COMMENTARY

Protecting Family Medicine by Changing the Reimbursement Model Post-COVID-19

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The United States spends billions of dollars each year preparing for medical emergencies. Noticeably absent from that budget is an effective process to protect the frontline defenders delivering primary care. (J Am Board Fam Med 2021;34:S10–S12.)

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Much of the public's perception of health care security comes from the infrastructure of emergency medical services, emergency departments, and intensive care units (ICUs) that are on standby, ready to serve at a moment's notice. Access to critical care has been recognized as so important that our entire nation was put into isolation to provide time to ensure adequate ventilators and ICU beds for the care of COVID-19 patients. "Flatten the curve" became the national headline from the onset of the pandemic.

For most Americans, however, the front line of defense in this pandemic was not a hospital, or even an emergency department. The first point of contact for most patients was, and remains, a primary care physician, most often a family physician. Unfortunately, there was no national agenda emphasizing "Protect America's PCPs" (primary care physicians). There was no widespread funding or support to protect the infrastructure or safety of primary care. As highlighted in this month's policy brief by Gausvik and Jabbarpour, this lack of preparedness had devastating effects for primary care.

The COVID-19 pandemic revealed widespread problems for America's front line of primary care physicians. It is now too late to save many of the offices that have closed, but the future of family medicine, and our preparation for the next pandemic, depends on how we respond to the lessons that we learned.

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Three lessons learned: (1) safety, (2) reimbursement, and (3) communication.

Safety

Very few family physicians had much personal protective equipment (PPE) in their offices. When this pandemic hit, family physicians were left on their own to learn the difference between an N95, a KN95, and a surgical mask. The lack of PPE, and the lack of knowledge about PPE, put lives in danger. It was a major reason for the initial, and continued, closure of many family physician offices.

Because it was impossible to purchase PPE, our family medicine office purchased lawn mower goggles from a hardware store. A local construction company donated a few painters' masks. We even bought gloves from a cattle feed store, meant for delivering calves, that extended above the elbow.

It was many months before our local medical societies organized the volumes needed to purchase legitimate PPE. Tragic months, while many offices across America closed.

We must have PPE readily available in primary care offices.

Reimbursement

America has no idea how financially challenged family physician offices have been for many years. The overhead for a typical family physician is usually 2 to 3 times his or her salary. So, if a physician is making $15,000/month, office expense before getting paid might be $30,000/month, or more. Very few offices have more than a month's expenses in reserve.

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In a large practice like ours with midlevel providers, overhead can easily be $500,000/month. When this pandemic occurred, we immediately began calling our 30,000 patients to cancel their appointments and to address their needs by phone, purely as a public service. Our office had no telehealth system in place or any way to bill for those services. Our focus was only on saving lives and helping patients. With no reimbursement revenue, and our belief that we would get a loan, we quickly used all our savings that had taken many years to build.

Nationally, only 11% of the first Small Business Administration Paycheck Protection Program (PPP) loan went to health care, and the big banks prioritized the companies that owed debt to them, so we did not get a PPP loan in the first round. That is unacceptable in a pandemic. We were essential and risking our lives, but we did not get a first-round loan.

America must make a law: *If a company offers an essential service, that company must be first in line for support.*

As highlighted by Gausvik,[1] primary care reimbursement must change; not just for Medicare but for all payers. Primary care must be paid *in advance* for the anticipated primary care budget for each patient. Medicare and insurance companies know the amount they anticipate paying for primary care every year. It is a budgeted amount and should be paid in advance to the primary care physicians.

Primary care does not need to be "insured." There is no catastrophic primary care expense. There is only catastrophic office closure with no revenue.

The fee-for-service model does not work in a pandemic. No revenue leaves patients without care and their physicians forced to close their offices. Advanced payments would protect family physician offices.

After distributing the advanced payments, value-based data should be used as a reward for quality care and patient satisfaction. This provides much-needed bonuses above the base pay and encourages health care savings for payers. Primary care should receive 10% to 15% of the total health care budget, like other developed countries,[2,3] for our effort to lower the overall health care costs and improve care.

Telehealth reimbursement has finally been recognized as a permanent part of billing. Telehealth should continue to use the same code, at the same fee, as an in-person visit.

There should be no requirement to use video for telehealth because that prevents access for rural or technologically disadvantaged areas. Telehealth text care should also be reimbursed the same as voice. Hopefully, with an advanced payment system, telehealth will be an included part of the package of excellent personal care, with no separate billing necessary.

Communication

The COVID-19 pandemic will forever be known by the miscommunication that divided a nation and divided physicians. The confusion and errors at the Food and Drug Administration, National Institutes of Health, World Health Organization, and Departments of Health can be understood, considering the circumstances, but conflicting information left our front lines in turmoil.

Family physicians were victimized by aggressive vendors by purchasing inadequate PPE. They were sold inaccurate COVID testing. Many offices purchased rapid test kits that were "emergently approved by the FDA," only to find they were ineffective or never arrived. There were no reliable resources to guide family physician as to treatment options, testing differences, or isolation guidelines. There was no forum to warn them of the fraud in the market.

In the first critical months of this pandemic, family physicians were serving on the front lines with very little guidance and no place to turn for communication. This should never be allowed to happen again.

Primary care physicians need a forum, other than social media, to discuss their ideas and insights with each other.

A national primary care pandemic coalition, with 20 to 30 practicing (nonacademic) family physicians, internists, and pediatricians, should be established. It must be outside the confines of government opinion or interference. The coalition physicians could be on standby in the event of a pandemic to contribute informal information updates. Responses should only be from the other coalition members, to avoid confusion on the site. Readers could contribute "thumbs up or down" to reflect majority agreement.

A primary care pandemic coalition does not replace our existing resources, but we discovered during this pandemic that those resources moved too slow. The goal is a different communication resource, of anecdotal, "grassroots" medicine. Such information is vital when a previously unknown

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pandemic occurs. Very few academic physicians have the experience of primary care physicians on the front lines during a pandemic, but there is no forum in which to share it.

Communication is critical to saving lives.

Summary

Family physicians are a critical part of the health care system and are the front lines of defense in the event of a pandemic. COVID-19 taught us that we must protect family physicians by improving safety and communication as well as change the existing reimbursement model.

Advanced payment, with additional value-based reimbursement, could protect access to high-quality, comprehensive primary care during a pandemic. A reimbursement change from fee-for-service to advanced payment could also allow family physicians to focus on patient-centered care, reduce overall health care costs, and boost the morale of physicians.

To see this article online, please go to: http://jabfm.org/content/34/Supplement/S10.full.

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