The Patient Protection and Affordable Care Act (PPACA) of 2010 has the potential to reestablish primary care as the foundation of U.S. health care delivery. Through the PPACA, a projected 32 million Americans will gain access to health care. This huge influx of insured individuals creates an urgent need to expand the nation’s primary care capacity. The professional workforce of the U.S. health care system has become oddly distorted. In countries with mature, similar economies, 50% to 60% of physicians practice in the primary care disciplines of general internal medicine, geriatrics, family medicine, or pediatrics (1). In contrast, only about 30% of U.S. physicians practice in primary care, whereas 70% are specialists. International studies show that better health is associated with a more equally split physician workforce (2). Therefore, we face the needs of the newly insured with a skewed workforce.

The rationale for a robust primary care physician workforce is based on 2 key aspects of modern health care delivery: health maintenance and continuous care of active, often co-occurring, diseases (3). In the former case, primary care offers the main opportunity to deliver such essential disease prevention services as cancer screening, vaccination, and lifestyle counseling to asymptomatic individuals who do not regard themselves as “patients.” In addition, primary care facilitates early identification and treatment of common diseases, such as high blood pressure, glucose intolerance, and hypercholesterolemia, that, if untreated, compromise health and productivity and can lead to costly complications. Primary care also plays a vital role in the delivery and coordination of care for individuals with 1 or more active chronic diseases. Improving the population’s health requires an accessible, high-quality primary care system (2). The implied mandate of the PPACA is for more and better primary care.

Legislators who crafted the PPACA recognized that existing reimbursement models have contributed to the imbalance of generalists and specialists. The current fee-for-service model favorably rewards specialty disease-based and procedurally based care (3). The PPACA supports several innovative payment models, such as expanded bundling, capitated payment, and gain sharing. In expanded bundling, a single payment covers a disease event and subsequent care for a specified interval. Capitated payment covers both institutional and professional expenditures for a specified interval. Gain sharing allows health care organizations to retain savings in care delivery for internal distribution. However, none of these models addresses the payment system’s devaluation of primary care services.

The resource-based relative value scale (RBRVS), launched in 1992 to provide accurate relative valuation for all professional services, has become the accepted method for determining physician payment in nearly all practice settings. Unfortunately, the Centers for Medicare & Medicaid Services (CMS) has not maintained the accuracy and relative valuation of the evaluation and management service codes to reflect the expanded content of modern generalist care (4). Because primary care physicians spend most of their time providing cognitive services, such as acquiring and assimilating information, developing management strategies, coordinating care, and counseling, their compensation has declined to levels that are 30% to 60% lower than those of specialists (5). If new reimbursement models maintain this same scale, the inequities between cognitive and procedure-based services will continue.

Other factors contribute to the diminishing number of medical school graduates who choose primary care careers, such as the heavy workload of primary care practice and an increasing expectation that primary care physicians will manage most aspects of an individual’s health care without adequate personnel or technical support. The PPACA can help reestablish generalist care if it builds programs to expand the primary care physician workforce, corrects payment inequities by repairing RBRVS, and supports new models of primary care practice. These changes have the potential to substantially improve primary care for both patients and physicians.
**Primary Care Workforce Stabilization and Expansion**

*The Promise*

The PPACA reauthorizes Title VII, Section 747, programs to support workforce education and training and provides funding to expand primary care capacity. These programs support residency training in primary care, provide need-based financial assistance for physicians in training and practicing primary care physicians, and support faculty and curriculum development. Funding favors programs with a good or improving record of training graduates who practice primary care and serve vulnerable populations. Federally supported loans will be available through this program for medical students who make a 10-year commitment to practice primary care. A National Health Care Workforce Commission will be established to make annual recommendations to Congress on the best use of federal resources to maintain a well-distributed, balanced workforce that meets local and national needs.

*The Peril*

Despite reauthorization for 5 years, appropriations for Title VII, Section 747, programs will need active support. Over the past decade, congressional appropriations for these programs have been nearly eliminated multiple times, only to have a small amount restored. Academic centers must collaborate with community-based providers to meet the challenge of training primary care physicians, faculty, and allied health care providers to meet the national primary care workforce needs. Unfortunately, medical schools and residency training programs have often failed to prioritize workforce needs. If we do not educate and train the primary care physicians and allied health professionals necessary to fulfill the promise of the PPACA, we will jeopardize our national commitment to achieving universal access to health care.

**Physician Payment Reform**

*The Promise*

Legislation stipulates that the Secretary of the Department of Health and Human Services identify and adjust misvalued service codes. This provides the opportunity for CMS to ensure that RBRVS accurately reflects the relative value of professional work based on unbiased, accurate, and representative data. The CMS can create a process that is open to the entire professional community for review. The legislation provides primary care physicians with a 10% increase in payment for 5 years (2011 to 2015). It also funds Medicaid payments to Medicare levels for 2 years (2013 to 2014), thus temporarily ending the penalties some physicians face when they care for patients covered by Medicaid.

*The Peril*

Physicians in specialties that profit from the status quo may try to stall any correction to RBRVS formulae, perpetuating the discrimination against primary care. Even an increase of 10% for primary care services for 5 years may be insufficient to attract and retain medical graduates in primary care practice without a long-term correction. However, increased payment for primary care means that Congress will expect evidence from the primary care community that readjusting RBRVS formulae to promote primary care and improving Medicaid payment is a worthwhile investment in the health and welfare of the public.

**Practice Innovation**

*The Promise*

Congress funded a new Center for Medicare and Medicaid Innovation to evaluate and promote creative payment and service models, such as the patient-centered medical home (6, 7), and to develop financial incentives for providers to adopt successful models. States also have the opportunity to experiment with all-payer systems of care that benefit every patient in a practice, not just those with specific insurers. Legislation enables the creation of accountable care organizations that can directly contract with CMS for payment for all inpatient and professional services. These organizations can retain savings for internal distribution.

*The Peril*

These new models of care may not correct the legacy of skewed payment rates that undervalue primary care services. Will patients agree to join “homes,” or will they see the model as managed care in sheep’s clothing? Will specialists become engaged and active participants in a patient-centered medical community? A new hybrid payment model, which combines aspects of fee-for-service (with incentives to see patients when needed) and case-mix–adjusted capitated payments (for electronic and other non–visit-based services), may be required (8). However, any system of capitation invites institutions and individuals to discover ways to avoid caring for complicated and expensive patients.

**Next Steps for Primary Care Advocates**

The 2010 health care legislation clearly enhances opportunities for the United States to move toward a robust, self-sustaining primary care physician workforce. To fully realize this potential, physicians and others must actively engage with and capitalize on specific aspects of the PPACA. Primary care physicians need to lead innovation of primary care practice. Researchers must assess and document the health and economic value of increased payment for cognitive services as well as new models of primary care delivery. Patient advocates must share their stories about the value of primary care for themselves, their families, and their communities. Corporate leaders must partner with the health care community, as in the Patient Centered Primary Care Collaborative, in support of primary care innovation. Finally, professional organizations...
have a special opportunity to seek more effective collaborative relationships with one another and with other groups to promote primary care. All physicians should transcend the focused interests of their own discipline and share a commitment to the health of patients based on effective, affordable models of care. As a nation, we will all be healthier and more prosperous if we make a concerted effort to regenerate an effective workforce of primary care physicians.

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Potential Conflicts of Interest: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M10-0778.

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