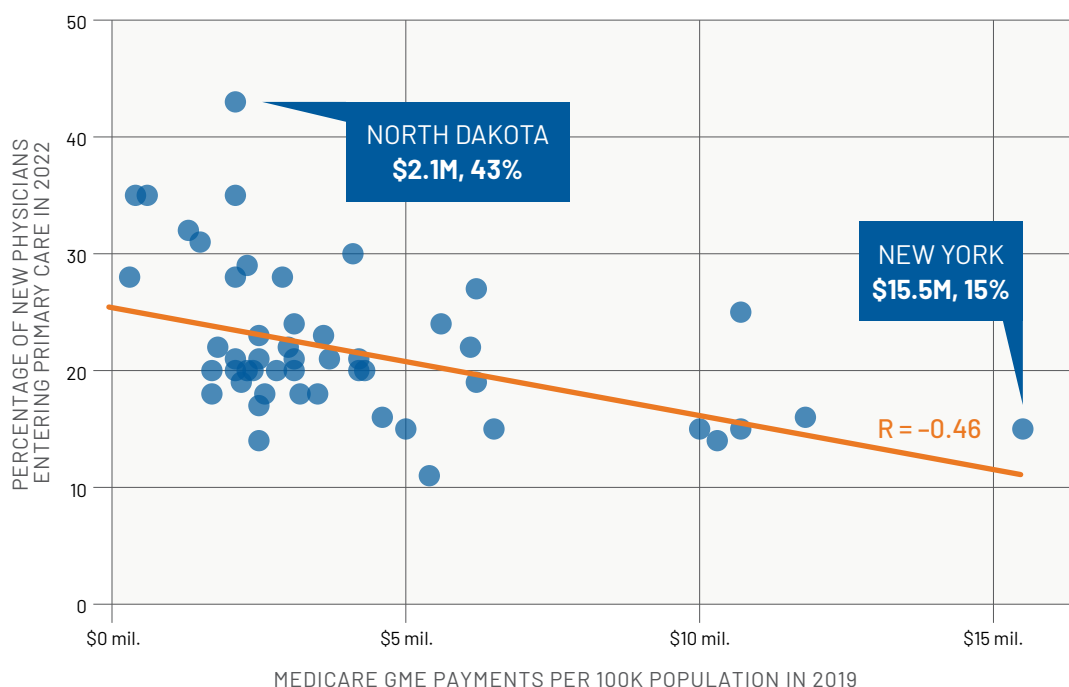
Figure 9. Percentage of New Physicians Entering Primary Care Drops to Lowest Rate in a Decade (Hospitalists vs Non-Hospitalists) (2012–2022)



Data Sources: Analyses of the 2024 American Medical Association Historical Residency File, the 2024 American Medical Association Masterfile, and the 2012–2022 Center for Medicare and Medicaid Services Physician and Other Practitioners data
Notes: Primary care specialties included family medicine, general practices, internal medicine, geriatrics, and pediatrics. Specialty for doctors of osteopathy (DOs) are not always included in the American Medical Association Masterfile, so these data may be an underestimation of the true workforce. (See limitations in Appendix for more details.)

While unfavorable views of the primary care lifestyle and underpayment of PCPs contribute to this attrition, the way that the US graduate medical education (GME) system is financed also plays a role. A majority of the approximately \$24 billion spent on GME comes from Medicare (\$17.8 billion in 2021),⁶⁸ and a large portion comes from Medicaid (\$7.38 billion).⁶⁹ Although there are other sources of GME funding, including the US Department of Veterans Affairs, the Department of Defense, private payers, and the Health Resources and Services Administration (HRSA), these sources are dwarfed by CMS. CMS GME funding is intended to develop a workforce to effectively and efficiently care for Medicare and Medicaid patients, but that goal is not being met. Despite the reality that most patient care occurs in primary care settings,⁷⁰ Medicare and Medicaid funding is not effectively building a primary care workforce. Our state-level analysis shows a negative association between Medicare GME funding and the percentage of physicians entering primary care three years later: the more funding a state receives, the fewer physicians join primary care after three years (Figure 10). For example, New York received the highest level of Medicare funding for GME in 2019 at \$15.5 million, but had very low primary care production, with only 15% of its physicians entering primary care three years later. By comparison, North Dakota received only \$2.1 million in Medicare GME funding, but 43% of new physicians in the state entered primary care.

Figure 10. More Medicare GME Funding (2019) in a State Is Associated with Lower Percentage of New PCPs (2022)



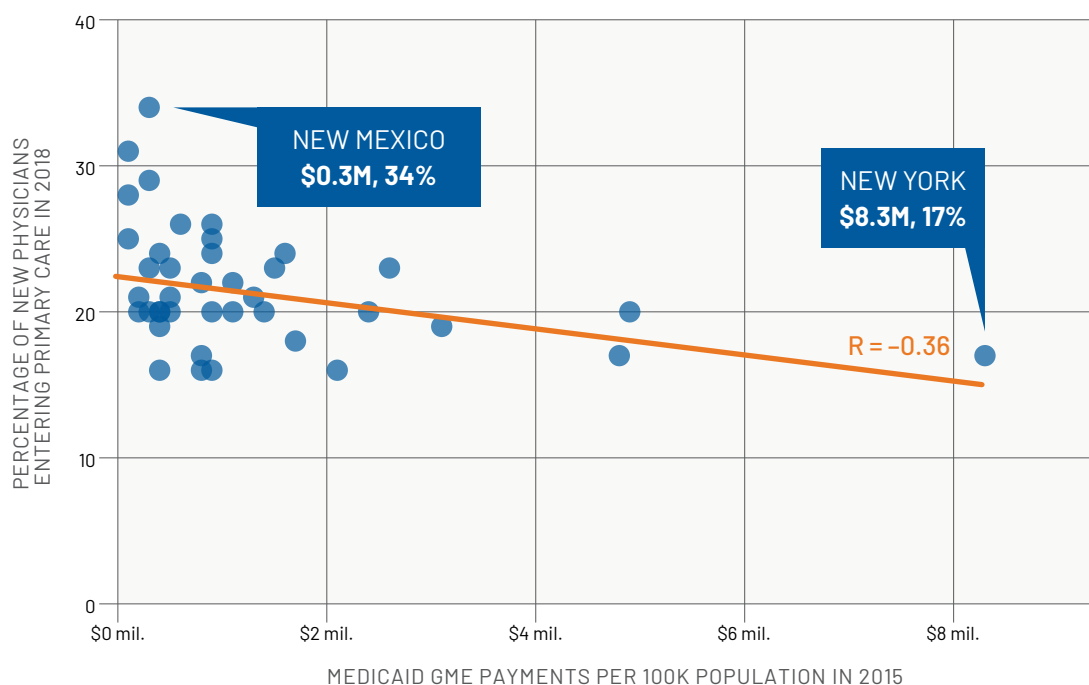
Data Sources: Analyses of the 2019 RGC's Graduate Medical Education For Teaching Hospitals; the 2019 Area Health Resource File; the 2024 American Medical Association Historical Residency File; the 2024 American Medical Association Masterfile; and the 2012-2022 Center for Medicare and Medicaid Services Physician and Other Practitioners data

Notes: DC was excluded. Primary care specialties included family medicine, general practices, internal medicine, geriatrics, and pediatrics. Hospitalists were excluded. Specialty for doctors of osteopathy (DOs) are not always included in the American Medical Association Masterfile, so these data may be an underestimation of the true workforce. (See limitations in Appendix for more details.)

State Standout: Training

As of 2022, three western states stand out on Scorecard training measures: Montana, North Dakota, and Idaho. Montana is the highest-ranked state for community-based training, providing 65% of its training to primary care residents in community settings (broad definition); the national average is just 16% (Figure 12). North Dakota has the greatest share of new entrants in primary care, at 46.6% of all new physicians (or 43.1% when excluding hospitalists), nearly double the national average (Figure 10). Idaho has the largest share of total primary care clinicians, with the percentage of physicians, NPs, and PAs in primary care at 31%, 42%, and 41%, respectively. By comparison, the national averages are 27% of all physicians, 30% of all NPs, and 24% of all PAs. See the [data dashboard](#) for more state data.

Figure 11. More Medicaid GME Funding (2015) Leads to Lower Percentage of New PCPs (2018)



Data Sources: Analyses of the 2016 AAMC's Medicaid Graduate Medical Education Payments: A 50-State Survey; the 2015 Area Health Resource File; the 2024 American Medical Association Historical Residency File; the 2024 American Medical Association Masterfile; and the 2012-2022 Center for Medicare and Medicaid Services Physician and Other Practitioners data.

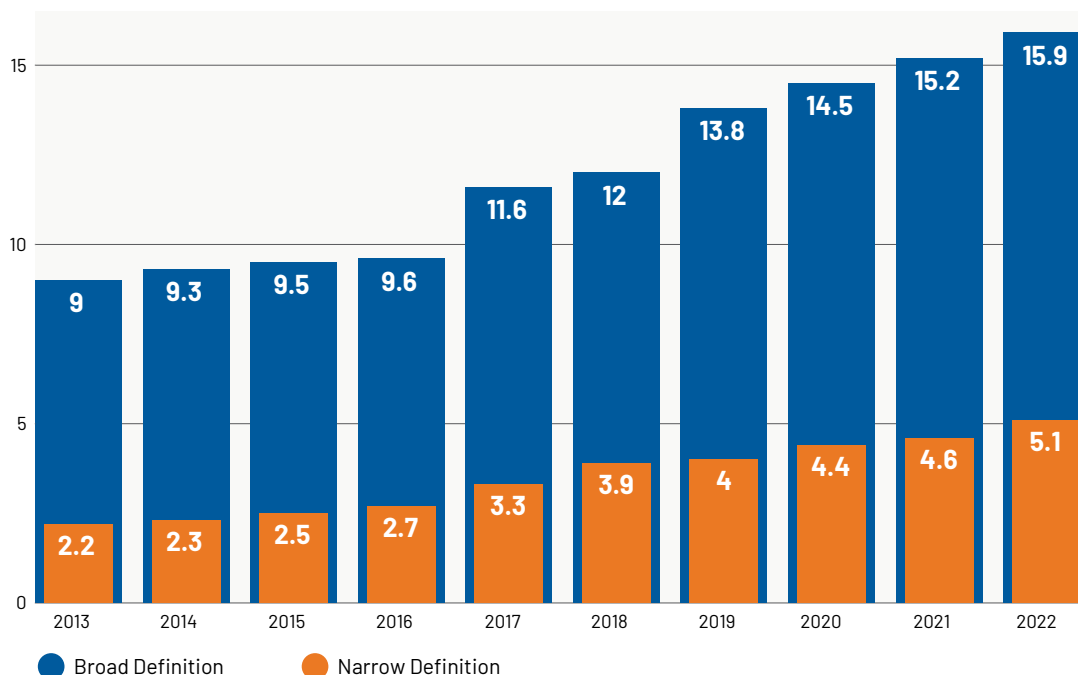
Notes: DC and states with \$0 Medicaid GME (AK, CA, MA, NC, ND, NH, RI, and WY) were excluded. Primary care specialties included family medicine, general practices, internal medicine, geriatrics, and pediatrics. Hospitalists were excluded. Specialty for doctors of osteopathy (DOs) are not always included in the American Medical Association Masterfile, so these data may be an underestimation of the true workforce. (See limitations in Appendix for more details.)

Why is it that traditional GME funding from CMS is not contributing to the creation of a robust primary care workforce? One answer lies in where the money goes. Data suggest that how and where a physician trains dictates how and where they end up practicing.⁷¹⁻⁷⁵ At present, most GME funding is provided by Medicare and funneled directly to academic hospitals.^{76, 77} Consequently, the majority of CMS-funded residency training occurs in large academic hospitals rather than community-based settings, leading many physicians to pursue hospital-based specialties as opposed to community-based primary care.⁷⁸

Community-based training programs can bolster the primary care workforce – but low funding limits their reach

The Teaching Health Center (THC) program is one example of a training program that is primarily community-based. Residents in these programs end up staying in primary care and working with more vulnerable patient populations.⁷⁹ Unfortunately, funding for community-based programs such as THCs is low (\$155 million in 2022)⁸⁰ and unstable.^{81, 82} As a result, most residents in the United States do not receive community-based training, with funding favoring traditional GME programs (Medicare-funded) in large academic hospitals over community-based programs like THCs. When examining the percentage of residents training in community-based settings – defined broadly as programs outside academic medical centers or hospitals affiliated with medical schools, or narrowly as rural training tracks or HRSA THC GME grant programs – we found that only 5.1% of primary care residents spent the majority of their training in outpatient settings with underserved populations (Figure 12). By not funding more community-based training, the GME system is failing to produce a workforce that meets the needs of the US population.

Figure 12. Increase in Percentage of Primary Care Residents Training in Community-Based Settings (2013–2022)



Data Sources: Analyses of Accredited Council of Graduate Medical Education program-level data to get counts for medical residents; FREIDATM American Medical Association Residency & Fellowship Program Database, a rural residency program list from the RTT Collaborative, and Health Resources and Services Administration Teaching Health Center Graduate Medical Education program dashboards to identify community-based training programs, 2013–2022.

Notes: Community-based training was identified if the majority of training does not take place in a university academic medical center or a hospital with a medical school affiliation (broad) or programs with rural training track or Health Resources and Services Administration Teaching Health Center Graduate Medical Education grant (narrow). Primary care specialties included family medicine, internal medicine, geriatrics, and pediatrics.

➔ Progress on Policy Solutions: Training

ACTION 3.1: Health care organizations should strive to diversify the primary care workforce and customize teams to meet the needs of the populations they serve. Government agencies should expand educational pipeline models and improve economic incentives.

✅ Some medical schools such as the University of California–Davis are investing in new pathway programs to recruit and retain medical students from underrepresented communities and prepare them for primary care residencies.

❌ No pipeline expansion on the government side.

ACTION 3.2: CMS, [Veterans Affairs], HRSA, and states should redeploy or augment Title VII, Title VIII, and GME funding to support interprofessional training in community-based primary care practice environments.

❌ The federal government has not yet rebalanced GME funding to prioritize training in community-based primary care practice environments, but new bipartisan draft legislation proposes creating new residency positions in primary care and public reporting on federal GME programs.

- ✗ HRSA's overall budget in 2024 was slightly less than the budget for 2023, but it did increase spending on "interdisciplinary, community based linkages"⁸³ by \$1 million.
- ✓ CMS's request for information on the "primary care exception" in the CY25 Medicare PFS indicates promising change on the horizon. The primary care exception allows resident physicians to perform limited services without the physical presence of a teaching physician while under the supervision of that physician. Not only does this allow for firsthand decision-making on the part of the resident, but it also allows for greater revenue for teaching practices in the community.
- ✓ A Senate committee request for information on needed GME reform was sent to stakeholders. Roundtable discussions were convened with numerous stakeholders in primary care, including physician membership organizations such as the American Academy of Family Physicians.
- ✓ The proposed Medicare PFS could also provide incentives for practicing physicians to serve as preceptors, bolstering educational opportunities in community-based settings.
- ✓ Florida legislation passed in 2024 requires Medicaid GME-funded facilities to account for the number and type of physicians being trained and established a GME committee to use this data to oversee the use of funding to better meet the state's needs.

Florida Brings Transparency to the Distribution of Medicaid GME Funding

By Christine Haran

The majority of graduate medical education for physician residents and fellows is taxpayer-funded. Given that Medicaid is the second-largest source of this funding behind Medicare, some states are taking steps to bring more transparency to the process of allocating these funds in ways that help to improve population health.

In 2024, Florida passed legislation to better track Medicaid GME dollars! "We have between \$1 billion and \$2 billion a year going to residency programs or hospitals and the handful of outpatient clinics that have resident slots," said Christopher Cogle, MD, chief medical officer at the Florida Agency for Health Care Administration. "We get very little information back from the training sites except for bills."

The new legislation requires that the sites report on how the money is being used and account for the number and specialty type of their graduating physicians. Dr. Cogle explained that his agency will analyze these data to help a newly established state GME committee shape policy that will align the distribution of Medicaid GME dollars with the state's needs by geography, specialty, and setting. The new data will help the state track, for the first time, the level of need for primary care residents as compared to other specialties.

The first accountability reports are due to the legislature in December 2025. "We're doing this in a stepwise fashion," Cogle said. "Everyone knows that we want to make data-informed decisions for improving Florida's health."

i The 2024 Florida statutes. Online Sunshine website. http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0409/Sections/0409.909.html. Accessed January 13, 2025.

Drawing More Medical Students to Primary Care Requires More than Free Tuition

By Mary Louise Gilburg

Given the urgent need to increase the primary care workforce, some medical schools are taking action through creative financing and admission processes to encourage more medical students to pursue primary care.

Major donations have allowed some medical schools to offer free tuition to all students.ⁱ Many hoped that reducing the financial burden of medical school would lead students to choose primary care residencies with lower compensation. Early residency match data from these schools does not support this theory. In the years following the free tuition program at NYU Grossman School of Medicine, for example, the residency match rates for primary care decreased,ⁱⁱ falling below the national average. The data suggest that making medical school tuition free led to a more competitive applicant pool and a more selective admissions process.ⁱⁱⁱ This trend favors high-income applicants who are more likely to specialize, while lower-income students from backgrounds underrepresented in medicine are more likely to go into primary care.

The new NYU Grossman Long Island School of Medicine, however, is one free tuition program that does appear to be increasing the number of primary care residents. Three years into offering free tuition, the primary care residency (including internal medicine, pediatrics, obstetrics and gynecology, and general surgery) match rate is over 60%.^{iv} This high percentage is due to the school's focus on primary care and community-based primary care, said Dean Gladys M. Ayala, MD, MPH. The school recruits students who have experience working with primary care doctors and working in underserved areas and who are interested in patient advocacy.

In addition to offering free tuition, the medical school is accredited as a three-year program. "When we originally started this, one less year of medical school was already a way of reducing educational debt," Dr. Ayala said. "The fact that we now have our own endowment to foster our tuition-free status is a great thing for us to continue to work on primary care shortage issues."

Around 40 medical schools across the country offer a three-year medical education through an accelerated pathway, resulting in much lower lifetime loan repayment. The University of California–Davis School of Medicine offers an Accelerated Competency-based Education in Primary Care (ACE-PC) program that trains students who often have backgrounds that are traditionally underrepresented in medicine, such as students with low socioeconomic status, students from racial and ethnic minority groups, and students from rural areas. The school uses an internal scale that quantifies socioeconomic disadvantage and complies with the state's 1997 affirmative action ban. Graduates from the program are more likely to practice primary care and serve in communities with high proportions of Medi-Cal patients.

The track was developed to address the primary care shortage, recognizing that one of the biggest barriers to medical education is finances, said Mark C. Henderson, MD, MACP, the associate dean for admissions. UC Davis has four other tracks focused on rural health, urban underserved community health, tribal health, and providing care to California's Central Valley communities.^v

Both the NYU Grossman Long Island School of Medicine and UC Davis select for students who are poised to help alleviate the primary care shortage. "More and more we've emphasized the lived experiences of the students — where they grew up, what kind of community that was, [and] what kind of barriers were faced in that community — because these are many of the barriers that our patients face every day," Dr. Henderson said.

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ii Emanuel EJ, Guido M. Free med school tuition won't solve the shortage of primary care physicians. *STAT First Opinion*. <https://www.statnews.com/2024/04/22/free-medical-school-tuition-primary-care-doctor-shortage>. Published April 22, 2024. Accessed January 13, 2025.

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iv Residency match day results for MD students. NYU Grossman Long Island School of Medicine website. <https://medli.nyu.edu/education/md-degree/md-admissions/match-day-results>. Accessed January 13, 2025.

v REACH. US Davis School of Medicine website. <https://health.ucdavis.edu/mdprogram/REACH-PRIME/about.html>. Accessed January 13, 2025.

IV. Technology: The lack of investment in EHRs has led to burdensome systems that drain clinicians' time, thereby reducing patient access to care

EHRs, as currently designed and implemented, continue to be a burden for primary care practices

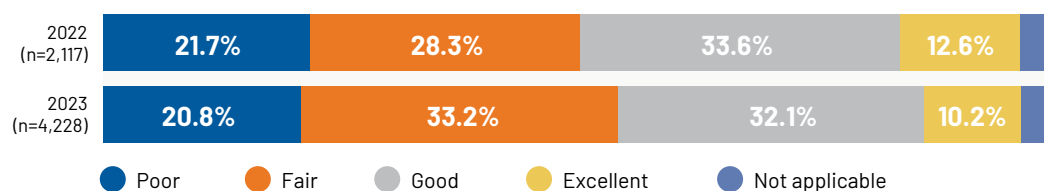
Primary care clinicians spend more time on electronic health records (EHRs) than clinicians in any other specialty.⁸⁴ While increased utilization of the EHR can improve clinical, organizational, and societal outcomes,⁸⁵ these gains come at a significant cost.⁸⁶ Increased EHR usage can impede face-to-face time with patients, reducing clinical effectiveness and increasing physician burnout.^{87,88} Current EHR technology also lags in interoperability between different health settings and facilities.⁸⁹ Similar to last year, data from the American Board of Family Medicine (ABFM) demonstrate that almost half of family physicians view EHR usability (a measure combining ease of finding information and usefulness of alerts) as poor or fair ([Figures 13-1](#) and [13-2](#)), and over one-quarter of family physicians were not satisfied with their EHR. In fact, a slightly greater percentage of family physicians reported that they were very dissatisfied with their EHR in 2023 compared to 2022 ([Figure 13-3](#)).

Figure 13. Almost Half of Family Physicians View EHR Usability as Poor or Fair, and Over One-Quarter Are Dissatisfied Overall with Their EHR (2022–2023)

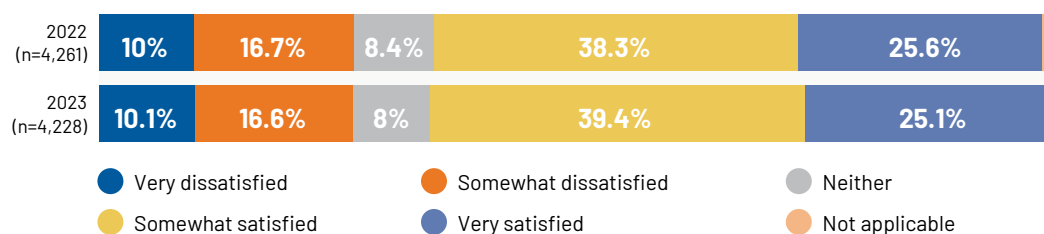
13-1. EASE OF FINDING INFORMATION



13-2. USEFULNESS OF ALERTS



13-3. ELECTRONIC HEALTH RECORD OVERALL SATISFACTION



Data Sources: Data Sources: American Board of Family Medicine Continuing Certification Questionnaire (CCQ), 2022–2023
Notes: A total 6,345 respondents completed EHR usability questions. A total 12,709 respondents completed EHR satisfaction questions.

Because of the high cost of EHRs and the difficulties of integrating them effectively and efficiently into the practice of primary care, many primary care practices are left with EHRs that are suboptimal in meeting the needs of the practice and their patients.^{90,91} The cost of implementing a robust system ranges drastically, from \$32,000 to \$70,000 per full-time employee, and these expenses can easily reach millions for an individual hospital.⁹²⁻⁹⁵ This price range can also vary depending on factors such as on-site versus cloud-based EHR deployment type and the level of implementation assistance,⁹⁴ as well as the overall quality of the EHR, which can significantly impact interoperability.⁸⁹

Lack of investment in primary care is stalling innovations that could make technology more useful

Despite the many hours PCPs spend on the EHR doing inbox management, responding to portal messages, and coordinating care for patients, these efforts do not generate RVUs and this time is generally non-reimbursable.^{87,96} Since the COVID-19 pandemic, time spent in the EHR has continued to grow, elevating the need to improve EHR technology at the organization and systems level.^{86,97}

Research has shown that useful tools such as digital scribes,⁹⁸ artificial intelligence,⁹⁹ and other investments into EHRs can greatly reduce time spent on the EHR and improve clinical efficiency. The lack of investment in primary care has made implementing these new critical technologies extremely difficult, primarily due to up-front costs, but also technical, time, legal, organizational, psychological, and social constraints.^{98,100}



Progress on Policy Solutions: Technology

ACTION 2.4: CMS should permanently support COVID-era rule revisions such as payment for telehealth services.

- ☒ A bill for temporary extension of COVID-era telehealth provisions is being considered by Congress

ACTION 4.1: The Office of the National Coordinator (ONC) for Health Information Technology and CMS should develop the next phase of digital health certification standards that support relationship-based, continuous, and person-centered care; simplify the user experience; ensure equitable access and use; and hold vendors accountable.

- ☒ The Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP) has used the ABFM data to create an Interoperability Index to be included in the HHS Federal Dashboard on Primary Care that can be utilized to improve policies and standards.

ACTION 4.2: ONC and CMS should adopt a comprehensive aggregate patient data system that is usable by any certified digital health tool for patients, families, clinicians, and care team members.

- ☒ No movement

Ready or Not, Here Comes AI

By Elise Blaseg

Primary care doctors are often overwhelmed by clerical burdens, such as note-taking during visits, that detract from patient care! The integration of artificial intelligence (AI) into the world of medicine holds promise for freeing up some of their time. Clinicians are using AI to assist with everything from electronic health record updates to predictive analytics like identifying hospital readmission risks.ⁱ

Still, primary care practices will need to be thoughtful about how they safely and effectively introduce these tools. Experts raise concerns such as the potential for overreliance on the technology for clinical decision making and the increased risk of exposing patient information to cyberattacks and data breaches.ⁱⁱⁱ In a landscape deeply imprinted with health disparities, AI algorithms can also perpetuate established biases and further marginalize vulnerable populations.^{iv} Another concern is that the technical and financial burden of AI implementation will worsen disparities by making the tool inaccessible to smaller practices or less-resourced facilities like federally qualified health centers.

St. Mark's Family Medicine Residency is a training program and small nonprofit independent family medicine clinic in Salt Lake City, Utah, that introduced an AI scribe service into their practice in April 2024. According to St. Mark's resident John James, MD, "AI is really the first tool that I've seen that has actually delivered on [decreasing administrative burden] and . . . sped up my process without compromising on the quality of care that I deliver." The clinic is financing the residents' use of the scribe tool with GME funding, while the faculty's use of the tool is funded by the clinic, cumulatively costing less than 0.1% of the total operating budget. Providers who wish to use generative AI tools for tasks like patient education materials or email templates must pay for these services themselves.

The University of Rochester Medical Center, a large health system in Rochester, New York, has expanded its AI use from integrated scribe services to the inception of their own generative AI triage tool for online patient messages. Michael Hasselberg, PhD, chief digital health officer for URM, reported that over the eight months they have been testing the triage system, it has shown great potential in reducing the administrative burden of clinic staff and nurses. Additionally, URM has started to fully automate quality reporting and registry processes. While some of the budget for the AI efforts come from the medical center's IT and operations departments, URM is utilizing other university resources to create cost-effective, customized technology. "We put [our] data scientists next to the primary care docs and [other] clinicians to understand what their problems are, and then we develop the tech solutions in-house."

Both health care facilities have seen a marked improvement in clinicians' quality of work life with the new tools. At URM, the initial response has been overwhelmingly positive, with users reporting decreased cognitive load, reduced burnout, and improved clinician well-being. Likewise, Dr. James of St. Mark's noted, "My job is more satisfying to me because it . . . frees my brain up for the more high-level critical thinking and creative processes that actually make medicine successful and rewarding."

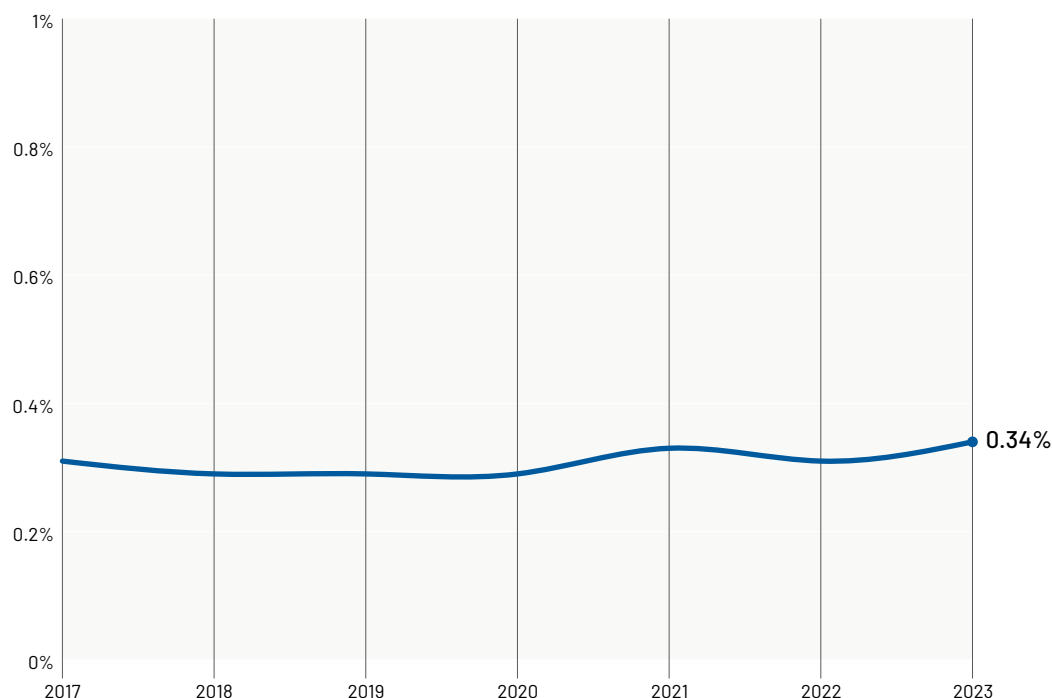
Of course, clinics, practices, and health systems will need to invest in policies that help ensure the responsible and ethical use of the technology, while developers will need to continue to refine the technology itself to eliminate bias and make it more secure. And at a clinic level, education of clinicians and transparency with patients is critical. According to Hasselberg, while AI will never replace the clinician, "doctors and nurses who use AI will replace doctors and nurses who don't use AI."

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 - iv Nazer LH, Zatarah R, Waldrip S, et al. Bias in artificial intelligence algorithms and recommendations for mitigation. *PLoS Digit Health.* 2023;2(6):e0000278. doi:10.1371/journal.pdig.0000278.

V. Research: The lack of research dollars to study the practice of primary care is limiting evidence-based improvements in care

Despite the dire picture much of these data paint for the state of primary care, there are bright spots where primary care is flourishing. Yet more research is needed to discover, analyze, and scale innovations that are moving primary care forward. As the primary care landscape evolves, with hospitals and for-profit entities increasingly acquiring primary care practices, it is crucial to examine the effects of these changes on both clinicians and their patients. Currently, less than 1% (0.34%) of all federal research dollars are spent on investigating primary care despite its status as the backbone of our health care system (Figure 14).

Figure 14. Federal Research Funding for Primary Care Grows Marginally but Remains Below 1% of Total Budget (2017–2023)



Data Sources: NIH RePORTER, 2017–2023.

Notes: Federal investment includes spending from the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, and the Food and Drug Administration. Funding given to family medicine departments was used as a proxy for funding to primary care.

Since the last edition of this report, there has been an increase in federal funding for primary care research. Specifically, the National Institutes of Health (NIH) made a \$30 million investment in primary care research networks, suggesting that federal agencies are recognizing the importance of studying what is happening in primary care practices.¹⁰¹ While these dollars are being spent on how primary care clinicians can impact patients with certain disease processes and not necessarily going toward understanding models of primary care that may benefit the entire population, the investment is a step in the right direction and underscores the value of primary care for the health of the population.

ACTION 5.1: The HHS secretary should establish a Secretary’s Council on Primary Care to coordinate primary care policy, ensure adequate budgetary resources for such work, report to Congress and the public on progress, and hear guidance and recommendations from a Primary Care Advisory Committee that represents key primary care stakeholders.

- ☒ No movement on creation of Secretary’s Council. In 2024, however, NASEM established a Standing Committee on Primary Care to work in the areas identified in the 2021 NASEM primary care report and serve as a point of contact and accountability with the US Department of Health and Human Services.

ACTION 5.2: HHS should form an Office of Primary Care Research at NIH and prioritize funding of primary care research at AHRQ.

- ☒ No movement on an office of Primary Care Research at NIH.
- ☒ NIH has taken steps toward increasing funding for primary care research with a \$30 million investment in studies that are conducted within rural practice-based research networks.
- ☒ AHRQ’s Healthcare Extension Service is funding states to accelerate the dissemination and implementation of patient-centered outcomes research with the goal of significantly reducing the time span between evidence generation and its use in health care delivery, including primary care.

ACTION 5.3: Primary care professional societies, consumer groups, and philanthropies should assemble, regularly compile, and disseminate a “High-quality primary care implementation scorecard” to improve accountability and implementation.

- ☒ The Milbank Memorial Fund, in conjunction with the Physicians Foundation and the Robert Graham Center for Policy Studies in Primary Care, have developed and published this national primary care scorecard and dashboard with state-level data for the past three years.
- ☒ The federal government has proposed measures for creation of a federal dashboard on primary care.
- ☒ Organizations in states such as Massachusetts, Virginia, and New York have created state dashboards that track primary care workforce, quality, and related issues at the state level.

CONCLUSION

Over the past decade, the neglect of primary care in the United States has contributed to a fragmented health care system that often fails to meet the needs of patients. This year’s report highlights the ways in which the lack of appropriate investment in primary care underpins all the worrisome findings the Scorecard has highlighted over the past three years. This year, we found:

- Declining investment and the fee-for-service payment model are hindering primary care clinicians’ ability to meet patients’ growing needs.
- Insufficient funding is diminishing the primary care workforce and access to care.
- Misdirected graduate medical education funding is failing to produce enough new primary care physicians, exacerbating patient access issues.
- The lack of investment in technologies that benefit primary care has resulted in burdensome systems that limit clinicians’ time, thereby reducing patient access to care.
- The lack of research dollars to study the practice of primary care is limiting evidence-based improvements in care for patients.

This year’s report highlights examples that demonstrate the benefits of significant and smart investments in primary care. From implementing AI scribes to scaling value-based payment models in Medicaid, these investments have the potential to make a significant difference in quality of life for primary care clinicians and the quality of care provided for patients. The report also looks at what it takes for medical schools to draw more medical residents to primary care, and how one state is working toward better aligning Medicaid GME dollars with residents’ population health needs, including their need for primary care.

These successes, however, often occur despite the larger policy environment, not because of it. While the report found that some policy changes are underway in all areas studied — payment models, workforce, training, technology, and research — it remains to be seen whether these changes will make an appreciable difference in the primary care experience for clinicians and their patients. Without decisive action and substantial investment in primary care, we are perpetuating a cycle of neglect that undermines the very foundation of our health care system and endangers the health of our communities.

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Our acknowledgment of these leaders' contributions does not imply that any of these individuals endorse the contents or conclusions of this report.

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