When the same bone breaks in my right foot, I know immediately. The lateral aspect of that foot had been causing discomfort for months, but in trying to work around the left foot, I ignored the right one, putting all my weight on it until suddenly I couldn't. But there are unexpected perks to having both feet broken at the same time. Beyond the relative ease of balancing in two boots rather than one and the thrill of abandoning the scooter, being confronted with the inadequacy of one's workarounds forces a change in course. Something similar may be true of medicine.

Facing growing unease among both doctors and patients, medicine teeters atop an edifice of workarounds. We insert the words "patient-centered" in front of all we do, pursue "personalized medicine," grade physicians on their patient-experience scores, and hire scribes so that, for 2 minutes, we may actually look at our patients. Meanwhile, physicians are told to somehow both tend to their own wellness and complete additional tasks for more patients in less time. What was once a profession as life-giving to physicians as it was to patients has become, for many, a job. For physicians like Jones, the act of discovery was intimately tied to the treatment of disease; today, these pursuits are largely separated — for those who have opportunities for discovery at all. Although for many physicians, patient relationships are all that's left to create, the time for forging these connections is too often consumed by box-checking.

An audio interview with Drs. Rosenbaum and Drazen is available at NEJM.org

When my dad calls the Sunday after the Pittsburgh synagogue shooting, we talk about how we grieve the familiar. I had sent him a tribute to Jerry Rabinowitz, a family medicine physician and one of the 11 people killed.[4] In the tribute, Ben Schmitt tells a story about his father, one of Rabinowitz's patients, developing a gastrointestinal illness while on business in India. The elder Schmitt called Rabinowitz, who promptly called him back — and then called again every day until Schmitt returned home. My dad says, "He was the kind of doctor we all want to be."

Evidently, Rabinowitz, who lacked traditional heirs, had stood every week during the Jewish prayer of mourning, in honor of deceased community members who had no living relatives to stand for them. At Rabinowitz's funeral, 300 people stood in his honor. I hope that the medical community will rediscover how to stand for all that he stood for, too. I don't know how Rabinowitz found the space to care meaningfully, but somehow he shut out the noise — until he couldn't. Rabinowitz had been in another room when he heard the gunshots — safely out of the line of fire. But he rose and continued to live as he would soon die: running to help those in need.

Disclosure forms provided by the author are available at NEJM.org.

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A Step toward Protecting Payments for Primary Care

Bruce E. Landon, M.D., M.B.A.

Even as the U.S. health care system increasingly adopts alternative payment models such as accountable care organizations, the traditional fee-for-service system continues to be the most commonly used method of physician payment. Moreover, although alternative payment models often involve budgets that require organizations to accept risk for spending, fee for service is still the principal payment method under these models and is used to track spending against the budgets. Thus, challenges posed by fee-for-service payment will not be solved simply by more rapid adoption of new payment models.

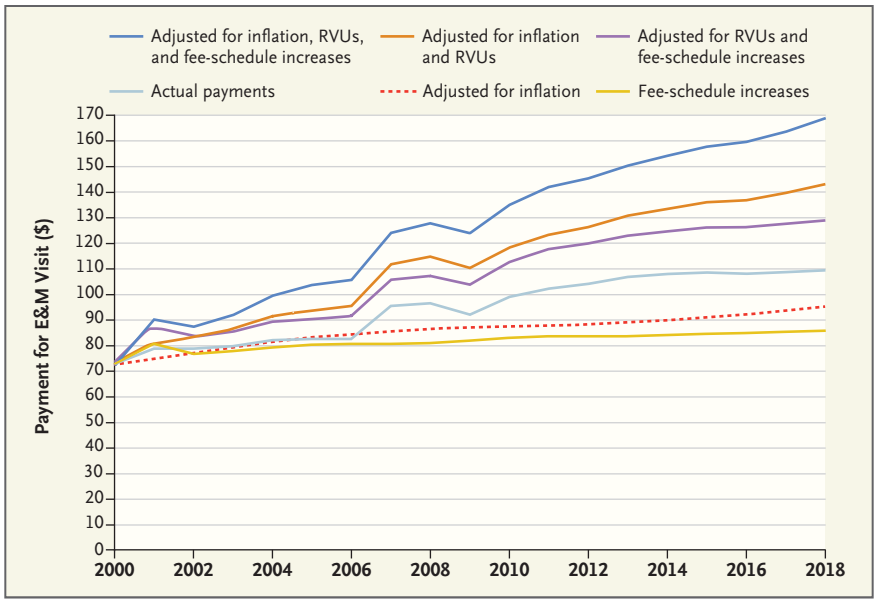
A major criticism of the fee-for-service system is that it penalizes primary care physicians and others who principally provide evaluation and management

(E&M) services. Even after Medicare implemented the resource-based relative value scale payment system, which was in part designed to address this problem, the Medicare fee schedule continued to be criticized for short changing E&M services. Recently, the Centers for Medicare and Medicaid Services (CMS) proposed a substantial revision to E&M payments. Under this proposal, CMS would replace the graded payments for the increasingly complex level 2 through level 5 visits with a single flat payment rate.[1] This proposed rule would ease documentation requirements for physicians providing E&M services, but total payment levels for these services would be relatively unchanged. Although the proposal would make a substantial revision to E&M payments, it would maintain features of the current system for updating the value of relative value units (RVUs) for existing services and assigning RVUs for new services that have exacerbated distortions in payment over time. I believe that any change to make E&M payments more reflective of the work involved in delivering such services should address these features of the system as well.

The first key feature is related to the process used for valuing new services and updating the values of existing services. Though CMS is responsible for final approval, it largely delegates the evaluation activity to the 31-member Relative Value Scale Update Committee (RUC), which is appointed by the American Medical Association. To set or update these values, the RUC relies on specialty-society surveys, typically of at least 30 physicians, that present a case vignette and ask respondents to rate the work involved in the procedure as compared with existing procedures. The survey responses are unvalidated self-reports, however, and the Government Accountability Office has found that respondents typically have a vested interest in overreporting time and effort.[2] Moreover, when a procedure is first introduced, it is often time consuming and difficult to perform, and thus deserving of a relatively high RVU value. Over time, however, as physicians gain more experience with the procedure and new technologies are introduced to make it easier and safer to perform, downward adjustments to the RVU values (when they are made) often fail to accurately reflect the reduced time and effort required.[3] For instance, a 2013 study showed that hourly revenue for performing a colonoscopy was four times that for a similarly time-intensive complex E&M visit, even after the work RVUs for colonoscopy had been reduced several times.[4]

The updating feature of the resource-based relative value scale is particularly important, because Congress stipulated that these updates must be budget-neutral — which is the second problematic feature retained in the CMS proposal. To the extent that new codes with high reimbursement are introduced or split off from existing codes, the payments for all other codes are adjusted downward to compensate, by lowering the conversion factor (by which the RVUs are multiplied to obtain the payment amount). The impact of this budget-neutrality adjustment has important implications for payments for E&M services, which absorb the largest part of this downward adjustment because they are by far the most frequently used codes. Moreover, in contrast to many procedures, the work content of E&M is not subject to the same efficiency gains. If anything, E&M work content has been increased, rather than reduced, by technological innovations such as the electronic health record, and many experts would argue that the issues that need to be addressed by primary care physicians and clinicians in other "cognitive specialties" have only increased in complexity over time.

The impact of these features is illustrated in the graph, which shows payments, under various assumptions, for an office-based physician providing a complex (level 4) E&M visit from 2000 through 2018. Note that the conversion factor actually went down slightly between 2000 and 2018 ($36.60 to $36.00), even though Congress authorized total payment increases to the physician fee schedule that cumulatively amounted to nearly 18% over that period (yellow line). As a result, increases to E&M payments over that period were attributable solely to the periodic adjustments to RVU values, as reflected in actual payments (light blue line). Although that increase might seem reasonable, it amounts to a compound annual growth rate of just under 3.0% per year, starting from a point when E&M payments were already considered low. Over the same period, cumulative general inflation was approximately 50%, and CMS's more conservative Medicare Economic Index (red dashed line), a measure of practice-cost inflation, increased by more than 30%. If



Payments for Level 4 Evaluation and Management (E&M) Visits over Time, under Various Scenarios.

Fee-schedule increases are overall increases in the fee schedule that were passed by Congress. Inflation adjustment is based on the Medicare Economic Index, a measure of practice-cost inflation developed by CMS. Actual payments are the payments for a code 99214 visit. Adjustments to relative value units (RVUs) were periodically made to E&M payments over the study period. The conversion factor, annual RVU values, and actual payment data are from CMS (the Medicare Fee Schedule Search Tool, https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx), as is the Medical Expenditure Index (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html).

fee increases had kept up with both medical inflation and the changes in E&M RVU values, they would be more than 30% higher than they currently are (orange line); if they had kept up with inflation, legislated fee-schedule increases, and changes in RVUs, they would be more than 50% higher (blue line).

Clearly, this analysis suggests that fixing payment levels for primary care physicians and others providing E&M services will require strategies both for adjusting current levels of payments and for mitigating the deleterious consequences of the updating process. CMS has taken several concrete steps related to the first strategy, such as expanding the number and types of billable services for primary care — introducing payments for annual wellness visits, transitional care management, and chronic care management services, for instance. But the uptake of these auxiliary codes has been low, probably because complex requirements must be met in order to bill for these codes, and whether their use improves care remains unclear.[5] Moreover, billing for services using these codes adds complexity to documentation and service delivery, an effect contrary to the spirit of the proposed payment rule.

A complementary approach that would more directly address problems with the updating system would be to remove payments for E&M services performed by cognitive specialists from the set of services whose reimbursement must be adjusted downward to accommodate increased spending on services with new or revised procedure codes. This proposal could be implemented simply by establishing a separate conversion factor for these services. Such a policy would serve two functions. It would keep actual payments for primary care and other cognitive-based specialties flat or allow them to increase at the rate of increase in the overall fee schedule that is written into legislation. And it would directly address (at least in part) the lack of appropriate downward adjustment of RVU values for procedures by forcing payment amounts for existing procedures to counterbalance the increases for new or updated procedures. This approach would also address the concern that the RUC largely represents the interests of procedural specialists.

Although the resource-based relative value scale was designed to improve the fairness of the reimbursement system, the combination of the updating process and budget-neutrality requirements has resulted in substantially lower payments for E&M services over time. As adjustments to payments for primary care are debated, we should consider addressing these other features of the system. Creating a separate conversion factor for some set of E&M services would help prevent further erosion of E&M payment rates and create downward pressure on procedure payments to reflect increases in efficiency over time.

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From the Department of Health Care Policy, Harvard Medical School, and the Divisions of General Medicine and Primary Care, Beth Israel Deaconess Medical Center — both in Boston.

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Risk Compensation and Clinical Decision Making — The Case of HIV Preexposure Prophylaxis

Julia L. Marcus, Ph.D., M.P.H., Kenneth A. Katz, M.D., M.S.C.E., Douglas S. Krakower, M.D., and Sarah K. Calabrese, Ph.D.

Imagine a daily pill that prevents an unwanted consequence of sexual intercourse. Does it give users a "license for promiscuity"? Will its widespread availability lead to "sexual anarchy"? These questions were posed more than a half-century ago about oral contraceptive pills, which enabled condomless heterosexual sex with a far lower risk of pregnancy.[1]

Similar concerns have now arisen about preexposure prophylaxis (PrEP) for HIV, especially when it's prescribed to gay men and other men who have sex with men. PrEP, as currently approved by the Food and Drug Administration (FDA), is a once-daily antiretroviral pill that is more than 90% effective in preventing HIV infection when taken as prescribed. But as with oral contraception, some people view PrEP as a double-edged sword: PrEP may protect people against acquiring HIV, but absent that risk, users might have more partners or more condomless sex, thereby increasing their risk of non-HIV sexually transmitted infections (STIs). This anticipated pattern of behavior — greater risk taking in response to an increased sense of protection — is in keeping with a theory called risk compensation. Clinicians' concerns about risk compensation may be one reason for the slow uptake of PrEP in the United States.

PrEP is still in its infancy. The first trial demonstrating its efficacy, conducted among both men who have sex with men and transgender women, was published in 2010. FDA approval came in 2012. The Centers for Disease Control and Prevention (CDC) issued comprehensive clinical guidelines for PrEP in 2014 and updated its guidelines in 2017. Expanding access to PrEP is now a primary goal of the National HIV/AIDS Strategy.

PrEP was initially evaluated in clinical trials that promoted concurrent use of condoms, the mainstay of HIV prevention. Accordingly, CDC guidelines state that when discussing PrEP with patients, clinicians should encourage condom use. But some studies have suggested that, for some people, condom use decreases after PrEP initiation. This trend may reflect a broader decline in condom use among men who have sex with men, which predated PrEP; it may also reflect risk compensation.

Even when used by people who have condomless sex, however, PrEP has proven remarkably effective in real-world settings[2]; only a handful of HIV infections have been identified among people taking it as prescribed. At the same time, studies have demonstrated that people living with HIV cannot transmit the virus when they are successfully treated with antiretroviral therapy. As awareness of the effectiveness of these biomedical HIV-prevention