Council on Medical Practice

November 13, 2025
2:30 – 4:30 p.m.
Location: Spectrum
Zoom connection information:
Meeting ID: 884 0585 8992
Passcode: 376943
Link: https://us02web.zoom.us/j/88405858992?pwd=maLUIjGcOzA0pAjaFaae1wKwKrKzt3.1

AGENDA

1. Call to order by Triwanna Fisher-Wikoff, MD, chair (David Vaughan, MD, vice chair)
2. Introductions
3. Approval of report – April 4, 2025
4. Current business
    a. Discuss the activity of our task force on patient attribution and announcement of our presentation at the Member Assembly.
    b. Discuss practice management legislation passed by the Texas Legislature.
    c. Discuss Cigna's downcoding policy and AAFP's response.
    d. Review team-based care resources as a start for building a toolkit for tafp.org.
    e. Discuss next steps in monitoring AI use in family medicine and primary care clinics.
5. Other business
6. Adjourn

Jonathan Nelson and Heather Osborne are the staff liaisons for this council.

COUNCIL ON MEDICAL PRACTICE REPORT

Author: Jonathan Nelson
Meeting date: April 4, 2025
Meeting Location: Kalahari Resort, Round Rock

The following members attended the meeting in person: Triwanna Fisher-Wikoff, David Vaughan, Nimat Alam, Lara Gaines, Oscar Garza, Serene Selli, Khanh Thoai Truong, Donald Niño

The following members attended the meeting virtually: Sandra George, Jennifer Greenblatt, Nicole Lopez, Ernst Nicanord, Samrita Varde

The following members attended the meeting as guests: Richard Young, Lindsay Botsford, Terrance Hines, Puja Sehgal

This council is staffed by Heather Osborne and Jonathan Nelson.

ACTION ITEM

1. That the council form a task force to develop and propose a presentation and discussion on problems with patient attribution for the next Member Assembly.

MINUTES

1. The meeting was called to order by Triwanna Fisher-Wikoff, MD, chair at 2:33 p.m.
2. The council report from the meeting on November 7, 2024, was approved.
3. The council received an update on resolution to the AAFP Congress of Delegates asking for further advocacy and resources to address problems related to patient attribution. The AAFP Committee on Quality and Practice voted to approve this resolution for action at its Winter Cluster 2025 meeting.
4. The council discussed what more should be done to address problems with patient attribution, noting that residents need to know about this before going into practice. Questions and ideas raised included:
    a. Can we cooperate with STFM to get info on this into training curriculum?
    b. Can we add a course on this to our medical business training modules for residency programs, Practice MEd?
    c. Our council will propose a presentation and discussion on this topic at the next Member Assembly.

5. The council discussed ways to educate members on the appropriate use of add-on codes and other “practice hacks.” Ideas included:

    a. Highlighting Family Practice Management articles on this topic in stories and references in TAFP member communications.

    b. Seek for a concise resource on modifiers and the best ways to get them paid.

    c. Feature a practice that does this well in a TAFP communications article.

    d. Consider resources for residents in training and residency programs as well.

6. The council reviewed the TAFP Strategic Objective No. 1.3 – Champion a physician-led, team-based approach to patient care – and discussed ideas for future action. One idea was to partner with the Texas Primary Care Coalition to achieve this goal.

7. Tom Banning led the council in a discussion of managed care issues under consideration by the 89th Texas Legislature.

8. The council reviewed the AAFP/Rock Health Artificial Intelligence survey and discussed recent developments in the use of AI in health care.

9. The meeting was adjourned at 5 p.m.

Family medicine tallies significant victories for patients and communities in the 89th Texas Legislature

Download our in-depth report, "The 89th Texas Legislature: A Summary from the Texas Academy of Family Physicians"

By Jonathan Nelson

July 24, 2025

The 89th Texas Legislature adjourned its regular session on June 2, 2025, and gaveled back in for a special session on July 21. In a regular session that was focused largely on items not related to health care, TAFP and its coalition partners were able to secure significant wins for patients and communities across the state.

A member of TAFP's advocacy team, Helen Kent Davis has written an extensive overview of the session from the perspective of family medicine and public health entitled **"The 89th Texas Legislature: A Summary from the Texas Academy of Family Physicians."** The document contains a bonus section on the predicted effects of Congress's passage of H.R. 1, the so-called "One Big Beautiful Bill Act," on the health care industry.

Here are some highlights from the session.

The budget

Unlike some recent legislative sessions, lawmakers convened in January with a sizeable budget surplus and a rosy fiscal forecast. They passed a $338 billion budget including state and federal funds for the next two years, $5 billion more than the current biennial budget. Some of that new funding will go to upgrade the state's aging eligibility system for Medicaid, the Children's Health Insurance Program, and the Supplemental Nutrition Assistance Program. About $160 million in new spending will go to support programs to improve rural health, including much-needed help for rural hospitals.

Women's health program funding remained stable as lawmakers maintained spending levels for the Healthy Texas Women program, the Breast and Cervical Cancer Screening Program, and the Family Planning Program. As a steering committee member of the Texas

Women's Healthcare Coalition, TAFP fought for programs and initiatives designed to address Texas' maternal mortality and morbidity crisis, and to increase access to maternity care.

Family medicine obstetrics fellowships

In what amounts to a major win for rural communities across the state, budget writers included $5 million to "support the development or expansion and administration of family medicine obstetrics postgraduate training grant programs and to support the salaries and benefits of the training physicians." The Texas Higher Education Coordinating Board will administer the funds and establish rules to guide institutions in the creation and expansion of the fellowships.

After participating in the publication of the **"2025 Rural Texas Maternal Health Rescue Plan"** last fall, TAFP began **calling for the creation of obstetrics fellowships for family doctors** to increase access to maternity care in rural Texas. According to the March of Dimes, 47% of Texas counties are "maternity care deserts" — meaning they lack obstetrical services entirely — compared to 33% of counties nationally. The Robert Graham Center says family physicians deliver babies in more than 40% of U.S. counties, and they are the sole maternity care clinicians in 16% of maternity care deserts across the country.

TAFP believes family doctors can play an important role in increasing access to maternity care for rural Texans, but more training opportunities are needed. For family physician residents seeking additional maternity and women's health care training, there are only five FMOB fellowships available in Texas and only 48 fellowships in the country. By establishing the new Family Medicine Obstetrics Postgraduate Training Grant Program, the Legislature has given family medicine the opportunity to help struggling communities.

Primary care and rural physician workforce funding

The Legislature opted to stay the course on a raft of programs designed to recruit and train primary care physicians and to encourage more to practice in rural and underserved communities. Funding for these five programs remained unchanged from the current biennium.

The Family Practice Residency Program

The FPRP is a strategy in the budget under the Texas Higher Education Coordinating Board designed to increase access to primary care by providing direct funding to family medicine residency programs. The program, which has suffered from inconsistent funding in past sessions, maintained funding at $16.5 million for the coming biennium.

The Physician Education Loan Repayment Program

The PELRP pays up to $180,000 of student loans for physicians who agree to practice in a Health Professional Shortage Area in Texas for four consecutive years. The program will receive $35.5 million for the biennium.

The Texas Primary Care Preceptorship Program

The TPCPP aims to increase student interest in primary care by placing first- and second-year medical students in primary care practices for two- to four-week rotations. Its funding will stay at $4.85 million for the biennium.

The Rural Resident Physician Grant Program

The RRPGP awards grants for the creation of new graduate medical education positions in rural and nonmetropolitan areas. The program was established in 2024 and will get $3 million for its second biennium.

The Joint Admission Medical Program

JAMP seeks to recruit economically disadvantaged undergraduate and high school students to pursue careers in medicine by offering scholarships, internships, mentorship, and other support. Its funding held steady at $11.7 million for the biennium.

Other key legislation

Expansion of value-based primary care

House Bill 2254, which reforms outdated insurance laws that block value-based care models in many employer-based health plans, made it through the session and is awaiting the governor's signature. TAFP and a coalition of health plans, business and employer groups, and primary care organizations worked to bring this issue to the Legislature. H.B. 2254 allows employers and primary care physicians to enter value-based contracts with innovative payment models like advanced primary care and direct primary care that could improve patient outcomes and lower health care costs.

The Life of the Mother Act

Lawmakers in both houses passed Senate Bill 31, the so-called Life of the Mother Act, with broad majorities. The bill should provide pregnant women, physicians, and hospitals a common understanding of what constitutes a medically necessary exception to Texas' abortion ban, allowing physicians to perform the procedure when needed to save a mother's life or prevent serious medical harm.

Scope of practice

As expected, the house of medicine faced numerous attempts by nonphysician providers to expand their scope of practice. Once again, TAFP and other physician organizations succeeded in defeating the measures. This session's biggest threat was S.B. 3055, which would have given advanced practice registered nurses, or APRNs, independent authority to diagnose and treat patients — which is by definition the practice of medicine — without collaborating with physicians.

In written testimony to the Senate State Affairs Committee, TAFP President Lindsay Botsford, MD, MBA, laid out the Academy's concerns with the legislation. "Rather than another debate regarding physician versus nurse credentials, the Academy urges lawmakers to consider ways to strengthen the entire primary care network, including APRNs, by redoubling efforts to promote team-based care — the only model that can achieve our mutual goals to increase access, improve health outcomes, and constrain health care costs," she concluded. The bill did not make it out of committee.

Stay tuned …

The current 30-day special session called by Gov. Abbott is focused on legislation in response to the recent floods in Central Texas, regulation of THC products, the redrawing of the state's congressional districts, and a number of conservative-backed proposals that failed to pass during the regular session. Of interest to family physicians, lawmakers will likely consider legislation to restrict the manufacturing and distribution of abortion medications. TAFP will continue to advocate for family doctors, their practices, and their patients, and as always, keep an eye on your inbox for the latest news in TAFP News Now.

Your Academy extends a huge "thank you" to all members who participated this session, either by testifying, or writing and calling your representatives, or by serving as Physician of the Day. Your effort, your voices, and your membership led to TAFP's successful advocacy.

Cigna's downcoding policy gets pushback from physician groups

https://www.aafp.org/pubs/fpm/blogs/gettingpaid/entry/cigna-downcoding-em.html

Family Practice Management's Getting Paid blog

Sept. 16, 2025

Editor's note: Cigna has paused this policy in California after the California Medical Association sent an inquiry to state regulators about its legality there.

A Cigna plan to downcode certain E/M visits is drawing opposition from physician groups, including the American Academy of Family Physicians (AAFP). Beginning Oct. 1, Cigna will launch a new "Evaluation and Management Coding Accuracy" policy (R49) that downcodes visits reported with 99204-99205, 99214-99215, and 99244-99245 when the insurer believes a physician consistently uses them for visits where the primary diagnosis and other claim-based criteria do not indicate that level of E/M. Two example diagnoses Cigna gives are "earache" and "sore throat."

The AAFP raised concerns about this approach in letters to both Cigna and the insurer advocacy group AHIP (formerly America's Health Insurance Plans). The letters emphasize CPT rules that state medical record documentation is needed to determine if the level of an E/M visit has been correctly coded based on total time or medical decision making — the primary diagnosis on a claim is not sufficient. In addition, automatic downcoding policies based on diagnosis alone fail to reflect the continuity and complexity of care family physicians provide, which often includes managing multiple chronic conditions, coordinating with specialists, addressing behavioral health needs, and considering social drivers of health, all within a single visit.

The AAFP urged Cigna to take a proactive, comprehensive, educational approach to addressing concerns relative to the coding practices of family physicians and welcomed the opportunity to collaborate with them on educational outreach initiatives.

What this means for your practice

In response to Cigna's policy change, practices should take the following steps:

- **Review clinical documentation practices:** Ensure that records clearly justify the level of service billed to payers through regular internal review.

- **Check claims information after submission:** Determine if your claims are being downcoded by reviewing the explanation of benefits.
- **Challenge individual claim reductions:** Submit supporting documentation quickly to contest downcoded claims. Monitor for recurring trends that may indicate broader systemic issues. Documentation should be faxed to 833-392-2092.

Cigna says they expect almost 99% of all in-network clinicians will remain unaffected by this policy when it is first implemented, including more than 97% of those who bill level 4 and 5 E/M codes.

According to Cigna's program FAQs, physicians who experience five or more downcoded claims and believe they are billing in alignment with American Medical Association (AMA) guidelines may request to bypass the policy by emailing EMCodingAccuracy@CignaHealthcare.com. Cigna Healthcare will then review clinical documentation for a subset of the physician's claim history. If the review substantiates that at least 80% of the adjusted claims for E/M services were billed appropriately, the bypass request will be granted. The clinician's continued exclusion from the policy will be determined by their coding patterns and alignment to the AMA E/M services guidelines. Cigna Healthcare will conduct periodic claim reviews to verify compliance.

Supporting documents

- AAFP Coding for Evaluation and Management Services: Answer to Common Questions
- AAFP Coding and Payment policy
- AMA payer downcoding resource with tips for documenting and defending E/M services.

— Brennan Cantrell, AAFP Senior Strategist, Market Transformation

AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

September 11, 2025

Mike Tuffin
President and CEO
America's Health Insurance Plans (AHIP)
601 Pennsylvania Avenue NW
Suite 500
Washington, DC 20004

Dear Mr. Tuffin,

On behalf of the American Academy of Family Physicians (AAFP), which represents 128,300 family physicians and medical students across the country, I write to express our concern regarding new health plan payment policies that downcode professional Evaluation and Management (E/M) codes 99204-99205, 99214-99215, and 99244-99245 to a lower E/M code based solely on the diagnosis code submitted on the claim. We have heard from our members that national and regional plans have already begun implementing these policies. Most recently, Cigna announced its Evaluation and Management Coding Accuracy (R49) policy that states "*Cigna may adjust code 99204- 99205, 99214-99215, 99244-99245 to a single level lower when the encounter criteria on the claim does not support the higher-level E/M CPT® code reported.*" These policies ignore Current Procedural Terminology (CPT) guidance and we are deeply concerned about the impact these policies will have on family physicians and the care they provide for your plans' members.

When the Evaluation and Management (E/M) CPT code set and reporting guidelines for E/M services were updated in 2021, the stated goals were to simplify coding and reduce documentation burden on physicians. The appropriate level of coding for an outpatient E/M visit can be based on the level of medical decision making (MDM) or total time spent on the date of the encounter. Importantly, the guidance clearly states that documentation from the medical record is needed to determine if the level of MDM or total time spent on the date of the encounter has been correctly coded. This cannot be determined by the primary diagnosis on the claim.

Under these policies, claims may be downcoded based solely on diagnosis code or other encounter claim criteria, without reviewing the clinical documentation. This conflicts with CPT guidelines that state the final diagnosis presented on the claim is not representative of the time and effort required to arrive at that diagnosis. We are concerned that automatic downcoding policies fail to reflect the continuity and complexity of care family physicians provide, which often includes managing multiple chronic conditions, coordinating with specialists, addressing behavioral health needs, and considering social drivers of health, all within a single visit. These activities are not a function of the diagnosis alone but are

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representative of the comprehensiveness and complexity of family medicine. Our concern is consistent with CPT guidance that clearly states, *"The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition."*[1]

The AAFP believes plans should pay appropriately submitted claims as presented, absent some rational basis for questioning the claim. The AAFP strongly supports appropriate coding and payment practices, as outlined in its Coding and Payment Policy. We urge plans not to request additional documentation and further burden overtaxed family medicine practices and strongly recommend plans consider a more proactive, educational approach to addressing any concerns they might have. The AAFP stands ready to support them in that effort with family physicians as our E/M coding guidance and education is robust and accurate.

We also urge AHIP to promote consistency and transparency in any downcoding policies and procedures. The AAFP's Transparency policy supports our members' right to access reporting information that can be easily verified for accuracy. In alignment with this policy, we ask that AHIP encourage its members to implement the following actions:

- **Clearly and proactively communicate parameters of the program.** Notify physicians when they are identified as outliers, including a description of the data used and the reasons why before making adjustments to individual claims. Offer these physicians additional education. We reiterate our offer of support in this regard.
- **Streamline appeals and determination processes.** This includes offering an easy-to-use appeals process, making determinations in a timely manner, and including detailed information on the remittance advice if an appeal is denied.
- **Identify a pathway for being removed from the program.** Equip physicians with a clear understanding of the changes or improvements necessary to no longer be considered an outlier and thus removed from the program.
- **Disclose the use of artificial intelligence, algorithms, and analytic solutions.** In accordance with the AAFP's Ethical Application of Artificial Intelligence in Family Medicine policy, we urge Cigna to transparently communicate its methods for executing this program to its in-network physicians and practice managers to offer assurances that determinations are being made appropriately.

The AAFP is concerned that the inappropriate financial impacts and administrative stress created by these new policies may disproportionately affect physicians whose care is

[1] CPT 2025 Professional. Chicago: American Medical Association. 2024: 9

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substantially comprised of E/M services. As the cornerstone of primary care delivery in the U.S., family physicians are essential to ensuring your members receive high quality, comprehensive primary care. The increasing prevalence of chronic conditions across all age groups makes that care even more essential and complex. We believe it is in your plan members' best interest to ensure that their members are receiving the highest quality care for their conditions in the lowest cost setting. We further believe they have a vested interest in family physicians and other primary care clinicians being sufficiently resourced to deliver this care that is proven to simultaneously improve outcomes and manage health care spending.

The AAFP further objects to broad brush comparisons that conclude those billing at higher levels are acting fraudulently. This presumption will lead to a corresponding inappropriate undercoding, which fails to accurately capture the complexity of care and the resources involved to meet plan members' needs. We are also particularly concerned about independent physician practices and/or those in rural and underserved communities where the staffing and data systems may be less robust.

We strongly encourage AHIP to discuss these concerns with your member organizations, including taking immediate steps to address these disparities and ensure equitable treatment across all settings.

We have reviewed Cigna's and other plans' policies closely. They are scant in the level of information relative to who will be impacted and why. The AAFP urges AHIP to direct its members to take a proactive, comprehensive, educational approach to addressing any concerns relative to the coding practices of family physicians and welcome the opportunity to collaborate with you and/or your members on educational outreach initiatives. We encourage you to contact Brennan Cantrell, Market Transformation, Senior Strategist at 913-906-6172 or bcantrell@aafp.org.

Thank you for your attention to this matter.

Sincerely,

Stephanie Quinn
Senior Vice President, External Affairs & Practice

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TEAM-BASED CARE

Team-Based Care Operations

Find the knowledge you need to build and sustain successful care teams and achieve your practice goals in this online toolkit from AAFP.

How to Use Advanced Team-based Care in Family Medicine

https://www.aafp.org/family-physician/practice-and-career/managing-your-practice/advanced-team-based-care-family-medicine.html

Already using team-based care? Implementing advanced team-based care, which can include hiring new team members and optimizing your workflows, is a strategy that can elevate your practice. Watch the Practice Hack below for a member perspective on advance team-based care, and review highlighted steps from the video.

How to Start a Care Management Program

https://www.aafp.org/family-physician/practice-and-career/delivery-payment-models/medical-home/care-management.html

When you care manage patients, even simple steps can bring about major benefits: the right program can lead to better patient outcomes, lower health care costs, and improved experiences for your patients, yourself and your team. It's an ideal approach for family physicians who were drawn to the power of individualized care and relationship building. Practices and health care systems that are patient-centric and outcome-driven are well-equipped to succeed in care management.

FPM Resource

Learn more about these and other opportunities to expand into advanced team-based care in FPM's article "Taking Team-Based Care to the Next Level." Discover the benefits that implementing team-based protocols can have on care team well-being, and tap into additional resources available to support you in establishing and sustaining advanced team-based care in your practice.

FREE CME: Non-Physician Clinician Supervision

Learn how to confidently build an effective working relationship with your non-physician clinicians. Free CME link.

Team-based care resources – prescriptive authority

Requirements for a prescriptive authority agreement

When services are provided by an advanced practice registered nurse or physician assistant, the grantee must ensure that a properly executed prescriptive authority agreement, or PAA, is in place for each mid-level provider. The PAA must meet all the requirements delineated in Texas Occupations Code. You can find them on the Texas Department of Health and Human Services website.

For an abbreviated description of PAAs, visit this page on the Texas Medical Association website.

Guidelines on the Supervision of Non-Physician Clinicians

AAFP presents a general overview of the supervision responsibilities in this policy statement.

Legal Requirements for Physicians Supervising Nurse Practitioners and Physician Assistants: FAQ

AAFP provides an in-depth examination of the legal requirements for supervising NPCs including a free CME video in the Managing Your Practice department of its website.

FPM: State laws are key when supervising non-physician clinicians

This Quick Tips post from Family Practice Management explores important considerations in deciding whether to supervise NPCs.

AI in Primary Care

Compiled by Jonathan Nelson, 11/7/2025

AAFP: Artificial Intelligence in Family Medicine

AI hub on aafp.org: https://www.aafp.org/family-physician/practice-and-career/managing-your-practice/artificial-intelligence.html

The Starfield Signal: A Shared Vision and Roadmap for AI in Primary Care

Review the collective insights of a diverse group of leaders from the Starfield Summit on Advancing AI and Digital Health in Primary Care and how artificial intelligence can strengthen primary care. This meeting and report were presented by AAFP and Rock Health.

https://www.aafp.org/dam/AAFP/documents/practice_management/ai-road-map.pdf

Overview of Current Reporting on AI in Primary Care

AI is primarily used for clinical documentation through **ambient intelligence and natural language processing** tools that transform physician-patient conversations into structured, integrated, and accurate medical notes. This automation drastically reduces administrative burden, freeing physicians to focus on patient interaction.

How AI Clinical Documentation Works

The core functionality of AI documentation tools relies on several key technologies and processes:

- **Ambient Listening Technology:** Unobtrusive systems (often a small device or a mobile app) securely listen to the natural conversation between a clinician and a patient during a visit.
- **Speech Recognition and NLP:** The AI uses advanced speech-to-text technology and natural language processing (NLP) to transcribe the dialogue. Unlike simple transcription, NLP allows the system to understand the clinical context, differentiate between the speakers, and filter out irrelevant small talk.

- **Data Analysis and Structuring:** The AI analyzes the transcribed text, identifies key clinical information (symptoms, diagnoses, treatment plans, medications, etc.), and organizes it into a structured medical note format, most commonly the SOAP (Subjective, Objective, Assessment, Plan) note format.
- **EHR Integration:** The generated note is then automatically populated into the appropriate fields of the primary care clinic's Electronic Health Record system, often without manual data entry.
- **Physician Oversight ("Human-in-the-Loop"):** The AI-generated note functions as a high-quality first draft. The physician quickly reviews, edits for nuance or accuracy, and signs off on the note, ensuring clinical validity and legal compliance.

Key Features and Tools

Several AI tools are prominent in the market, including **Nuance Dragon Ambient eXperience (DAX), Abridge, Suki AI, DeepScribe, and Augmedix**, among others. Common features of these tools include:

- **Real-time Note Generation:** Notes are drafted as the conversation happens or shortly after the visit.
- **Contextual Understanding:** The AI can pull relevant patient history (labs, prior diagnoses, medications) from the EHR to enrich the current documentation.
- **Coding and Billing Support:** The system can suggest appropriate ICD-10 or CPT codes based on the documented content, which helps ensure accurate billing and reduces claim denials.
- **Customizable Templates:** Physicians can personalize note formats to fit their specific workflow or specialty needs.

Benefits

- **Reduced Administrative Burden:** Physicians can save hours daily on documentation, drastically reducing the "pajama time" (after-hours charting) that contributes to burnout.
- **Enhanced Patient Interaction:** By eliminating the need to type during a visit, AI allows clinicians to maintain eye contact and focus on the patient, improving the doctor-patient relationship and overall experience.

- **Improved Documentation Quality and Accuracy:** AI captures details in real-time, reducing reliance on memory and leading to more comprehensive and consistent records than manual methods.

Challenges

- **Accuracy and Bias:** While highly accurate, AI can still make errors or reflect biases present in its training data, requiring diligent human oversight.
- **Data Privacy and Security:** The handling of sensitive patient information necessitates robust encryption and strict compliance with regulations like HIPAA.
- **Integration and Training:** Seamless integration with existing EHR systems and effective training for staff are essential for successful implementation and adoption.

Valuing Cognitive Effort in Primary Care: Rebalancing Medicare Physician Payment

David Muhlestein, Yuvraj Pathak, Samia Imtiaz

Health Affairs -- September 3, 2025

https://www.healthaffairs.org/content/forefront/valuing-cognitive-effort-primary-care-rebalancing-medicare-physician-payment

NOTE: This is a ChatGPT-generated summary of a 1,900 word article.

Primary care providers in the United States are in short supply, leading to long wait times and reduced access to preventive and longitudinal care. A major driver of this shortage is the persistent income gap between primary care and specialty physicians. In 2023, specialists earned an average of $394,000 compared to $277,000 for primary care physicians—a disparity that discourages medical students from pursuing primary care. Reforming payment structures is essential to strengthening this foundation of the U.S. health system.

Under the Medicare Physician Fee Schedule (MPFS), payments are determined by the resource-based relative value scale (RBRVS), which measures physician work, practice expense, and malpractice costs in relative value units (RVUs). The “work” component—intended to capture time, skill, and effort—undervalues the cognitive and emotional labor central to primary care. Office visits requiring detailed evaluation, diagnosis, and care coordination often take as long as many specialty procedures but receive 30–75 percent lower RVU values. The system rewards technical procedures that can be performed repetitively, while undercompensating the sustained mental effort of managing complex, chronic patients.

This undervaluation is perpetuated by the RVS Update Committee (RUC), which advises CMS on RVU assignments. The RUC is dominated by specialty representatives—primary care holds only 19 percent of seats despite providing 35 percent of visits—and operates through opaque, survey-based processes that lack scientific rigor. Although CMS has adopted most RUC recommendations, the committee’s bias and secrecy have led to structural underpayment for cognitive work.

CMS has begun addressing these issues by introducing new 2025 billing codes for chronic care management that reduce administrative burden and offer per-month payments. However, broader reform is needed. The value of physician services should reflect both technical skill and the mental intensity of clinical reasoning, coordination, and judgment.

Policy recommendations:

1. CMS should publicly acknowledge that cognitive care has been historically undervalued and commit to correcting this imbalance.
2. Increase RVUs for primary care evaluation and management codes to better reflect mental effort.
3. Commission an independent, evidence-based assessment of physical and cognitive effort across services to replace the opaque RUC process.
4. To maintain budget neutrality, reduce RVUs for technical procedures requiring less cognitive intensity.

Strengthening primary care through fair valuation of cognitive work will improve access, outcomes, and overall system efficiency.