

U.S. Health Reform – Monitoring and Impact

# Impact of the COVID-19 Pandemic on Primary Care Practices

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at [www.rwjf.org](http://www.rwjf.org) and [www.healthpolicycenter.org](http://www.healthpolicycenter.org).

## INTRODUCTION

The COVID-19 pandemic has brought enormous upheaval to the United States, dramatically altering the way we live, work, go to school, and, importantly, obtain health care services. That upheaval has been apparent in primary care, the foundation of our health care system. Primary care physicians (PCPs), nurse practitioners, and physician assistants are often the first health care professionals individuals encounter when facing illness or injury, deliver the majority of preventive and chronic disease services, and, particularly in rural and underserved areas, serve as experts and community leaders

on a wide range of health care issues. As such, these clinicians have had a front row seat on the ravages of the virus that causes COVID-19. They have also directly felt the financial impact of the pandemic's economic fallout and responded in ways that could result in long-term changes to the delivery and financing of primary care. In this paper we discuss observations from interviews with practicing PCPs across the country on the ramifications of COVID-19 on their practices, their patients, and the future of primary care. For example, we learned that:

- Early in the pandemic, many PCP practices were forced to close their doors or significantly reduce services, leading to financial shortfalls that threatened their viability. They also faced new expenses, such as acquiring personal protective equipment (PPE).
- Independent PCPs responded to the pandemic in a wide variety of ways, but all demonstrated nimbleness as small business owners, quickly implementing changes to their practice and modes of service delivery in order to survive. PCPs also received significant government and community support in the early phases of the public health emergency. PCPs reported significant challenges diagnosing and treating COVID-19 while also keeping themselves and their staff safe. Obtaining an adequate supply of PPE has been a challenge throughout the pandemic, and many practices determined they could not test symptomatic patients safely. Others noted that the unpredictable course of the virus, lags in testing results, and patient demands for unproven therapies have made it a difficult illness to treat, particularly when trying to do so remotely.
- PCPs expect that they will continue to deliver a significant proportion of their services via telehealth, so long as reimbursement remains adequate. Several also noted a new willingness to enter into capitated payment arrangements with payers, in order to avoid the financial uncertainties of fee-for-service should utilization once again be suppressed. Others, however, continue to resist any payment arrangements that require them to take on financial risk.
- PCPs reported rising levels of burnout for themselves and their staff, but none indicated they would leave the profession, retire, or seek acquisition by a larger practice or health system due to the pandemic. Indeed, for some, COVID-19 has only reinforced their commitment to the profession and to their patients.

## BACKGROUND

In spite of serving as our health system's front line of defense, primary care has typically been underfunded and undervalued.<sup>1</sup> As non-traditional providers of primary care services have emerged, such as minute clinics, urgent care centers, and telehealth-only providers, many PCPs have struggled to remain financially viable.<sup>2</sup> This has led many independent or small-group practice PCPs to be more receptive to acquisition by larger groups, hospitals, or health systems. Indeed, by 2018, over half of U.S. physicians were affiliated with a larger health system.<sup>3</sup> Others have shifted to "concierge" financing models, serving primarily higher-income patients who can afford monthly or annual fees for personalized attention and care.<sup>4</sup> At the same time, the number of U.S. medical students choosing to enter primary care is far less than the number needed to support a growing and aging population, although international medical school graduates have helped fill the gap. There is also a projected increase in the number of graduated advanced non-M.D. primary care providers, including nurse practitioners and physician assistants in the coming years.<sup>5,6</sup> Even so, the Association of American Medical Colleges projects a shortage of up to 55,200 PCPs by 2032, raising concerns about access to care, particularly in rural and other underserved areas.<sup>7</sup>

These challenges existed well before January 2020, when the U.S. health care system encountered a new and unprecedented test: COVID-19. By early March, the United States had the highest number of COVID-19 cases in the world.<sup>8</sup> Although rates of infection fluctuated throughout the summer, as of January 21, 2021, the U.S. has experienced over 400,000 COVID-19-attributed deaths and over 24 million total reported cases.<sup>9</sup> As public health experts encouraged Americans to stay at home and practice "social distancing," governors declared temporary stay-at-home orders, and hospitals cancelled non-essential services, many people chose to delay or forego primary care services as well. At the same time, the pandemic forced many employers to lay off or furlough workers, resulting in an estimated 3.1 million people in America losing their employer-sponsored insurance (ESI) between March and September 2020, and millions of others experiencing a decline in income making it more difficult to afford health care-related cost-sharing.<sup>10</sup>

These concurrent trends resulted in significant declines in PCP patient volume and practice revenue.<sup>11,12</sup> As late as July and August, an American Medical Association survey of 3,500 physicians found that 81 percent reported lower revenue than they had before the pandemic.<sup>13</sup> By October,

however, some of that volume bounced back, with physicians reporting that adult primary care visits, both in-person and via telehealth, were 13 percent above pre-pandemic levels. This uptick in services suggests many patients were making up for appointments missed during the spring.<sup>14</sup>

In March, the U.S. Congress enacted legislation to provide COVID-19-related financial relief. The \$1.8 trillion Coronavirus Aid, Relief, and Economic Security (CARES) Act established the Paycheck Protection Program (PPP), which provided \$659 billion in forgivable loans to small businesses, and the Provider Relief Fund (PRF), a \$175 billion fund to compensate providers for lost revenue or treatment costs related to the pandemic. Recipients of PPP loans who used the funds for payroll, business mortgage interest payments, rent, or utilities can request loan forgiveness, relieving them of any obligation to pay back the funds.

Of the PRF funds, the federal government distributed a large portion automatically to providers who participate in Medicare, based on their total net patient revenue. This resulted in large hospitals and health systems receiving the bulk of the money; small PCP practices have received a relatively small proportion of these funds.<sup>15</sup>

In March 2020, the Centers for Medicare & Medicaid Services (CMS) began advancing Medicare payments to providers under the Accelerated and Advance Payment Program in order to help them through COVID-19-related revenue shortfalls, and the CARES Act expanded the program. These are essentially zero-interest loans from the federal government; CMS will reduce future Medicare reimbursements to offset the amount providers received in advance payments. However, the vast majority of these payments went to hospitals and other providers that participate in Medicare Part A.<sup>16</sup>

In a broader change during March 2020, CMS increased flexibility around rules for the Medicare reimbursement of telehealth visits, increased payment levels to provide parity with payment for in-office visits, and started covering audio-only phone calls, with additional changes to reduce or waive cost sharing for telehealth visits.<sup>17,18</sup> This was the model for later changes in some state Medicaid plans and private payers' coverage of telehealth services, providing financial incentive for providers to begin delivering much, if not a majority of their services remotely.

# RESEARCH APPROACH

This study aims to capture the perspectives of PCPs as their practices responded to the COVID-19 pandemic and its attendant health and economic challenges. We focused on practicing internal or family medicine PCPs who are senior or managing partners in independent, majority-primary care (>70 percent) practices, and who have knowledge of their practice's financials. We also sought a diversity of practice sizes, locations, and patient demographics. To identify interview subjects, we contacted national and state associations representing primary care physicians, who in turn reached out to their members on our behalf. This approach meant that, while we were able to interview 16 PCPs in a short amount of time, they are not necessarily representative of independent PCP practices nationwide.

In addition to a review of published data documenting physicians' pandemic experiences, we conducted 16 interviews with PCPs. Practice sizes varied from solo practitioners to large, multi-specialty practices and federally qualified health centers (FQHCs). The largest practice employed 370 physicians and served approximately 500,000 patients. All practices employed a number of non-M.D.

providers including nurse practitioners and physician assistants. The smallest, a solo practitioner, has approximately 3,000 patients. Practices were located in the following states: California, Florida, Georgia, Massachusetts, Michigan, Missouri, New Jersey, North Carolina, Texas, and Virginia. They serve rural, suburban, and urban areas. Patient demographics varied widely. Some practices served a relatively affluent population, in which the majority of patients were privately insured; others had predominantly low-income patients who were either uninsured or on Medicaid. Most practices reported a mix of Medicare, Medicaid, and commercially insured patients, although a few limited the number of Medicaid patients due to the program's low reimbursement rates. Interviews were conducted between October 2 and November 10, 2020.

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## OBSERVATIONS

The PCPs we interviewed provide a window on how the COVID-19 pandemic has challenged our already-fragile system of primary care. These have included threats to their financial viability, particularly for smaller, independent PCP practices, and difficulties delivering quality care while ensuring safety for their patients, clinicians, and staff. At the same time, these PCPs have proven to be capable and nimble business owners, quickly shifting to new modes of care delivery. They have also taken advantage of government and community support to sustain their ability to serve their patients. But these efforts have taken their toll, and many report a significant level of burnout that could have long-term implications for our nation's system of primary care.

### **Early Challenges: Empty Waiting Rooms, Revenue Shortfalls**

In general, PCPs were committed to keeping their doors open during the initial wave of the COVID-19 pandemic. Several respondents noted that they were an essential source of care in communities facing a primary care shortage. For them, shutting their doors was simply not an option. Others did temporarily close shop, or significantly reduced the services

they offered. For many, that reduction was not entirely by choice, as patients were, in the words of one doctor, "too afraid to go to an office." For example, a Miami-based practice reported a 60 percent decrease in patient volume during the initial weeks of the pandemic; another PCP in Florida put the decline closer to 75 percent. The PCPs reported that demand was down not just for preventive and routine care services, but also for urgent care.

Several PCPs chose to discontinue offering "non-essential" services such as physicals and well-child visits, in part to reduce the transmission risk for themselves and their staff. This was no small decision, one noted, as these are the services that "pay the bills." However, the downside of an outbreak among the clinical or administrative staff was too great. One rural Texas practice was "crippled" after multiple physicians tested positive for COVID-19, requiring the clinic to close its doors until the rest of the staff was able to receive testing results. Similarly, a small Michigan practice had to shut down when only one physician was left to treat patients, after the other doctor and staff fell ill. Other practices determined that certain patients, such as the immunocompromised or

elderly, would not be allowed to come into the office for in-person visits.

Another key factor driving PCPs' decisions to close or reduce their services was the lack of PPE, including masks, gloves, and gowns. Most reported that acquiring necessary PPE has been difficult, if not impossible, at multiple points during the pandemic. This was particularly true for the smaller practices, which must compete with large health systems and hospitals for supplies. A Massachusetts doctor reported that they no longer treat patients with symptoms of COVID-19 in-person, due to inadequate PPE. After a Virginia hospital was overrun with COVID-19 patients, its administrators asked local PCPs to share the load. But without sufficient PPE, at least one practice turned down the request, determining they did not have the necessary protection to be "frontline evaluators and treaters of COVID-19."

Most PCP respondents reported dramatically reduced revenue in the early phases of the pandemic. For example, a Massachusetts doctor reported that his practice experienced a 40 percent decline in revenue. These PCP practices generally did not have large financial reserves to sustain them during this time. Several also reported that their monthly expenses were running higher than normal, thanks in large part to the high cost of PPE. As a result, several PCPs reported that they reduced their own salaries, imposed staff furloughs, pay cuts, or implemented a combination of these tactics. A Massachusetts doctor reported asking staff to take voluntary furloughs, leading to a 15 percent reduction in payroll. A Texas practice cut its hours by 20 percent, and a Florida PCP reduced staff salaries by 25 percent.

### **It Takes a Village: PCPs are Finding Multiple Sources of Support During the COVID-19 Crisis**

In order to stay financially viable and maintain quality primary care services during the pandemic, PCPs had to implement new and creative changes to the way they do business, and they did not take these steps without support. However, they were operating without any standard blueprint or national-level guidance on how to manage through the pandemic. In large part, PCPs' response to COVID-19 was a bottom-up process, with PCP practices making mostly independent, rapid, and varied decisions to fundamentally shift the way they deliver care. Every practice approached this with their own unique lens, often dictated by the number, age, and risk factors for physicians and staff. Decisions also often hinged on whether the practice was located in an underserved area, or whether there were other providers in the community able to help diagnose and treat COVID-19 patients. In each case, practices had to make difficult decisions about whether and how to operate safely and continue to provide essential primary care services to their patients. They were helped

along the way with government assistance and for many, local community support.

### **PCPs are Nimble Small Business Owners**

#### *Practices Shifted Rapidly, and Relatively Seamlessly, to Telemedicine*

Almost every practice interviewed had shifted a significant portion of their services to telehealth, with the goal of protecting staff and patients. Many of the larger practices had begun to develop a telehealth infrastructure prior to the pandemic, but even smaller practices that had not done so found the transition to telehealth more seamless than they anticipated. Telehealth prior to the pandemic involved purchasing the necessary hardware (webcams computers, etc.). It also required purchasing HIPAA-compliant software (or a platform) from a vendor to conduct the actual visit. Emergency federal guidance, which allowed them to use technology platforms that did not meet federal privacy and security standards, helped in this regard. Several PCPs noted that the ability to interact with patients using noncompliant technologies was critical to ensuring they could deliver timely services, particularly to patients with limited technological access or ability. One rural doctor noted, "[Federal rules] allow FaceTime which is excellent, because a lot of people have iPhones and the quality is good. My first FaceTime patient was 99-years old; she already used it to talk to her kids."

Respondents generally found that most of their patients could navigate the technology relatively easily, but some noted that those of lower socio-economic status often had "no access and no idea" about telehealth options, producing a modest "digital divide." A few respondents emphasized that audio-based telehealth (aka the telephone) has proved to be invaluable, and preferable to video-based telehealth in many circumstances.

Nearly every practice reported that telehealth was a vital lifeline for their practice financially. "It's been a lifesaver," reported one Florida physician. A Missouri doctor told us that, without telehealth, they would be under 50 percent capacity. The practices also reported that purchasing the necessary technology and engaging with telehealth vendors was relatively affordable. Some vendors offered free trial periods or discounts during the initial outbreak. A rural Texas doctor reported that his vendor had yet to charge him for the service, noting, "They're being gracious and letting us try before we buy."

State and federal reimbursement mandates also helped. The Medicare program is reimbursing for telehealth visits at parity with reimbursement for an in-person visit during the public health emergency, and several PCPs practiced in states that require private insurers to do the same. Some

insurers in states that did not require they reimburse at parity did so voluntarily, but can discontinue doing so at any time. PCPs noted that, without these government requirements, telehealth would not have been a viable alternative to in-person services during the pandemic. Further, at least one state – Massachusetts – required insurers to waive consumer cost-sharing for telehealth visits during the COVID-19 emergency period. A PCP there reported that this requirement has been a financial boon for her practice. “Deductibles are what has been killing our practice [financially],” she said. “This policy change enabled us to survive.”

### **Practices Retooled In-person Service Delivery**

Practices have been extraordinarily creative in adapting their operations to provide a safer working environment and continue delivering quality care. Many PCPs shut down indoor waiting rooms, asking patients to wait in their cars or check in outdoors. “We’re at about 85 percent telehealth [visits],” one PCP reported, with “10 percent in their cars, especially the elderly who don’t have devices. The rest – just 2-6 people per day – I see in the office.” Others have set up Plexiglass barriers in their waiting rooms, staggered patient appointment times, and arranged for pre-visit screenings and post-visit payments to be conducted over the phone or online. Many require temperature checks of patients, although there was skepticism over the effectiveness of this tactic. “Waving thermometers around, it’s stupid, but it’s a county regulation,” one said. “Half the people are asymptomatic.”

### **Government Funds Came to the Rescue**

#### *CARES Act Relief Funds*

The PCPs we spoke to consistently praised the CARES Act PPP funding as the most helpful form of financial assistance from the federal government. When asked about the impact, a Texas physician said, “It was huge. I could actually keep my staff. They were wondering every day if they were going to be furloughed or fired....Having a PPP loan allowed us to breathe easier.” A California practice reported that, without the PPP funds, “we couldn’t have continued our operations.”

The PRF was viewed as far less helpful. The amounts received in the initial, automatic payment from the government was relatively small for most practices. Several PCPs were unaware they had received it at all. Others were aware of it but observed that the amount was too low to have an impact. Along with the PRF many practices applied for and received Medicare advance payments, which were perceived as beneficial as a part of the larger relief package. Most viewed it as more impactful than the automatic payments of the PRF, but not as helpful as the PPP.

### **PCPs Report Support from their Communities, but Less from Payers**

Many practices reported that they had received donations from local residents, foundations, and non-profits. Some donated PPE and provided financial assistance. One doctor reported that patients were making them masks. At the same time, although many private insurers have touted<sup>19</sup> their efforts to support primary care during the pandemic, the physicians that we interviewed largely reported that insurers have done nothing to help them. A few have offered grants or loans, but those came with strings attached. For example, one insurer offered financial help to an independent practice in Virginia, but only on condition they refrain from being acquired by a hospital or larger physician group for a number of years. However, in a few cases providers reported that insurers were continuing to pay for telemedicine services at parity with in-person services, even though the state mandates to do so had lapsed. These providers found this to be very helpful to their ability to continue to deliver services and remain financially viable.

### **Primary Care Providers: a Front Line against the COVID-19 Pandemic**

#### *To Test or Not to Test? Early and Ongoing Challenges with Diagnosing COVID-19*

Primary care clinicians were among the first providers to see COVID-19 patients in this country and are often the first stop for patients experiencing COVID-19 symptoms. A critical early question for PCPs was whether and how to offer their patients COVID-19 tests. The decision whether to do so varied from practice to practice. In some cases, despite a lack of PPE and personnel, practice leaders decided they had to offer testing services, because there were few or no other options in their communities. “I don’t mean to sound overly pious, but that’s why we got into this [profession],” said one physician. “I didn’t want to turn away any patients and [our community] doesn’t have a lot in the way of resources. The other clinics closed. It was really us, or no one.”

PCPs that chose not to offer testing services cited the lack of PPE and concerns about staff safety. Some also have had limited staff capacity, whether because personnel are immunocompromised or unable to come into work due to childcare obligations. However, a few acknowledged that finding local sites for their patients to receive timely testing can be a challenge. “It’s a full-time job just finding testing locations [for our patients],” reported one PCP.

One practice decided only to test asymptomatic individuals, and then only in their parking lot. “We decided we did not want our staff around people who were acutely ill,” the doctor said. Conversely, another practice has decided to test only

symptomatic individuals, finding they did not have the staff capacity to also test those without symptoms.

PCPs generally reported little difficulty receiving reimbursement for testing services, and one noted that her practice of requiring a telehealth visit prior to a test has brought in additional revenue for her practice. However, another practice has found it burdensome to help uninsured patients obtain Medicaid eligibility for testing purposes, a benefit authorized by the federal CARES act, noting that there is a lot of back-office paperwork for her staff.

### **Results May Vary: Long Lag Times Lead to Limited Clinical Utility of COVID-19 Tests**

Most PCPs reported that the turnaround time for test results has improved since the initial surge of COVID-19 cases in the spring. But others, particularly those interviewed later in the fall, observed that labs have started to take longer to return results. For the PCR tests, the physician respondents reported turnaround times between 2 and 14 days over the course of the pandemic. One referred to results received after a few days as “worthless” from a clinical or public health perspective. The slow results prompted one large practice to bring testing capacity in-house, which has reduced their turnaround time to 24 hours.

Some PCPs were also using the rapid antigen tests, but several noted these have “significant limitations,” (with high false negative rates). Some PCPs also observed that, when testing is done offsite, they rarely, if ever, have access to information on the type of test or the results. “I don’t know if [the test] was a PCR, antigen, or antibody,” one noted.

Several PCPs also observed that their patients of color have been disproportionately impacted by the pandemic and the inequities in access to health care services. “The first drive through testing locations were only in the affluent areas [in our community],” reported one PCP. Another reported treating patients of color whose complaints had not been listened to by other doctors or emergency room staff, even when they complained of shortness of breath. Almost universally, PCPs with a high prevalence of COVID-19 among their patients of color also reported that these individuals tend to work in higher-risk settings, such as meatpacking, service jobs, prisons, and other sectors requiring regular and often close interaction with other people, and often live in multi-generational housing.

### **Treatment Challenges**

Several of our respondents expressed frustration over the many inexplicable aspects of the virus, particularly the variance in how different patients respond. For example, one cited his experience with an otherwise healthy 22-year-old who barely survived, and still suffers effects, versus a frail

84-year-old who remained completely asymptomatic. Others cited the humbling experience of treating a new disease they knew little about. For example, COVID-19’s unpredictable course of progression often made it difficult to identify when a patient should be sent to the hospital. “I used to think I was a good doctor,” one said, “But now I know I just know how to read a textbook.”

For the most part, PCPs are treating COVID-19 patients remotely, monitoring their symptoms via telemedicine. “We made a decision not [to have COVID-19] patients in the office,” said one physician, noting that that in their small office there was no way to do so and keep themselves and their non-COVID-19 patients safe. However, providers serving predominantly low-income communities often did not have this option. “Technological capacity has been a challenge, especially in the poorer communities with larger minority populations,” observed a physician with a large urban FQHC. Another PCP explained they had to work to stay on top of their COVID-19 patients’ conditions with follow up phone calls and emails.

Several PCPs expressed concerns about patients requesting unproven drugs or interventions that they had seen touted by politicians or online. “They all want hydroxychloroquine,” said one doctor, who has refused to prescribe it, noting that it was the drug of choice among patients who also refused to wear a mask. Another reported that he had patients yell at him when he denied them a hydroxychloroquine prescription.

### **Looking Ahead**

#### *Preparing for a Second (or Third) Wave*

Many public health experts predicted the COVID-19 pandemic would come with a summer lull in cases, followed by a “second wave” in late fall, as colder weather initiated the annual flu season and people began to return to indoor activities. However, as we began our interviews with PCPs in October, the pandemic was already raging in most parts of the country. Indeed, some respondents reported that they never experienced a COVID-19 “lull.” “It’s an ongoing tsunami,” one said. One Michigan practice had just closed their office during the week of our interview, due to rising caseloads in their area.

That said, most PCPs felt they were better prepared to weather a fall-winter spike in cases, having developed approaches to better assure safety for their patients and staff than they had in the spring. Respondents generally agreed that access to PPE had improved, as well as their protocols to minimize contact with possible COVID-19 patients. Increasing comfort with and use of telehealth was also a factor. PCPs further felt they had become more proficient at diagnosing

and treating COVID-19 patients, improving outcomes and helping to reduce transmission.

However, many PCPs appeared resigned to their lack of control over the course of the pandemic, which some observed had been worsened by the lack of trust in their communities in government recommendations on mask wearing and social distancing. Indeed, in spite of their best efforts, some practices informed us they were once again experiencing staff and clinician shortages, due to their age or risk status, as well as, for many, childcare challenges.

Several also raised concerns about lack of trust in the safety or efficacy of a COVID-19 vaccine. A PCP working in a FQHC noted that this lack of trust was a particular problem among the “disenfranchised, poverty-stricken” population served by her clinic.

### **The Future of Telehealth**

Our PCP respondents agreed that expanded use of telehealth has become an integral part of primary care but differed somewhat on the proportion of their services that can be effectively provided through this modality over the long term. Estimates ranged from 20 percent to as high as 70 percent. PCPs reported they now have a clearer idea of the clinical conditions for which telehealth is appropriate, as well as those where it falls short. For example, video-based telehealth can be good for diagnosing rashes, but not for delivering pediatric or gynecological care, which require physical examinations and/or immunizations. Some pointed to telehealth’s particularly useful role delivering behavioral health services but noted that confidentiality can be a problem.

Several respondents observed that telehealth has become very popular among their patients due to its convenience and safety. “Most of my patients absolutely love it, particularly my working population,” one said. However, in some cases PCPs felt that patients loved it too much. One practice established a rule that no patient could have more than three consecutive telehealth visits without an in-person visit. Another commented that patients, once acclimated to telehealth, were demanding immediate appointments, placing unexpected demands on his practice’s ability to respond. Such patient behavior raises policy concerns that expanded use of telehealth could lead to overutilization, particularly if reimbursement remains at parity with reimbursement for in-person care.<sup>20</sup>

Respondents generally felt that their shift to telehealth as a significant portion of their interaction with patients was only viable because of altered payment rules and increased

reimbursement for telehealth services. However, some PCPs reported that insurers had begun cutting back on the generosity of telehealth reimbursement and re-imposing patient cost-sharing for telehealth visits. Most respondents thought that if telehealth payments were to return to at or near pre-pandemic levels, it would not be financially sustainable. However, research demonstrates that the cost of delivering services via telehealth is significantly lower than an in-person visit, so payers may seek to discontinue full parity for telehealth services once the public health emergency is lower.<sup>21</sup>

PCPs were uniformly critical of telehealth-only vendors that consult with patients outside any established relationship with a PCP or other clinician. Many of these have been developed and encouraged by insurers. As one PCP pointed out, insurers “undermine us and send ads that there will be no co-pays with a ‘teledoc’ doctor compared to your regular doctor.” In his view, these telehealth-only providers are not invested in the long-term health of the patient, leading to fractured care and inappropriate treatment, such as overuse of antibiotics for minor upper respiratory infections. Universally, PCPs felt that “if you don’t have an established relationship with the patient, you can’t provide the same level of care.” That said, at least one respondent admitted that many primary care practices are not always as responsive to patients as they could be, especially outside business hours. This physician thought that telehealth could help his practice improve access for their patients, but only as long as reimbursement remained favorable.

### **COVID-19’s Impact on Patients and the Community**

PCPs serving patients in more affluent areas reported little first-hand experience with patients losing their jobs or insurance coverage in the wake of the pandemic. However, those serving more low-income patients discussed several examples of individuals losing employer-sponsored insurance or having their hours cut because they worked for hotels, restaurants, or other businesses affected by COVID-19 social distancing strictures. A Florida physician reported that he has had more patients sleeping in their cars or having to choose between buying food or medicine. Other PCPs suggested their communities had not yet seen the full impact of job loss. “I think it is a slow burn,” one said.

Although perception of the economic impact of the pandemic varies across practices, PCPs uniformly agreed that COVID-19 has produced markedly increased levels of anxiety and depression among their patients. A Virginia physician observed, “It’s taken a toll on a lot of people; even those who are mentally quite healthy are tired, anxious, and depressed.”

Some described increases in alcohol and other substance abuse.

Most respondents could also point to patients who had foregone care because of COVID-19, including needed preventive care and chronic disease management. An Atlanta doctor reported a recent patient with stage 4-breast cancer, which would have been caught at an earlier stage if she hadn't deferred her appointment due to COVID-19. A Dallas physician reported concerns about missed immunizations: "Our biggest fear is that we finish with COVID and wind up with a measles outbreak."

### **New Receptiveness to Payment Reform?**

For most of our respondents, their significant shortfalls in revenue during the early weeks and months of the pandemic was a result of their reliance on a fee-for-service method of payment. In theory, if insurers paid them on a per-person, per-month basis (often called capitation), these providers would have been insulated from the financial effects of a sudden drop in services. However, in our interviews with PCPs, there was wide disagreement over the benefits of capitation as a basic payment method. A few view capitation as "unethical" because they believe it gives clinicians a financial incentive to limit services, particularly for higher need patients. On the other hand, some respondents said they have long supported

replacing fee-for-service with capitated payments. Some of these physicians have hopes that the financial swings associated with COVID-19 could persuade more providers to embrace capitation.

Indeed, a few PCPs told us that they were newly interested in capitated payments. "It might just be a means of survival at this point," said one. Another suggested that COVID-19 had opened his eyes to capitation because "I would not have to argue [with an insurer] about what gets paid."

Despite this new openness to capitation, several PCPs expressed concern about the lack of transparency in how insurers would calculate the payments. Small, independent practices noted that they lacked the leverage and expertise to assure payment levels would be "fair." One expressed concern that insurers would reduce the level of payments over time, essentially shifting more financial risk onto their practice. On the other hand, capitation could give practices more flexibility to manage the mix of telehealth vs. in-person visits, potentially disciplining unwarranted patient demand. And the practices, rather than payers, could determine the appropriateness of audio-only versus video-based telehealth modalities.

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## **CONCLUSION**

The COVID-19 pandemic continues unabated, with surges in cases, hospitalizations, and deaths in most parts of the country. Although federal financial assistance and the increased use of telehealth helped many practices stay afloat in 2020, current trends in virus transmission will continue to put financial and safety pressures on primary care practices. Additional federal support is likely needed, at least in the short-term, to ensure continued access to sufficient PPE and adequate reimbursement for services delivered via audio and video technology. Many practices may also need support for general operating expenses due to depressed patient demand for well visits and other elective services. Future outlays from the PRF should ideally be better targeted than past payments, in order to support those providers most in need.

Young medical students do not choose to enter primary care to become rich. It is among the lower-paid physician specialties. Our interviews with PCPs bore this out, as they universally demonstrated that their first priority is to serve their patients and communities and deliver quality services. At the same time, many have proven themselves to be

capable businesspeople, making tough decisions to cut expenses, pursue new financial opportunities, and make necessary changes to their workflow and procedures. The unrelenting nature of the pandemic has and is continuing to exercise a steep toll, with PCPs noting rising levels of burnout and exhaustion for both themselves and their staff. Even so, not one suggested to us that they intended to quit the profession or retire because of COVID-19. Indeed, for at least one the pandemic has reinforced her commitment to this work: "COVID made me realize I can't retire. I'm like the glue that keeps it all together."

# ENDNOTES

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