Investing in Primary Care

The Missing Strategy in America's Fight Against Chronic Disease

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EXECUTIVE SUMMARY

Evidence shows a declining share of US adults and children have a usual source of primary care. This report examines the role of primary care, the specialty designed to provide routine care, in the prevention, early detection, and management of chronic disease, including the most common causes of illness and death in this country, like heart disease, diabetes, and cancer. The analysis of Medical Expenditure Panel Survey data from 2016 to 2022 (most recent year of data available) shows:

- Nearly all adults (95.5%) with a usual source of primary care received preventive services for chronic disease, compared to 67.6% of those without a usual source of primary care.
- Children with a usual source of primary care were also more likely to receive preventive services for vision testing (73.7% vs. 20.9%), accident or injury prevention (43.7% vs. 21.7%), secondhand smoke exposure prevention (37.1% vs. 20.9%), and obesity prevention (95.6% vs. 80.6%).
- For those adults who do develop chronic disease, having a usual source of primary care lowered their odds of going to the emergency department (ED) by 11%, and of hospitalization by 20%.
- For children with chronic disease, having a usual source of primary care lowered their odds of going to the ED or being hospitalized for a condition that can be treated in an outpatient setting condition by 50%.
- Having a usual source of primary care was associated with having nearly 54% lower total health care expenditures for adults with chronic disease, and nearly 40% lower health care expenditures for children with chronic disease, compared to those who did not have a usual source of primary care.

The analysis of Medicare fee-for-service claims data from 2018 to 2019 (years available to research team) finds that:

- For Medicare patients with chronic disease, a higher rate of contact over time (or increased continuity) with a primary care clinician was associated with lower rates of hospitalization, lower rates of ED use, and lower overall costs.

To address the burden of chronic disease, more people should have access to a usual source of primary care, but a declining number of people have one. To reverse this trend, federal, state, and private sector health care leaders can change how and how much primary care is paid, building on promising recent changes in Medicare; minimize beneficiaries' financial barriers to accessing a usual source of care; and ensure medical education prioritizes the training of primary care clinicians, especially for communities with limited access to primary care.

INTRODUCTION

Last year's Health of US Primary Care Scorecard report found that chronic underinvestment in primary care is creating gaps in access to health care, which are likely contributing to lower life expectancy than that of peer nations.[1] We found less than 5% of total health care expenditures in the United States were spent on primary care in 2022. Such financial neglect is leading to a dwindling and overburdened primary care workforce, with only 19% of physician trainees entering primary care and less than 35% of nurse practitioners and 20% of physician associates working in primary care in 2022. Partly as a result, almost one-third of adults and 12% of children went without a usual source of primary care in 2022.

In a health system that is often inaccessible until someone is already sick, and among an aging population, chronic disease rates are rising rapidly. Cardiovascular disease is the leading contributor of death from chronic disease, followed closely by cancer.[2] Treating these conditions is expensive, with heart disease costing the US health care system $233.3 billion a year[3] and the cost of cancer care expected to rise from $210 billion a year to more than $240 billion a year by 2030.[4] In response to the health and economic toll of chronic disease, the US Department of Health and Human Services' Make America Healthy Again agenda calls for a shift toward preventing chronic disease, or stopping it before it starts, and slowing its progression when it appears.

Studies have shown that robust primary care systems are associated with lower overall health care costs, improved mortality rates, and better health outcomes for all communities.

Primary care is the specialty best positioned to lead this shift. Defined by the comprehensiveness of its care and its focus on prevention, primary care enables patients to build trusting, long-term relationships with clinicians who understand all their health needs. Studies have shown that robust primary care systems are associated with lower overall health care costs,[5] improved mortality rates,[6,7] and better health outcomes for all communities.[8]

Although the management of many life-threatening chronic diseases often requires collaboration across multiple specialties, the responsibility for prevention of these diseases, including addressing modifiable risk factors and conducting early screenings, lies squarely with primary care clinicians. Using data from the Medical Expenditure Panel Survey and Medicare fee-for-service medical claims, we examined the role of primary care in preventing chronic disease and effectively managing chronic disease if and when it does start. In this report, a "usual source of primary care" is defined as a particular provider or a place where the individual usually goes when sick or in need of health advice. (See the methodology appendix for more details.)

FINDINGS

I. Adults and Children with a Usual Source of Primary Care Are More Likely to Receive the Preventive Services Needed to Avoid the Development of Chronic Disease

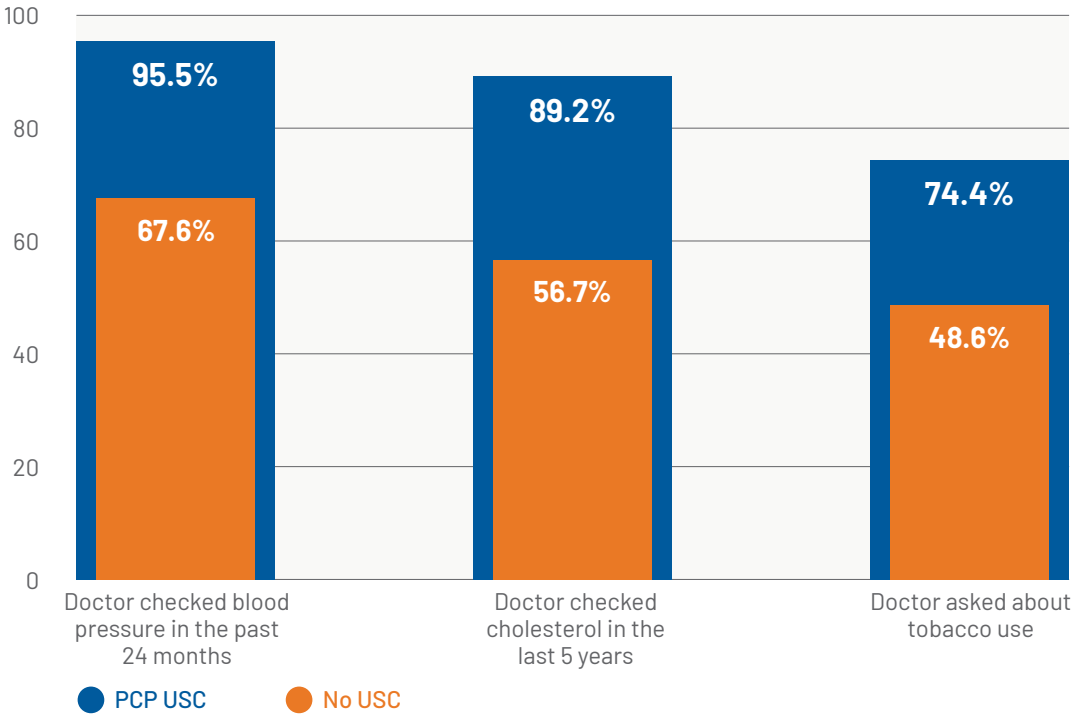
Prevention of the two leading causes of death in US adults, cardiovascular disease and cancer, is complex and depends on a combination of nonmedical factors (such as housing, environmental factors, and lifestyle) and medical factors (such as screening, risk factor management, and timely treatment). When people are unable to access continuous, comprehensive primary care[9] that provides preventive services, they either forgo care altogether or rely on episodic care from emergency departments (EDs),[10,11] urgent care centers, or subspecialists.[12,13] While this type of care may be necessary in certain circumstances, it is not a substitute for care provided by a trusted primary care clinician.

Primary Care's Role in Preventing Heart Disease

Using Medical Expenditure Panel Survey data (2016–2022), we found that having a regular source of primary care was associated with prevention of the most common chronic disease in the US: cardiovascular disease. Adults with a usual source of primary care (PCP USC) were substantially more likely to receive preventive services for heart disease, with differences of nearly 28 percentage points for blood pressure checks (95.5% vs. 67.6%), 33 percentage points for cholesterol screening (89.2% vs. 56.7%), and 26 percentage points for tobacco use screening (74.4% vs. 48.6%) (Figure 1).

Using Medical Expenditure Panel Survey data (2016–2022), we found that having a regular source of primary care was associated with prevention of the most common chronic disease in the US: cardiovascular disease.

Figure 1. Adults with a Usual Source of Primary Care Are More Likely to Be Screened for Cardiovascular Risk Factors (2016–2022)



Source: Authors' analyses of Medical Expenditure Panel Survey data (2016–2022).
Note: PCP USC=usual source of primary care.

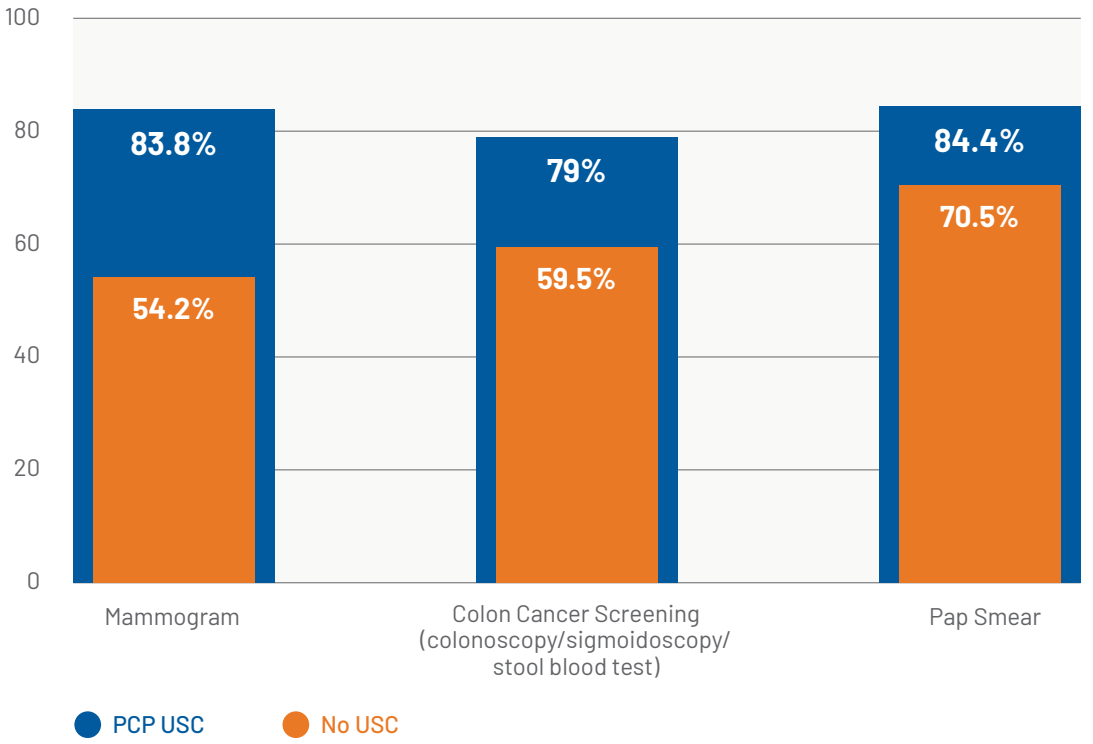
Our findings highlight that primary care clinicians routinely screen for hypertension, cholesterol, and tobacco use, which are all drivers of cardiovascular risk. When these factors are identified early and controlled, the likelihood of developing cardiovascular disease drops significantly.[14]

Primary Care's Role in Cancer Prevention

We also found that regular access to primary care increases the likelihood of timely screening for breast, colon, and cervical cancers — three cancers for which timely detection can prevent progression. The difference in the percentage of people receiving screening if they had a usual source of primary care was almost 30 percentage points higher for mammograms (83.8% vs. 54.2%), 20 percentage points higher for colon cancer screening (79.0% vs. 59.5%), and 14 percentage points higher for Pap smears (84.4% vs. 70.5%) (Figure 2).

We also found that regular access to primary care increases the likelihood of timely screening for breast, colon, and cervical cancers — three cancers for which timely detection can prevent progression.

Figure 2. Adults with a Usual Source of Primary Care Are More Likely to Receive Cancer Screenings (2016—2022)



Source: Authors' analyses of Medical Expenditure Panel Survey data (2016—2022).

Notes: PCP-USC=usual source of primary care. Of the eligible population, women 21—65 years old who have not had a hysterectomy and have no history of prior cervical cancer, the percentage who had a Pap smear in the last five years. Of the eligible population, women 50—74 years old who have not had a mastectomy or have no previous history of breast cancer, the percentage who had a mammogram in the last two years. Of the eligible population, all respondents 50—75 years old who have not had a colectomy or have no previous history of colon cancer, the percentage who had a colonoscopy in the last 10 years or sigmoidoscopy in the last five years, or stool blood test in the last one to three years.

Although evidence shows that these screenings lead to earlier detection and improved outcomes,[15-17] many people forgo these tests because of cost, convenience, or even fear of the results or tests themselves.[18] Primary care clinicians are particularly well positioned to promote these evidence-based screenings, owing to the ongoing relationships and trust established with their patients over time.

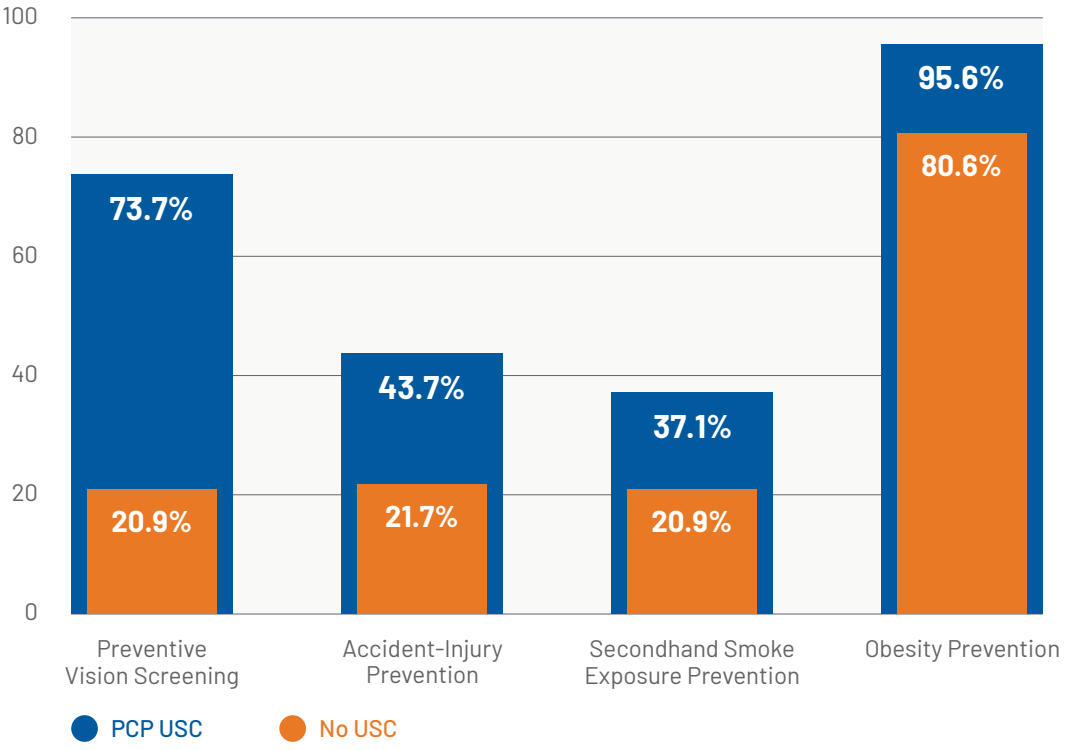
Primary Care Helps Set Children on the Pathway to Good Health

Childhood is a critical window for disease prevention, as prevention ideally begins long before unhealthy habits are entrenched and environmental exposures (such as diet, air quality, and neighborhood conditions) have had years to shape health outcomes. Primary care plays a central role in addressing both the leading cause of death in children — accidental injuries — and the most common chronic conditions in this age group: obesity and asthma. Morbidity and mortality from these conditions can be mitigated by strategies such as reinforcing safety measures (e.g., consistent use of seat belts and helmets), counseling on healthy diet and exercise, and reducing exposure to cigarette smoke.

Our analysis shows children with a usual source of primary care were more likely to receive these preventive services, which reduce the risk of injury, support healthy weight, and improve asthma management. There was a difference of over 50 percentage points for vision testing (73.7% vs. 20.9%), 22 percentage points for accident or injury prevention (43.7% vs. 21.7%), 16 percentage points for counseling on secondhand smoke exposure (37.1% vs. 20.9%), and 15 percentage points for obesity prevention (95.6% vs. 80.6%) when children had a usual source of primary care (Figure 3).

Our analysis shows children with a usual source of primary care were more likely to receive preventive services, which reduce the risk of injury, support healthy weight, and improve asthma management.

Figure 3. Children with a Usual Source of Primary Care Are More Likely to Receive Essential Preventive Screenings (2016–2022)



Source: Authors' analyses of Medical Expenditure Panel Survey data (2016–2022).
Note: PCP USC=usual source of primary care.

II. A Usual Source of Primary Care Reduces the Burden of Chronic Disease on People and the Health Care System

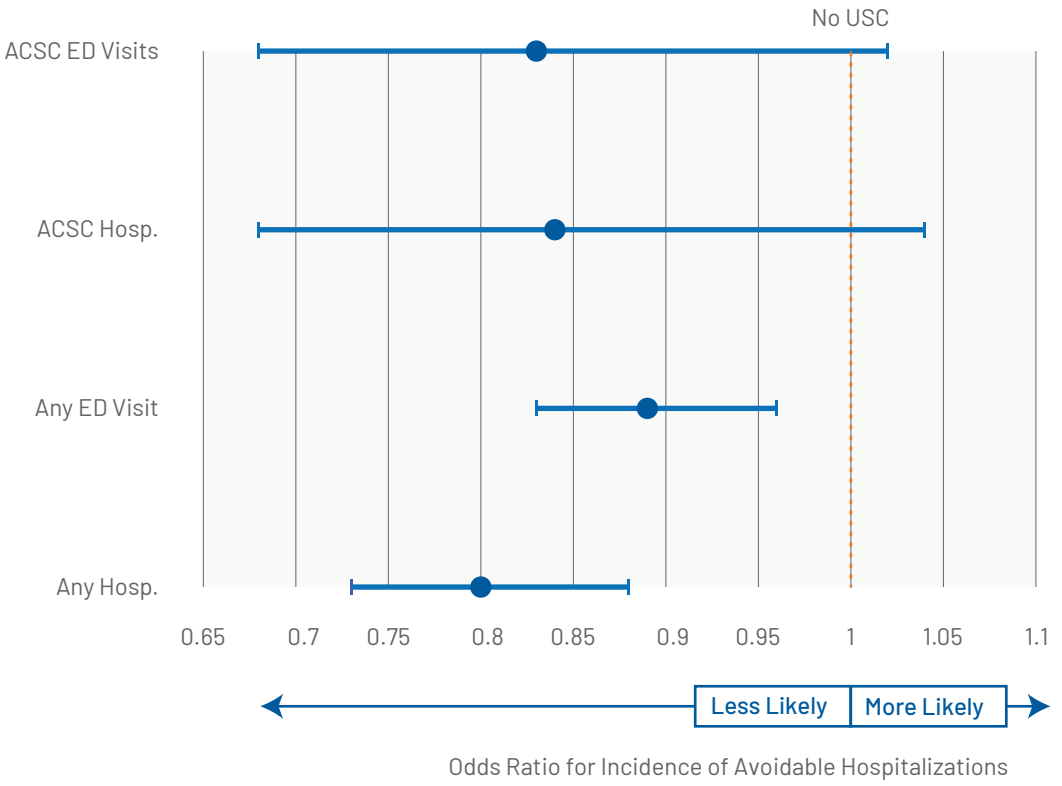
Even with adequate prevention, some individuals will still develop chronic disease. When that happens, the goal shifts to disease control: preventing progression, avoiding unnecessary ED visits, and reducing hospitalizations and overall health care costs. Studies have demonstrated that a continuous relationship with primary care results in fewer hospitalizations and ED visits and lower overall costs.[19] But few studies have examined whether this benefit remains for people who already have chronic disease.

Primary Care Lowers Rate of Hospitalizations and ED Visits

Our research finds that adults with chronic disease who had a usual source of primary care were 20% less likely to have a hospitalization and 11% less likely to have an ED visit for any reason than if they did not have one (Figure 4). The association, however, did not hold for ED visits and hospitalizations for conditions that can be treated in an outpatient setting.

Our research finds that adults with chronic disease who had a usual source of primary care were 20% less likely to have a hospitalization and 11% less likely to have an ED visit than if they did not have one.

Figure 4. Adults with Chronic Disease Who Have a Usual Source of Primary Care Are Less Likely to Have an ED Visit or Hospitalizations (2016–2022)

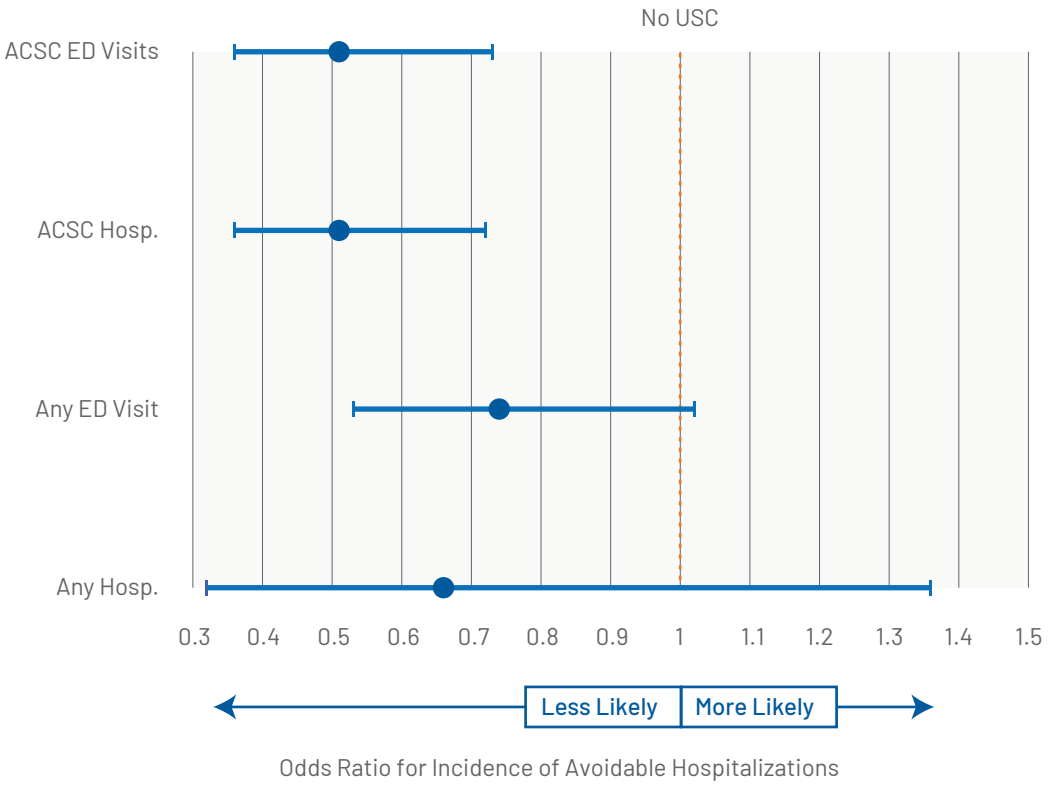


Source: Author analyses of Medical Expenditure Panel Survey data (2016–2022).

Notes: ACSC=ambulatory care sensitive conditions. ED=emergency department. USC=usual source of care. Chronic disease includes having any of the following: asthma, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, hypertension, or stroke. Adjusted for age, gender, race, education, income, insurance type, health status, region, and survey year.

For children with chronic conditions, the results were even more stark. The odds of ambulatory care sensitive conditions (ACSC) ED visits and hospitalizations were nearly 50% lower if children had a usual source of primary care (Figure 5).

Figure 5. Children with Chronic Disease Who Have Usual Source of Care Are Less Likely to Have an ED Visit or Hospitalization (2016–2022)



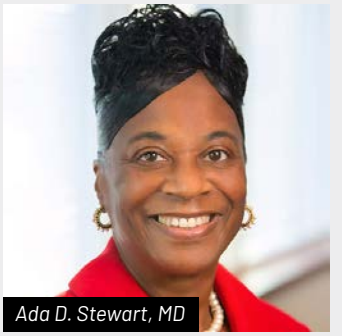
Source: Authors' analyses of Medical Expenditure Panel Survey data (2016–2022).
Notes: ACSC=ambulatory care sensitive conditions. ED=emergency department. USC=usual source of care. Chronic disease includes asthma, attention deficit hyperactivity disorder, diabetes, and epilepsy. Adjusted for age, race/ethnicity, gender, region, income, insurance status, health status, and survey year.

People living with chronic diseases such as diabetes, heart disease, and chronic obstructive pulmonary disease (COPD) are more likely to experience preventable complications that lead to costly ED visits and inpatient stays. Hospitalizations and ED visits contribute to lost productivity, strain on caregivers, and significant reductions in quality of life.[20] The personal financial toll of these acute care visits includes loss of personal wages, declining credit scores, and bankruptcy.[21]

Earning Their Patients' Trust

by Christine Haran

If you ask a primary care clinician what percentage of their patients has chronic disease, they may chuckle. "Nearly all of them who aren't children" is often the answer. Primary care clinicians see patients with diabetes, high blood pressure, coronary artery disease, and HIV day in and day out — and establish relationships with their patients that help to earn their trust.



Ada D. Stewart, MD

"We can have those conversations about lifestyle or social drivers of health [like a stressful housing situation], that they might not feel comfortable sharing with someone else," says family physician Ada D. Stewart, MD, lead provider and HIV specialist at Eau Claire Cooperative Health Centers in Columbia, South Carolina, where she sees multiple generations of patients in both urban and rural settings. "Or they might say, 'I'm taking my medication,' and I know that's probably not true. I'm able to say, 'Tell me, how many pills did you miss?'"

Jennifer Bacani McKenney, MD, is a family physician who owns a private practice started by her father in her rural hometown of Fredonia, Kansas. She considers continuity of care a tenet of rural primary care practice. Dr. McKenney will see her patients in the clinic, but also in the hospital, the emergency department, the nursing home, and at home. "It makes us effective at what we do," she says.

Jennifer Bacani McKenney, MD

A few years ago, McKenney facilitated a diagnosis of pulmonary hypertension of one of her longtime patients, Patricia Hess. Since Hess' diagnosis and recent double lung transplant, McKenney helps to coordinate Hess' complex care. "Jennifer keeps track of everything," Hess says. "The hospital is in Oklahoma City, so she'll fill in my transplant team or do blood work.... She is very involved, and I think that's because she looks at the patient as a whole." Hess adds that McKenney asks about her day-to-day life in a way that makes her feel valued rather than a patient visit to check off the list.

McKenney's practice helps its patients avoid costly care by acting on the patient data that it receives as a member of an accountable care organization. "We got information on [a] patient who was in the emergency room 42 times in one year." McKenney said. "Once we dug in, we found that most of the time, he was out of his medication or in pain over the weekend — things that were preventable. Our care manager started calling him every Friday to see if he needed to be seen or if he needed a refill. The following year, he only went to the ER twice. We were able to make sure that he was getting care at the right place, at the right time."

Policymakers, she says, need to "value primary care physicians appropriately because what we do is the most important piece of the puzzle. It's more obvious when someone gets their 'life saved' by a cardiac surgeon, but we are the ones who make sure someone never has that heart attack."

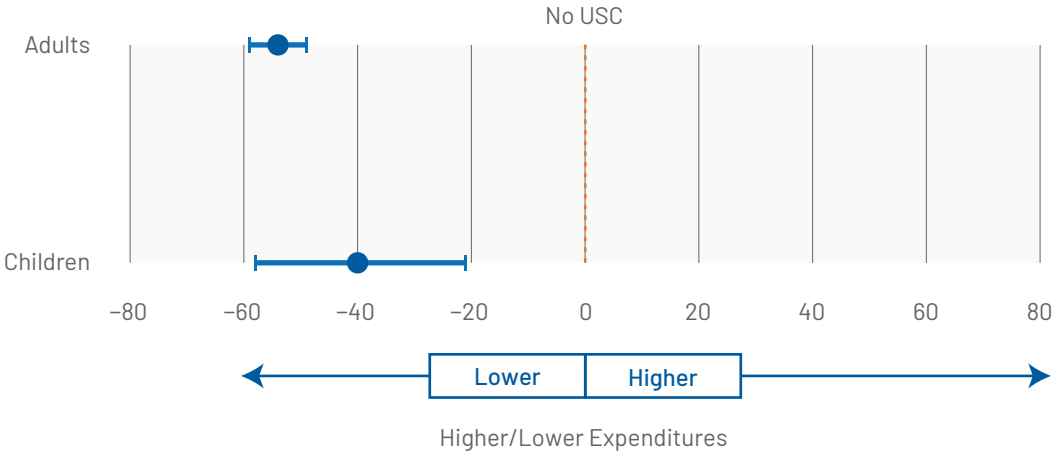
Primary Care Lowers Total Health Care Costs

Acute care visits represent a major driver of ballooning national health expenditures. Reducing unnecessary hospitalizations and ED use is therefore critical not only for the improvement of health outcomes, but also for the sustainability of the US health care system. Investments in robust, accessible primary care and proactive chronic disease management can play a pivotal role in averting high-cost encounters. The reductions in ED visits and hospitalizations associated with having a usual source of primary care translate to savings overall for the health care system.

We found that total health care expenditures for adults with a chronic condition who had a usual source of primary care were nearly 54% lower than for those without a usual source of primary care, and total health care expenditures for children with a chronic disease and a usual source of primary care were nearly 40% lower (Figure 6).

The reductions in ED visits and hospitalizations associated with having a usual source of primary care translate to savings overall for the health care system.

Figure 6. Adults and Children with Chronic Disease Who Have a Usual Source of Care Have Lower Total Health Care Expenditures (2016–2022)



Source: Authors' analyses of Medical Expenditure Panel Survey data (2016–2022).
Notes: USC=usual source of care. Adjusted for age, race/ethnicity, gender, region, income, insurance status, health status, and survey year.

III. Keeping the Same Source of Primary Care Is Essential to Prevent the Progression of Chronic Disease in the Sickest Americans and to Lower Health Care Costs

In primary care, having a usual source of care and keeping that same source of care, or maintaining continuity with a clinician, are both critical yet distinct elements that influence patient outcomes. A *usual source of primary care* refers to having a consistent person or place where a patient typically seeks medical attention. This consistency promotes access, coordination, and timely receipt of preventive and acute services, as our analysis previously demonstrated. *Continuity with a clinician* refers to an ongoing relationship with the same primary care clinician over time. Such continuity fosters trust, enhances communication, and supports more personalized, comprehensive care. While a usual source of care ensures stability within the health care system, continuity strengthens the therapeutic bond that underpins effective long-term management of chronic disease.

The Medicare population of adults over age 65 is unique in its high burden of chronic disease and multimorbidity, which account for a disproportionate share of US health care spending. Patients in this population often require complex medication management, coordination across multiple specialists, and monitoring for preventable complications. In this context, continuity with a primary care clinician is especially important. Consistent primary care provides proactive oversight, ensures that preventive screenings and chronic disease management occur on schedule, and reduces the risk of fragmented care that can lead to adverse events and avoidable ED visits or hospitalizations.

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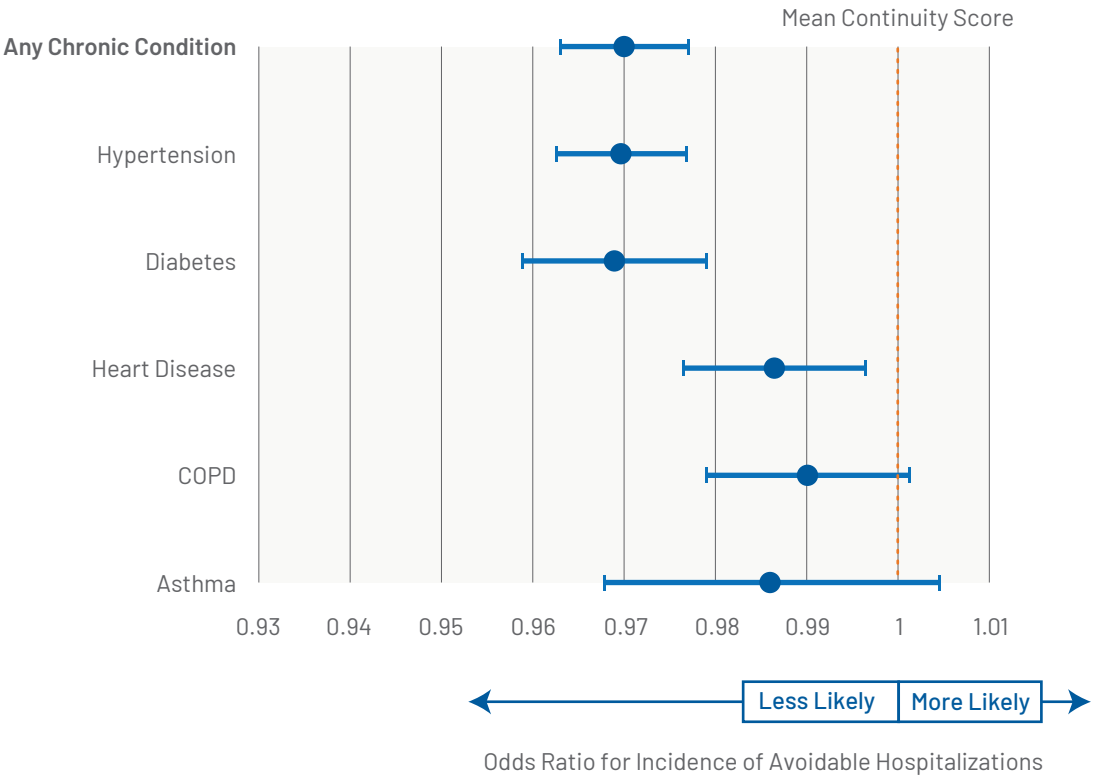
Avoidable Hospitalizations Are Reduced with Increased Continuity of Primary Care

Using Medicare claims data from 2018 to 2019, we show that higher continuity in primary care is associated with lower odds of avoidable hospitalizations among patients with chronic disease, highlighting the role of primary care in preventing serious complications before they require inpatient care.

Across all chronic conditions shown, higher continuity was linked to fewer avoidable hospitalizations. We found that patients with any chronic condition had about a 3—4% lower likelihood of being hospitalized for every 10% increase in continuity scores (odds ratio approximately 0.96—0.97). Similar reductions were seen for hypertension and diabetes, while the effects were somewhat lower for heart disease, COPD, and asthma (Figure 7).

Figure 7. Higher Levels of Primary Care Continuity Are Associated with Lower Odds of Hospitalization for Patients with Chronic Disease

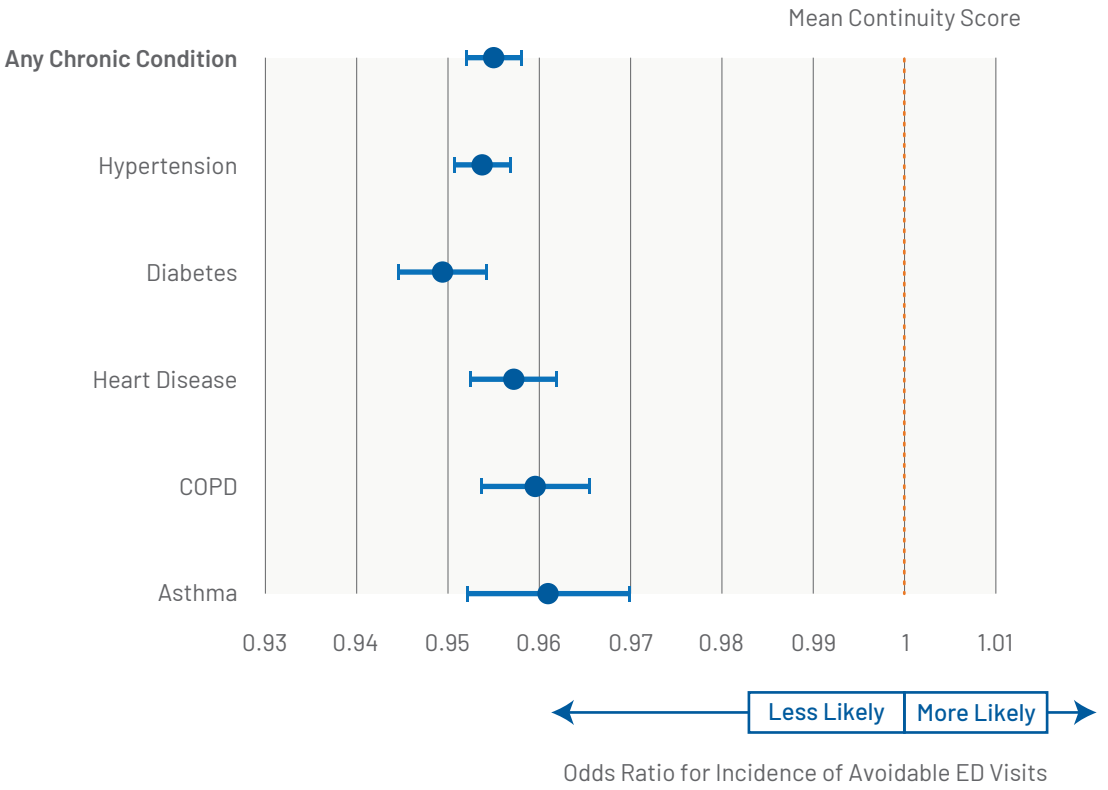


Source: Authors' analyses of Medicare fee-for-services claims data (2018—2019).
Note: COPD=chronic obstructive pulmonary disease. Adjusted for age, sex, race/ethnicity, dual eligibility status, comorbidities, total evaluation and management visits to a usual source of care provider, and census region.

ED Visits Are Reduced with Increased Continuity of Care

Our research shows a similar trend for ED visits, indicating that consistent primary care reduces reliance on emergency care for conditions that could be managed proactively. Across all chronic conditions, stronger continuity of care was associated with fewer avoidable ED visits. For patients with any chronic condition, each 10% increase in continuity scores corresponded to an approximately 4—5% lower likelihood of an avoidable ED visit (odds ratios approximately 0.95—0.96). Similar reductions were seen for hypertension, diabetes, and heart disease, while the decreases were slightly lower but still significant for COPD and asthma (Figure 8).

Figure 8. Higher Levels of Primary Care Continuity Are Associated with Lower Odds of ED Visits for Patients with Chronic Disease

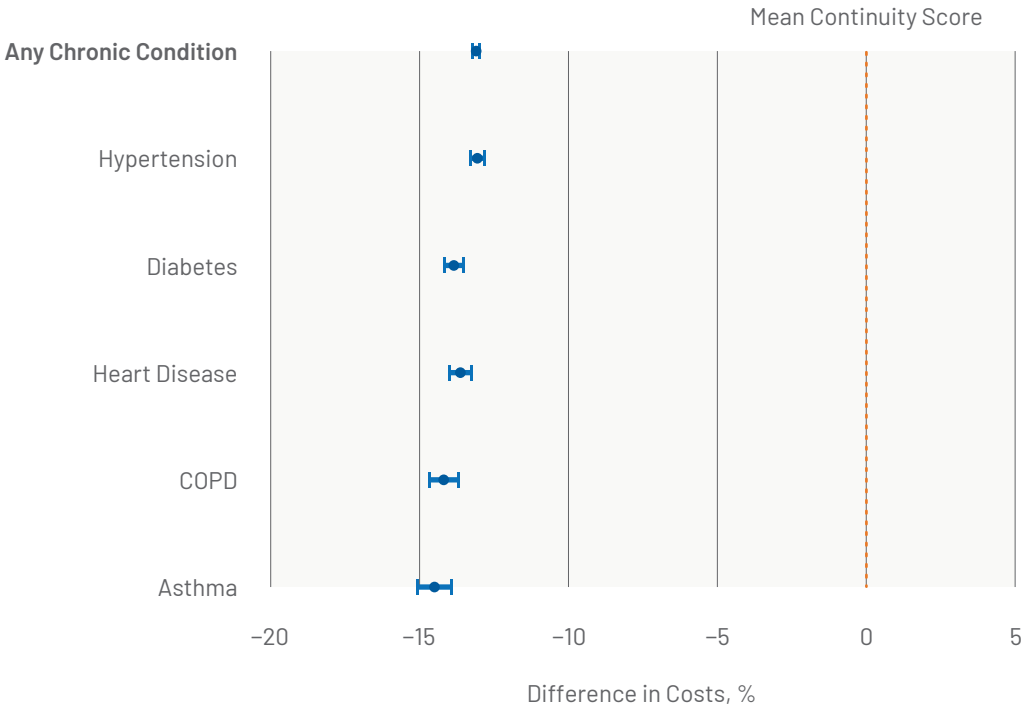


Source: Authors' analyses of Medicare fee-for-services claims data (2018—2019).
Note: COPD=chronic obstructive pulmonary disease. ED=emergency department. Adjusted for age, sex, race/ethnicity, dual eligibility status, comorbidities, total evaluation and management visits to a usual source of care provider, and census region.

Health Care Costs Are Reduced with Greater Continuity of Care

Our research confirms that consistent primary care leads to lower overall health care costs for patients with chronic disease. For patients with any chronic disease, costs decreased by nearly 15% for every 10% increase in their continuity score. By reducing avoidable hospitalizations and ED visits, ongoing primary care not only improves health outcomes but also alleviates financial pressure on patients and the health care system. (See Figure 9.)

Figure 9. Percentage Changes in Costs Associated With Increased Continuity of Primary Care



Source: Authors' analyses of Medicare fee-for-services claims data (2018—2019).
Note: COPD=chronic obstructive pulmonary disease. Adjusted for age, sex, race/ethnicity, dual eligibility status, comorbidities, total evaluation and management visits to a usual source of care provider, and census region.

By reducing avoidable hospitalizations and ED visits, ongoing primary care not only improves health outcomes but also alleviates financial pressure on patients and the health care system.

Given that hospitalizations and ED visits are among the largest contributors to Medicare spending, even modest gains in primary care continuity across this population would yield significant improvements in both health outcomes and Medicare's financial sustainability.

RECOMMENDATIONS

Reducing the burden of chronic disease will require strategies to ensure all people have a usual source of primary care. The following federal, state, and private sector policy changes can help strengthen primary care to meet that challenge — and build a healthier America.

1. MEDICARE should pay more for primary care and pay for it differently.

The addition of Advanced Primary Care Management (APCM) codes in the 2025 Medicare Physicians Fee Schedule and adjustments to the pricing of Evaluation and Management codes in the 2026 fee schedule are significant positive changes that should increase the portion of Medicare spending on primary care (currently 3% to 4%). The Centers for Medicare and Medicaid Services (CMS) should build on them in two ways:

a. **Prioritize increased use of APCM codes** in both Medicare fee-for-service and Medicare Advantage programs. By expanding their use and instituting monthly per-person payments through these codes, CMS will facilitate team-based care in a systematic way, thereby improving access to chronic disease prevention and management services. This will require monitoring their uptake and addressing identified barriers. Reimbursements should be sufficient to cover the costs of the care models needed to provide APCM services; this will significantly increase the share of Medicare spending that currently goes to primary care.

b. **Identify and use alternative sources of clinician service valuation** to the AMA/Specialty Society RVS Update Committee, as identified in the 2025 Report of the National Academies of Sciences Engineering and Medicine's Standing Committee on Primary Care.[22]

2. LARGE EMPLOYERS should purchase health plans with benefit designs that promote access to a usual source of primary care.

The rise in chronic disease exerts a toll on workforce productivity and well-being. Access to a usual source of primary care for employees can help prevent and manage chronic disease. Instead of applying high deductibles to all services, insurance benefits can be designed to **encourage or require employees to choose, or keep, a regular primary care clinician**. In addition, making primary care visits the least expensive and most convenient option incentivizes preventive care and care coordination.

3. MEDICARE should eliminate beneficiary barriers to having a usual source of primary care by defining primary care services as preventive.

By law, preventive services are exempt from Medicare Part B cost-sharing requirements. CMS has the authority to define what constitutes preventive services, and this report demonstrates the essential value of primary care in preventing chronic disease. CMS solicited comments in its proposed 2026 Medicare Payment Fee Schedule rule on **defining an expanded scope of services, or even all services, from a primary care clinician as preventive in nature**. Further steps should be taken to develop and implement this proposal, which would facilitate both retention of a usual source of primary care (at a time when fewer people report having one) as well as continuity of care.

4. **FEDERAL AND STATE POLICY should reform Medicaid funding to increase investment in primary care through enhanced reimbursement, flexible payment models, and support for practice transformation.**

While Medicare fee schedule reforms can influence broader payment trends, primary care must also be strengthened for non-Medicare populations, particularly children. Nearly half of US children are covered by Medicaid or the Children's Health Insurance Program,[23] and children with parents on Medicaid are more likely to receive recommended well-child visits compared to those with uninsured parents.[24]

To support families and ensure access to high-quality primary care, states should reform Medicaid funding. This includes **raising Medicaid reimbursement rates to at least Medicare parity**, which will help practices hire care teams, invest in infrastructure, reduce clinician turnover, and encourage acceptance of Medicaid patients. Beyond increasing overall reimbursement, states should require **Medicaid managed care organizations to report and meet primary care spending targets** and **adopt value-based payment models** to incentivize comprehensive, team-based care.[25] States should set primary care spending targets and ensure that the larger payments reach primary care practices. At a time of budgetary stress for Medicaid programs, it is important to reaffirm the value and priority of primary care for the program and its beneficiaries.

5. **STATES should commit to measuring and increasing primary care spending and ensuring those dollars benefit primary care practices.**

At the state level, initiatives to increase overall **primary care spending** are gaining momentum. To date, over one-third of states have committed to tracking or increasing the share of total health care dollars that go to primary care in recognition of its role in improving outcomes and lowering costs. These policies are encouraging, but their success depends on **ensuring that the money flows directly to primary care clinicians and practices, rather than being absorbed upstream by health systems or insurers**. When structured thoughtfully, these state efforts can stabilize struggling practices, support workforce retention, and enable greater access to preventive and continuous care.

6. **FEDERAL and state policies should prioritize expanding primary care capacity in underserved areas, with a goal of ensuring every patient has a usual source of primary care.**

Community health centers (CHCs) provide care to 10% of the US population and 20% of rural Americans, greatly improving access to primary care and other services for patients in underserved areas. Despite this reach, only 1% of total US health care spending goes toward CHCs.[26] Congress should work to **prioritize and increase CHC funding** — with the goal of doubling the number of patients seen in these settings by 2030 (see the "Triple Double"). Not only should an increase in funding be implemented, but **CHC reimbursement models should be updated** to cover the cost of caring for patients. This includes allowing CHCs to bill for multiple encounters in the same day and adopting alternative payment models that provide additional reimbursement to CHCs. CHCs' model of comprehensive team-based care can set a funding and staffing standard for other primary care practices.

The Primary Care Triple Double

The recommendations in this report are critical not only for the United States to address the burden of chronic disease, but also to strengthen primary care and population health overall. To establish a strong foundation of primary care for the US health care system, borrowing from the terminology for a stellar basketball achievement, Asaf Bitton, MD, Executive Director of Ariadne Labs, has proposed a "**triple double**" performance goal by 2030. The Triple Double involves doubling current performance in three critical areas: primary care investment, the portion of the US population receiving care in community health centers, and the share of new physicians selecting primary care as their specialty. Implementing this report's recommendations would put the nation well on the way toward hitting these marks, with benefits for everyone's health.

7. FEDERAL and state graduate medical education (GME) policies should transform how we pay for graduate medical education.

The selection of specialty (or secondary) care services instead of primary care as an area of practice is driven not only by perceptions of future professional satisfaction and compensation, but also by how GME is financed. The majority of GME funding, roughly $17.8 billion from Medicare and $7.4 billion from Medicaid in 2021, is directed primarily to large academic hospitals. Less than 0.1% of the US population is cared for in these institutions; training where most care is delivered receives relatively little secure funding. Evidence shows that clinicians tend to practice where they train, and because most CMS-funded training occurs in hospital-based settings, many physicians pursue specialty care rather than community-based primary care. However, community-based training programs such as the Teaching Health Center Program, funded by annual appropriations rather than Medicare entitlements, are more likely to produce graduates that work in primary care and underserved settings.[27] **Larger and more sustained federal investments in community-based training programs**, such as the Teaching Health Center Program, will help build a primary care workforce that serves all communities. In addition, every institution receiving Medicare GME funding should be held accountable for its role in developing the primary care workforce, **using metrics that track where graduates practice after training**.

Additionally, NPs and PAs are increasingly critical to primary care delivery, particularly in health centers and safety-net settings. Yet, federal support for their postgraduate training remains extremely limited. Outside of Veterans Affairs programs, the only federal funding is the Advanced Nursing Education-Nurse Practitioner Residency program. This program receives just a fraction of overall GME funding ($30 million in 2023, or 0.1% of 2021 GME funding) and is at risk of elimination during ongoing federal budget negotiations. Policymakers should consider **extending and strengthening Medicare and Medicaid GME investments to include NP and PA postgraduate training** programs with a priority on community-based settings.

CONCLUSION

Chronic disease places a debilitating burden on Americans and the country. The findings in this report show that having a usual source of primary care helps prevent chronic disease and slow its progression in children and adults. Specifically, we found:

1. **Adults and children with a usual source of primary care are more likely to receive the preventive services needed to avoid the development of chronic disease.**
2. **A usual source of primary care reduces the burden of chronic disease on people and the health care system.**
3. **Keeping the same source of primary care is essential to prevent the progression of chronic disease in the sickest Americans and to lower health care costs.**

Addressing the burden of chronic disease in the United States requires helping all Americans have access to a regular, trusted source of care, yet the number of people in the country who report having a usual source of primary care is declining. To reverse this trend, Medicare must accelerate recent changes in how much and how it pays primary care and eliminate financial barriers beneficiaries face to having a usual, ongoing source of care. State Medicaid programs and private health care purchasers must institute similar changes. To strengthen the primary care workforce, medical education funding must prioritize training primary care clinicians, especially for communities with little access to clinicians.

Taking these steps will allow all Americans to live longer and more fulfilling lives, and help communities to be healthier places for all and future generations.

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NOTES

1. Schneider EC, Shah A, Doty MM, Tikkanen R, Fields K, Williams II RD. Mirror, Mirror 2021: Reflecting Poorly. The Commonwealth Fund; 2021. https://doi.org/10.26099/01dv-h208
2. Centers for Disease Control and Prevention. Fast Facts: Health and Economic Costs of Chronic Conditions. CDC Chronic Disease. August 8, 2025. Accessed November 7, 2025. https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html
3. Martin SS, Aday AW, Allen NB, et al. 2025 Heart Disease and Stroke Statistics: A Report of US and Global Data from the American Heart Association. Circulation. 2025;151(8):e41-e660. https://doi.org/10.1161/CIR.0000000000001303
4. Mariotto AB, Enewold L, Zhao J, Zeruto CA, Yabroff KR. Medical Care Costs Associated with Cancer Survivorship in the United States. *Cancer Epidemiol Biomark Prev*. 2020;29(7):1304-1312. https://doi.org/10.1158/1055-9965.EPI-19-1534
5. Shi L, Starfield B, Xu J, Politzer R, Regan J. Primary Care Quality: Community Health Center and Health Maintenance Organization: *South Med J*. 2003;96(8):787-795. https://doi.org/10.1097/01.SMJ.0000066811.53167.2E
6. Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA Intern Med*. 2019;179(4):506-514. https://doi.org/10.1001/jamainternmed.2018.7624
7. Basu S, Phillips RS, Berkowitz SA, Landon BE, Bitton A, Phillips RL. Estimated Effect on Life Expectancy of Alleviating Primary Care Shortages in the United States. *Ann Intern Med*. 2021;174(7):920-926. https://doi.org/10.7326/M20-7381
8. Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. *Milbank Q*. 2005;83(3):457-502. https://doi.org/10.1111/j.1468-0009.2005.00409.x
9. Jabbarpour Y, Jetty A, Byun H, Siddiqi A, Petterson S, Park J. The Health of US Primary Care: 2024 Scorecard Report — No One Can See You Now. Milbank Memorial Fund; 2024. https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now
10. Greenwood-Ericksen MB, Kocher K. Trends in Emergency Department Use by Rural and Urban Populations in the United States. *JAMA Netw Open*. 2019;2(4):e191919. https://doi.org/10.1001/jamanetworkopen.2019.1919
11. Sabety AH, Jena AB, Barnett ML. Changes in Health Care Use and Outcomes After Turnover in Primary Care. *JAMA Intern Med*. 2021;181(2):186-194. https://doi.org/10.1001/jamainternmed.2020.6288
12. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; et al. Primary Care in the United States: A Brief History and Current Trends. In: Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. National Academies Press; 2021. https://www.ncbi.nlm.nih.gov/books/NBK571806
13. Schaefer SL, Dualeh SHA, Kunnath N, Scott JW, Ibrahim AM. Higher Rates of Emergency Surgery, Serious Complications, and Readmissions in Primary Care Shortage Areas, 2015—19. *Health Aff* (Millwood). 2024;43(3):363-371. https://doi.org/10.1377/hlthaff.2023.00843
14. Lloyd-Jones DM, Hong Y, Labarthe D, et al. Defining and Setting National Goals for Cardiovascular Health Promotion and Disease Reduction. *Circulation*. 2010;121(4):586-613. https://doi.org/10.1161/CIRCULATIONAHA.109.192703
15. US Preventive Services Task Force. Breast Cancer: Screening: Final Recommendation Statement. US Preventive Services Task Force. April 30, 2024. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening
16. US Preventive Services Task Force. Colorectal Cancer: Screening: Final Recommendation Statement. US Preventive Services Task Force. May 18, 2021. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening
17. US Preventive Services Task Force. Cervical Cancer: Screening: Final Recommendation Statement. US Preventive Services Task Force. August 21, 2018. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening
18. Sathiyaseelan G, Hashim SM, Nawi AM. Sociocultural Factors Influencing Women's Adherence to Colorectal, Breast, and Cervical Cancer Screening: A Systematic Review. *BMC Public Health*. 2025;25(1):2034. https://doi.org/10.1186/s12889-025-23118-z
19. Chung Y, Petterson S, Dai M, Phillips Jr. RL, Bazemore A. Primary Care Physician Continuity Is a Consistent Measure Associated with Lower Costs and Hospitalizations. J Am Board Fam Med. Published online 2025. doi:10.3122/jabfm.2025.250056R1
20. Moskop JC. Nonurgent Care in the Emergency Department: Bane or Boon? *AMA J Ethics*. 2010;12(6):476-482. https://doi.org/10.1001/virtualmentor.2010.12.6.pfor1-1006
21. Dobkin C, Finkelstein A, Kluender R, Notowidigdo MJ. The Economic Consequences of Hospital Admissions. *Am Econ Rev*. 2018;108(2):308-352. https://doi.org/10.1257/aer.20161038
22. National Academies of Sciences, Engineering, and Medicine. Improving Primary Care Valuation Processes to Inform the Physician Fee Schedule. The National Academies Press; 2025. https://doi.org/10.17226/29069
23. American Academy of Pediatrics. AAP Analysis: 49% of Children Insured by Medicaid or CHIP. *American Academy of Pediatrics*; 2025:2. https://publications.aap.org/aapnews/news/31491/AAP-analysis-49-of-children-insured-by-Medicaid-or
24. Searing A, Osorio A. How Covering Adults Through Medicaid Expansion Helps Children. Georgetown University McCourt School of Public Policy, Center for Children and Families; 2024. https://ccf.georgetown.edu/wp-content/uploads/2024/11/Medicaid-expansion-v2-2.pdf
25. Koller CF, Bianco D, Greene K, Hraber M, Wilkniss S. Implementing High-Quality Primary Care: A Policy Menu for States. Milbank Memorial Fund; 2025. https://www.milbank.org/publications/implementing-high-quality-primary-care-a-policy-menu-for-states
26. National Association of Community Health Centers. Community Health Center Policy Priorities. Published online September 2025. https://www.nachc.org/wp-content/uploads/2025/09/CHC-Priorities-and-Needs-Sept-2025-1.pdf
27. Bazemore A, Wingrove P, Petterson S, Peterson L, Raffoul M, Phillips Jr., RL. Graduates of Teaching Health Centers Are More Likely to Enter Practice in the Primary Care Safety Net. *Am Fam Physician*. 2015;92(10):868. https://www.aafp.org/afp/2015/1115/p868.html