

The Path to Coordinated Federal Leadership to Strengthen Primary Health Care

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INTRODUCTION

As the nation struggles to find a new equilibrium in health care services delivery and financing in the wake of the COVID-19 pandemic, it faces four foundational and interconnected population health challenges: a growing recognition of the toll of health inequities on vulnerable populations, pandemic recovery and future resilience, a resurgent opioid epidemic, and a growing mental health crisis, especially for children and teens.¹

Investment in primary care, which the 2021 National Academies of Science, Engineering, and Medicine (NASEM) report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* named a common good, will help the US address each of these challenges.² But aligning federal levers will be necessary.

The NASEM report recognized that primary care, the largest platform for health care and the only one associated with improved health equity, has no coordinating leadership at the federal level. The report recommended that the U.S. Department of Health and Human Services (HHS) fill this void by establishing a Secretary's Council on Primary Care, which would be advised by a Primary Care Advisory Committee, consisting of stakeholders.

Through its Initiative to Strengthen Primary Health Care, launched in 2021, HHS is currently coordinating a multiagency effort that will likely support a Secretary's Council on Primary Care. HHS commitment of staffing and resources to a council will be critical to coordinating primary care strategy on payment, workforce, research, technology use, and measurement. NASEM is prepared to support an advisory committee to help the council achieve success in its early stages. But sustaining this effort will eventually require congressional support for the creation of a robust Office of Primary Care, with dedicated funding and staffing to support a more permanent infrastructure.

The timing of this opportunity is critical. Primary care has generally lost ground in federal policy and in investment across all payers. There are powerful industry pressures on Congress and federal agencies to maintain the status quo, which makes primary care a perpetual financial loss leader. Growth in graduate medical education (GME) now largely serves the needs of recipient institutions rather than the populations they serve, meaning it provides subspecialty training to support more lucrative services. The primary care payment model experiments advanced by the Center for Medicare and Medicaid Innovation (CMMI), hampered by strict statutory language on cost effectiveness, struggle to achieve broader implementation. As a result, the portion of dollars in Medicare going to primary care relative to other specialties is decreasing, and health systems increasingly orient their services and physician training to higher-margin specialty services.³ As goes Medicare, so goes commercial health insurance provider payment policy, amplifying these trends. Without the triad of a coordinating council in HHS, an advisory committee, and an Office of Primary Care, the country is unlikely to be successful in addressing four of its most important health challenges: health inequities, pandemic response and resilience, the opioid epidemic, and access to mental health services.

PRIMARY CARE'S ROLE IN OUR NATIONAL HEALTH CARE CHALLENGES

Health Equity

While COVID resulted in notable life expectancy drops in the US, overall life expectancy was declining even before the pandemic, with marked disparities for underserved populations. Life expectancy gaps as large as 35 years have long been recognized for communities of color and people living in underresourced neighborhoods, health professional shortage areas (HPSAs), and rural communities.^{4,5,6} COVID-19 amplified these disparities. In 2020, there was an estimated 1.13-year reduction in life expectancy for the US as a whole. For the White population, the reduction was 0.68 years, for the Black population it was 2.10 years, and for the Latino population, 3.05 years; Native American and Pacific Islander populations were the most heavily affected.^{7,8}

Primary care is the only health care sector shown to improve health equity.⁹ Moreover, primary care is important for reducing inequities related to race, ethnicity, poverty, and rurality, potentially bridging partisan political concerns.

Primary care is the most widely distributed health care workforce in the country, and in rural America, it is often the only source of health care.¹⁰ Primary care clinicians are the predominant source of care for pregnant women in critical access hospitals, and the largest source of behavioral health and substance abuse treatment.¹¹ Federally qualified health centers (FQHCs) play a critical role in providing comprehensive primary and preventative care to more than 25 million people in the most vulnerable communities across the country, and states with more FQHCs have lower health outcome disparities.¹² Despite the growing role of FQHCs in shoring up the primary care sector, 40% of US counties are HPSAs, and people who live in them have, on average, nearly a year less life expectancy than people who do not.¹³

The failure to proactively address these workforce shortfalls, and the erosion of the primary care workforce in rural areas, has contributed to persistent health inequities and the reversal of life expectancy gains in this country over the last two decades.^{14,15,16,17}

The federal government's investments in primary care payment, workforce training, and data collection and analysis have been vital, but the strategies have been siloed, with the whole being less than the sum of its parts. There is also fragmentation within each of these three policy areas.

Payment

Conflicting or uncoordinated payment policies abound. Medicare, for instance, pays a HPSA bonus as an incentive to practice in shortage areas, but then reduces payments in rural areas based on a belief that practice overhead costs are lower.^{18,19} To support access for the one in four Americans covered by Medicaid and the Children's Health Insurance Program, the Health Resources and Services Administration (HRSA) has doubled the capacity of FQHCs twice in the last two decades. As important as this expansion has been, FQHCs are not able to serve most Medicaid patients. The lack of enforcement by the Centers for Medicare and Medicaid

Services (CMS) in response to states' violations of federal Medicaid access standards makes caring for Medicaid beneficiaries financially infeasible for most primary care practices that are not FQHCs.²⁰

Workforce Training

Coordinating the federal government's supporting role in workforce training represents another opportunity to address health inequities. Medicare, Medicaid, and the Veterans Health Administration collectively invest more than \$18 billion annually in GME, but only HRSA's programs (e.g., teaching health centers, children's hospital GME) have reporting requirements for training related to workforce needs, such as the percentage of graduates in general pediatric, underserved, and rural practice.²¹ Coordinated evaluation and accountability for all public training funds could improve access to care and provide more relevant preparation of the workforce to serve those communities.

Data Analysis

Responsibility for health workforce data management and analysis is spread across the National Center for Health Statistics, HRSA, and the Agency for Healthcare Research and Quality (AHRQ). As a result, HHS lacks the ability to understand whether primary care is being adequately deployed in service of national public and population health priorities.²² There is insufficient federal focus on enumerating and characterizing (size, location, insurance accepted, e.g.) practices where more than 300,000 primary care clinicians provide care to more than 200 million people.

A Secretary's Council on Primary Care would help achieve health equity by coordinating across AHRQ's practice tracking, HRSA's access programs, and CMS funding to train and recruit the needed workforce and retain them with financially viable practice models. GME payments would be deployed strategically in coordination with the Indian Health Service and HRSA's Federal Office of Rural Health Policy, resolving shortage areas and increasing primary care access. While separate from HHS, the Veterans Health Administration is increasingly contracting with community-based outpatient clinics in areas distant from VA hospitals and would be an important partner to the HHS Secretary's Council in developing a national strategy.

Pandemic Recovery and Resilience

The opportunity to leverage primary care was largely neglected during the COVID-19 pandemic despite its position as the health care setting where most people in the US turn for care. Primary care practices were financially underwater for most of the pandemic but had no specific congressional relief.²³

While mass vaccination sites and retail pharmacies enabled rapid vaccination, primary care could have been a valuable partner. As a country, we missed out on primary care's potential roles in delivering vaccines and tracking population vaccination uptake, as well the long-term relationships primary care teams have with their patients, which help instill trust in public health interventions.²⁴ In June 2021, more than a year into the public health emergency, the U.S. Surgeon General appealed to primary care physicians to help convince their patients to be vaccinated, saying, "You are the most trusted source of vaccine information for your pa-

The Maryland Primary Care Program (MDPCP) is a stunning exception to the overall neglect of primary care as a part of the COVID-19 response. The MDPCP is a collaboration between the Maryland Department of Health and CMS that provides funding, support, data, and technical assistance to primary care practices. Participating practices received COVID-19 guidance and support, and had lower incidence of COVID-19 infection, hospital admission, and death than nonparticipating practices.²⁶ The MDPCP “Triple Play” enabled practices to deliver vaccines, provided them with free test kits, and supported prescriptions or referrals for oral antivirals.²⁷

tients and your communities.”²⁵ Yet, there was no federal primary care strategy related to illness assessment, patient education, vaccination, or treatment.

Early in the pandemic, distribution of the intravenously delivered antiviral remdesivir was relatively easy for hospitalized patients, but it was clear that there would be a need for rapid and widespread distribution of oral antivirals such as Paxlovid. However, as was the case for vaccines, there was no clear plan to leverage primary care, which was well positioned to prescribe Paxlovid and conduct rapid clinical assessment of patients’ risk for drug interactions.

To be fair, HRSA supported FQHCs, rural health clinics, and rural hospitals with \$1 billion focused on vaccine delivery, health equity, and infrastructure resilience.²⁸ These efforts provided well-coordinated support to primary care services that care for more than one in 12 people in the U.S. who live in critical communities. But there was no plan for the rest of primary care across the country.

The Secretary’s Council on Primary Care would enable federal pandemic resilience plan needs to build on lessons from Maryland and HRSA, with a health care strategy that includes explicit plans for identifying, supporting, and deploying primary care clinicians in a coordinated and systematic fashion to reduce epidemic impact and speed recovery.

Opioid Epidemic

The national opioid epidemic worsened during the COVID-19 pandemic, and “deaths of despair” increased significantly, particularly in Native American communities.^{29,30} There is an urgent need to increase access to substance use disorder treatments.

Primary care clinicians provide the majority of medication-assisted treatment (MAT) for opioid use disorder.³¹ Patient visits with an opioid use disorder diagnosis are more than three times higher in primary care than psychiatry, and the number of MAT-waivered primary care physicians surpassed the number of psychiatrists with this credential more than a decade ago.³² Yet the 2022 White House announcement of its vision for Addressing Addiction and the Overdose Epidemic does not reference primary care.³³

Several states have developed multifaceted initiatives to address the opioid epidemic, with public health agencies leading efforts to educate the public on access to MAT that is coordinated by primary care practices.³⁴ State Medicaid agencies have broadened their benefits and provider payment policies to encourage primary care provider MAT prescribing and commercial insurers have been encouraged — or directed — to follow suit.³⁵

On the federal side, HRSA is again a bright spot, supporting FQHCs and rural communities with more than \$500 million from the Affordable Care Act Substance Abuse Service Expansion Supplement. These funds doubled the capacity of health centers to address substance use disorder and increased rural technical assistance capacity such that two-thirds of health centers now provide services for substance use disorder.³⁶

A Secretary's Council on Primary Care would help HHS coordinate an effective opioid strategy. This could include aligning CMS's Medicaid benefit coverage and payment policies for MAT and naloxone with HRSA education and training efforts to bolster the foundational role primary care plays in serving individuals with opioid use disorders.

Growing Mental Health Crisis

The pandemic increased the visibility and scale of the mental health care crisis, particularly for children and adolescents, almost one half of whom report feeling persistently sad or hopeless during the past year.³⁷ Primary care is where most mental health care is delivered.³⁸ Fully integrated behavioral health and primary care delivered by multidisciplinary teams improves outcomes at reduced cost, but is not viable under most health care payment systems.^{39,40} Coordinated federal efforts could change that.

Support for greater integration of primary care with behavioral health was recently touted by both the White House and Congress.^{41,42} Among federal agencies, HRSA has played a key role in advancing access to mental health services through an \$80 million expansion to the Pediatric Mental Health Care Access Program through the American Rescue Plan and \$15 million in support of telehealth access and infrastructure from the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act. The HRSA Bureau of Primary Health Care also supports mental health care in school-based clinics.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is a logical federal partner for expanding behavioral health in primary care outside of FQHCs, but its funding efforts to date have largely focused on integrating primary care services into behavioral health settings.

A Secretary's Council on Primary Care would be critical to developing and sustaining behavioral health integration in primary care to address this national priority. Elements of the Secretary's Council in a coordinated federal plan could include agency coordination on payments to support behavioral health integration in primary care, behavioral health benefits for both Medicaid and Medicare, training support for behavioral health integration from SAMHSA, and translations of HRSA's successes to other community primary care clinics. Redirecting federal GME investments could support community-based primary care residencies with exposure to team-based care models with integrated behavioral health.

A FEDERAL COMMITMENT TO STRENGTHEN HIGH-QUALITY PRIMARY CARE

Strengthen, Not Just Include

High-quality primary care is an essential part of an effective federal response to each of the urgent population health issues identified here, as well as of any long-term vision of a high-value health care system. However, this requires a commitment by the federal government not only to include high-quality primary care in its responses but to strengthen it.

To meet such a commitment, the Office of the Assistant Secretary for Health launched its Initiative to Strengthen Primary Health Care, which will propose a robust plan for the HHS Secretary.⁴³ Yet, that plan will need ongoing direction for coordinating and prioritizing federal actions. A Secretary's Council on Primary Care, with a robust stakeholder advisory committee, could provide this role. Secretary's Councils have limited life spans subject to changes in HHS leadership. There is a need for a more permanent infrastructure in the form of an Office of Primary Care.

Council members would engage HHS leadership, including the CMS administrator; the directors of CMMI, HRSA, SAMHSA, and AHRQ; the Assistant Secretary for Planning and Evaluation; and the Office of the National Coordinator for Health Information Technology. Other federal health stakeholders include the Veterans Health Administration, the U.S. Department of Agriculture, and the White House Domestic Policy Council.

To guide the work of the council, the NASEM report recommended six core interagency activities:

1. Assess federal primary care payment sufficiency and policy.
2. Monitor primary care workforce sufficiency, including training financing, production and preparation, incentives for federally designated shortage areas, and federal clinical assets/investments (health centers, rural health clinics, the Indian Health Service, and the U.S. Department of Veterans Affairs).
3. Coordinate and assess the adequacy of the federal government's research investment in primary care.
4. Address primary care's technology, data, and evidence needs, including interagency collaboration in the use of multiple data sources.
5. Promote alignment of public and private payer policies in support of high-quality primary care.
6. Establish meaningful metrics for assessing the quality of primary care that embrace person-centeredness and health equity goals.

The council would also ascertain whether agencies have allotted adequate budgetary resources to fulfill these responsibilities and would annually report to Congress and the public on the progress of its work.

External Input

An abundance of stakeholders — patients, certifying boards, professional organizations, health care worker organizations, payers, and employers — would be interested in the council's progress and could inform this important body as participants on the Primary Care Advisory Committee, which could be created by the HHS Secretary under the Federal Advisory Committee Act. The Federal Advisory Committee Act allows the NASEM to formally advise federal agencies, and a NASEM-hosted advisory committee could provide a deep bench of external research and policy experts and be prepared to host workshops or organize consensus studies, as directed. This arrangement with the NASEM could be faster, more effective, and less burdensome to HHS than launching an internal federal advisory committee.

Completing the Primary Care Triad

Although a Secretary's Council on Primary Care is essential to coordinating primary care strategies across agencies, few councils function perpetually. A council may not have the reach to coordinate with agencies outside of HHS. Establishing an Office of Primary Care accountable to the Secretary — which would require congressional action — would prioritize primary care on the HHS agenda and provide ongoing support to the council, including relevant analysis and evidence synthesis. While such an office was not a formal NASEM report recommendation, it would be critical for sustaining federal efforts to give primary care the foundational role that the US health system requires. Secretary's councils are typically important for short-term efforts to coordinate policy but are at risk of eventually running out of funding. An Office of Primary Care would support the Secretary's Council on Primary Care and the Primary Care Advisory Committee, forming a potent triad for coordinating, managing, and advising HHS primary care strategy and policy.

There is no shortage of federal innovation to inform strategy and policy, and a federal coordinating function could accelerate the spread of these successful models. For instance, the Veterans Health Administration's Patient-Aligned Care Teams have narrowed panel size while increasing primary care comprehensiveness through the addition of social workers, behavioral health clinicians, and oral health providers, resulting in reduced costs.⁴⁴ CMMI has also invested in primary care-based innovation models, some of which have resulted in better care if not lower costs.^{45,46} FQHCs are more likely to have more robust teams that enhance primary care comprehensiveness including mental health and substance use disorder treatment, social workers, and dental care.⁴⁷ Teaching health centers are more likely to produce primary care clinicians who go on to serve rural and underserved populations.⁴⁸ Each of these innovations is important, but absent the triad presented here they have not collectively translated into systematic investments or improvements in primary care or the broader health care delivery system.

What Is Different Now?

The 2021 NASEM report is hardly the first to call attention to primary care's perilous state or its criticality for health. The launch of FQHCs in the 1960s embraced community-oriented primary care, which the Institute of Medicine (now the National Academy of Medicine, part of the NASEM) documented and described.⁴⁹ The Institute of Medicine published its prior primary care report 26 years ago, and the Medicare Payment Advisory Commission has regularly called on Medicare to re-value primary care.⁵⁰

Why might now be the time that the irrefutable and widely accepted evidence of primary care's benefits to population health will hold sway over institutional self-interests and political power? Although calls for government promotion of a common good, as seen in the NASEM report, are hardly in keeping with the general trend to commercialize and commodify health care services, there are several reasons for optimism.

First, the private sector is betting on primary care to generate returns on publicly insured patients. Hedge funds, private equity, and existing insurers are all buying into Medicare Advantage, which is projected to care for half of all Medicare beneficiaries by 2030.^{51,52} Models like One Medical, ChenMed, Iora Health, Cityblock, and Oak Street Health are leveraging valuable primary care functions to improve health outcomes and reduce costs. While specific strategies vary, enhanced primary care is a common denominator. Many of these plans enable primary care to form strong relationships and provide more, timely care through small patient panels and robust primary care teams, much like the Veterans Health Administration. These models remain relatively geographically circumscribed, however, and often focus only on the highest-cost patients in Medicare and Medicaid, where investors' needs for short-term returns can be realized.

Second, states are growing tired of waiting for federal action. Rhode Island's and Oregon's alternate payment mechanisms and requirements for payers to increase primary care spending offer a path to action for the Secretary's Council on Primary Care. Primary care commissions in New York, California, Colorado, Virginia, Delaware, and Washington are working to strengthen primary care capacity and may well be models for a federal Primary Care Advisory Committee.

Third, policy related to high-priority health issues is shifting. The Biden administration made improving health equity an explicit health policy priority. Congress recognized the seriousness of the behavioral health issues facing America's youth in the wake of the pandemic.⁵³ The rapid growth of FQHCs in the last 15 years – supported by Republicans and Democrats – has been based in part on their ability to deliver returns on federal investment, including improvements in population health and reductions in health disparities. The road to health equity can only be navigated with strong primary care, and a Secretary's Council on Primary Care can make this connection even more obvious for policymakers.

Finally, demography is destiny. Baby boomers will swamp Medicare in the next 30 years, increasing its share of the federal budget. The US will likely not be able to afford the Medicare program it has now and will face agonizing alternatives that may limit the health care entitlement and social solidarity that seniors now enjoy. A fundamental federal commitment to strong universal primary care now could secure its future.

But these signs of optimism must be amplified with federal leadership. Life spans in the US are shortening. Health inequities based on geography, race, ethnicity, and income are growing. Our specialty and acute care-oriented health care system is not up to the challenge of a pandemic, an opioid epidemic, or a growing behavioral health crisis. We need to create and implement a national primary care strategy that includes workforce training, behavioral health integration, clinical comprehensiveness, and payment; that identifies best practices from both the public and private sectors for spread; and that coordinates existing federal programs and policies from GME to Medicare reimbursement to the Federal Employee Health Benefits Program. Creating the triad of council, office, and advisory committee would set the foundation for successful implementation of such a strategy.

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NOTES

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ABOUT THE AUTHORS

Robert Phillips, MD, directs the Center for Professionalism and Value in Health Care, which aims to create space in which patients, health professionals, payers, and policymakers can work to renegotiate the social contract. Dr. Phillips is also responsible for overseeing the American Board of Family Medicine's (ABFM) research and related collaborations, as well as the policy relationships related to family medicine and primary care.

Prior to being named executive director of the center in 2018, Dr. Phillips was the ABFM vice president for research and policy. From 2004 until 2012, Dr. Phillips was the director of the Robert Graham Center in Washington, DC.

Dr. Phillips was elected to the National Academy of Medicine in 2010 and has served the National Academies in several capacities since. In 2012, the health policy research fellowship cosponsored by the Robert Graham Center and Georgetown University was renamed the Robert L. Phillips, Jr. Health Policy Fellowship. He was named to the University of Florida College of Medicine Hall of Fame in 2016.

Dr. Phillips is a graduate of the Missouri University of Science and Technology. After graduation from the University of Florida College of Medicine with honors for special distinction, he completed training in family medicine at the University of Missouri in 1998, followed by a two-year fellowship in health services research and public health. Dr. Phillips is active in Scouting, including a term as Scoutmaster, and helped organize a community effort to reduce teen suicide risk in Fairfax, Virginia.

Alice Hm Chen, MD, is chief medical officer at Covered California, the state's health insurance marketplace, which actively works to ensure that Californians can find affordable, high-quality coverage. In this role she is responsible for health care strategy focused on quality, equity, and delivery system transformation with the goal of improving access and outcomes for all Californians.

Dr. Chen previously served as deputy secretary for policy and planning and chief of clinical affairs for the California Health and Human Services Agency. She led many of the Agency's signature health policy initiatives on affordability and access, and played a leadership role in the state's response to the COVID-19 pandemic in the areas of strategic reopening, hospital surge planning, equity, data analytics and therapeutics.

A graduate of Yale University, Stanford University Medical School, and the Harvard School of Public Health, Dr. Chen's training includes a primary care internal medicine residency and chief residency at Brigham and Women's Hospital. She is an alumna of the Commonwealth Fund Harvard University Fellowship in Minority Health Policy, the Soros Physician Advocacy Fellowship, the California Health Care Foundation Leadership Program, and the Aspen Institute's Health Innovators Fellowship. Proficient in Mandarin and Spanish, she maintains an active primary care practice at Zuckerberg San Francisco General Hospital and holds an appointment as clinical professor of medicine at UCSF.

Christopher Koller is president of the Milbank Memorial Fund, a 117-year operating foundation that improves population health by connecting leaders with the best information and experience. Before joining the Fund, he served the State of Rhode Island as the country's first health insurance commissioner, an appointment he held between 2005 and 2013. Under Mr. Koller's leadership, the Rhode Island Office of the Health Insurance Commissioner was nationally recognized for its rate review process and its efforts to use insurance regulation to promote payment reform, primary care revitalization, and delivery system transformation. The office was also one of the lead agencies in implementing the Affordable Care Act in Rhode Island.

Prior to serving as health insurance commissioner, Mr. Koller was the CEO of Neighborhood Health Plan of Rhode Island for nine years. In this role, he was the founding chair of the Association of Community Affiliated Plans. Mr. Koller has a bachelor's degree (summa cum laude) from Dartmouth College and master's degrees in social ethics and public/private management from Yale University. He has served on four Committees of the National Academy of Science, Engineering and Medicine, as well as its Health Care Services Board. He has also served in numerous national and state health policy advisory capacities and was the recipient of the Primary Care Collaborative's Starfield Award in 2019. Mr. Koller is a professor of the practice in the department of health services, policy and practice in the School of Public Health at Brown University.

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