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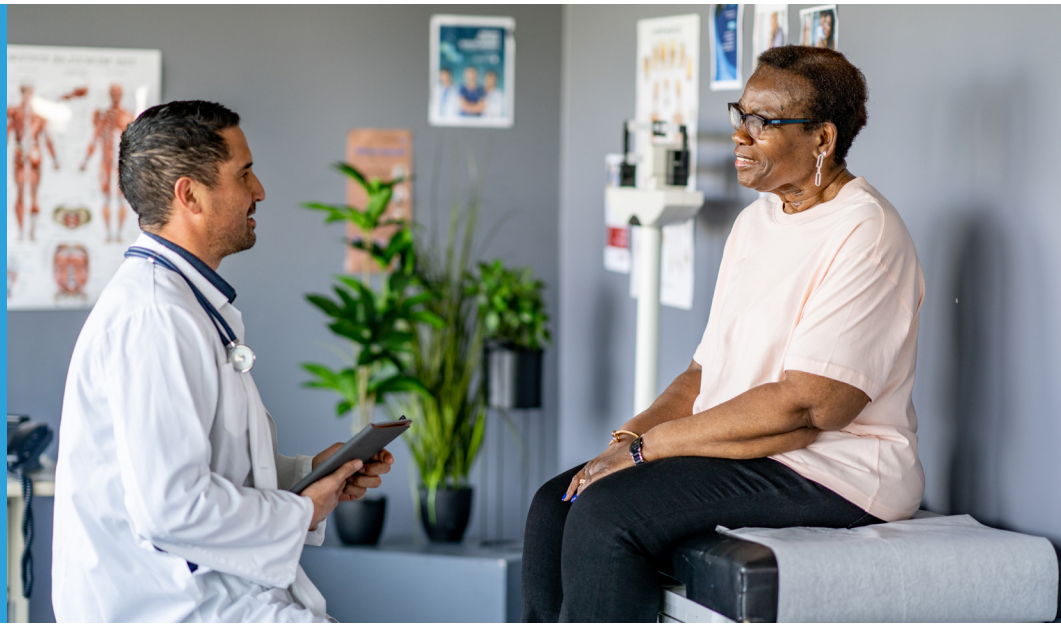
Lay of the Land: Primary Care, Provider Payments and What's Next



Introduction

High-quality primary care is the foundation of an efficient, effective and comprehensive health care system. Primary care serves as the main entry point into health care for families, children, aging adults and individuals across the country and acts as an essential setting for enhancing patients' experience with the health care system while improving affordability and reducing inequities.[1] Serving patients across the lifespan, primary care providers treat the common illnesses and injuries that most families experience at some point and manage the health of people with multiple or acute conditions. In the course of this work, **primary care providers build long-term, trusted relationships with their patients and serve as champions for improving their long-term health and well-being.**[2] It is the role of primary care practitioners (PCPs) to prevent illness before it starts and improve the health and quality of life of the estimated 129 million people in the U.S. living with a chronic illness.[3] As rates of chronic illness continue to climb, the U.S. will need robust primary care access to support the health of its people, particularly those most at risk of chronic illness, such as low-income communities, older adults and those living in rural areas.[4]

While primary care is critical to securing the health and well-being of people across the United States, decisions relating to primary care are often dominated by industry in an effort to preserve the status quo business model at the expense of consumers. Consumer advocates and allied stakeholders have a critical role to play in transforming our health care system to one that centers primary care to meet the diverse health needs of our communities and provide a meaningful counterweight to the influence of the health care industry. To aid in this work, **this publication outlines the problems facing the primary care system and details promising efforts taking place to promote access to high-quality, comprehensive primary care for all people in the United States.**

The problem: a system working against primary care

Despite the fundamental role that primary care plays in meeting the health needs of our nation's families, the U.S. primary care system is in crisis, driven by two fundamental causes:

1. Systemic underinvestment in primary care.
2. Broken fee-for-service (FFS) economics, which result in a fragmented physician payment system that reimburses providers for delivering specific services rather than supporting care teams in delivering whole-person care.[5]

Primary care practitioners are responsible for more than 35% of all health care visits, yet they receive less than 5% of total health care spending in the U.S. and an even smaller share of Medicare spending, significantly less than the average of 14% of health care spending in other high-income countries.[6] This **chronic underinvestment is a major driver of our national shortage of primary care providers.**[7] As a result, nearly 30% of Americans — or about 100 million people — do not have access to a family doctor when they need one.[8] Without access to primary care, small health problems turn into life-changing chronic diseases, the management of those chronic conditions becomes uncoordinated or stops all together, visits to the emergency department increase, and preventive care is underdelivered or becomes obsolete.[9]

Moreover, **fee-for-service economics** — which incentivize providers to make money by performing more high-profit or high-margin procedures rather than allowing providers to generate revenue by keeping people healthy and reducing disparities*— **are incompatible with delivering high-quality, comprehensive primary care.**[10] Yet, these broken FFS payment incentives are the basis for physician payment from one of the largest and most important payers in the U.S. health care system — the Medicare program — which predominantly pays physicians through the Medicare Physician Fee Schedule (MPFS).[11]

Underinvestment In Primary Care

PRIMARY CARE PHYSICIANS

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*To learn more about the impact of FFS economics read Families USA's publications: "Working Toward True Payment Reform to Ensure Our Health Care System Serves Families and Patients."

The underinvestment in primary care and overreliance on fee-for-service payment in U.S. health care are in large part driven by the way the Centers for Medicare & Medicaid Services (CMS) sets MPFS reimbursement rates.[12] Both the methodology* used to set the rates (referred to as the resource-based relative value units or RVUs) and the process for how CMS calculates the relative values of health care services delivered by physicians (through the overreliance on the recommendations made by the American Medical Association's Relative Value Update Committee or the RUC) are fundamentally flawed.[13] Importantly, because the MPFS is the model for most other health care payers' fee schedules, the payment distortions in FFS and in the methodology that establishes the payment rates that undervalue primary care are amplified through all forms of health insurance, including Medicare Advantage, Medicaid managed care, private insurance and traditional Medicare and Medicaid, including most value-based payment models.[14]

Of note, this longstanding underinvestment in primary care and the overreliance on fee-for-service economics were exacerbated by the COVID-19 pandemic. As patients delayed receiving in-office services, the number of services delivered sharply declined forcing primary care providers to struggle to keep their practices open. Because most primary care practice revenue is directly tied to volume-based reimbursement, many primary care practices were unable to absorb the financial losses caused by the sharp decline in the volume of services.[15] As a result, many practices had to close their doors or were bought by large health systems that had greater financial security due to value-based care contracts and other sources of revenue that helped to weather the financial impact of the pandemic.[16] The pandemic not only pushed the primary care system to the brink of collapse but also amplified the impact of deeply engrained economic, mental health and social health disparities and emphasized the urgency in shifting to a more sustainable payment model for primary care.[17]

Any efforts to advance high-quality primary care must be rooted in more accurately valuing primary care providers and their essential role in the health care system. Specifically, they must be grounded in a fundamental shift away from fee-for-service reimbursement, which rewards providers for delivering high volumes of high-cost services, and toward a system that incentivizes the delivery of high-quality, whole-person, team-based care with strong accountability for health care costs and quality. This means that primary care payment rates need to increase and that payment incentives for primary care need to be reoriented to support and equip providers with the resources and flexibility needed to meet the health needs of the communities and populations they serve. To that end, there are a number of promising new primary care payment policies focused on increasing investments in

*To learn more about Medicare physician payment methodologies, read Families USA's publication: "The Nuts and Bolts of Medicare Physician Payment."

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primary care and building a more sustainable reimbursement model that will allow primary care providers to do what they do best: manage and improve the health of their patients. To ensure access to comprehensive, high-quality and affordable primary care is a feature of our health care system available to all families, policymakers must build upon the improvements already made and work to create a health care system that provides adequate and sustainable funding to primary care providers.

Promising primary care payment proposals and models

Primary care-led accountable care organizations (ACOs)

Primary care-led ACOs are groups of health care providers that share responsibility for the quality, cost and coordination of care for a defined population of patients.[18] ACO programs have been piloted through CMS and the Center for Medicare and Medicaid Innovation (CMMI) and with private payers, and they can take different forms depending on local market dynamics and competition among providers.[19] The Medicare Shared Savings Program is the largest and most successful ACO payment model, helping to save more than $2.1 billion in 2023 alone while also improving health care quality and outcomes.[20] Importantly, it is the ACOs led by independent physician groups with high concentrations of primary care providers that drive the greatest health care savings and are critical to the success of ACO payment models.[21] Other types of ACO models making improvements in primary care include the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) model, which allows both primary and specialty care providers to collaborate to improve the quality of care and health outcomes for people with traditional Medicare.[22]

Primary care alternative payment models

Primary care has been a core focus of CMMI, which has tested a number of primary care payment models over the past decade, including Comprehensive Primary Care, Comprehensive Primary Care Plus, the Maryland Primary Care Program and Primary Care First.[23] These models have helped to lay an important foundation for building sustainable reimbursement for high-value primary care and serve as the precursor to the next generation of promising advanced primary care payment models, such as Making Care Primary and Primary Care Flex. They also carved a path for making important payment changes through the Medicare Physician Fee Schedule to support payment for primary care providers, which are discussed below in the “Creating and streamlining billing codes” section.[24]

Improving Primary Care Through Alternative Payment Models

Making Care Primary is a multipayer primary care payment model launched by CMMI in 2024 that aims to support the delivery of advanced primary care services.[25] This model offers opportunities to primary care clinicians to gradually move away from FFS health care payments and adopt prospective, population-based payments for their patient populations, helping to drive the delivery of high-quality, equitable and affordable primary care.[26]

Primary Care Flex is a payment model in the Medicare Shared Savings Program that, beginning in 2025, will provide prospective and flexible primary care payments to support ACOs in the delivery of high-quality and innovative primary care.[27] Importantly, these models include additional infrastructure payments and supports to help primary care providers build the infrastructure and capacity needed to fully participate in alternative payment models.[28]

Alternative payment models have been critical to the shift away from FFS. However, the vast majority of CMMI models are voluntary and time limited and often include significant barriers to participation. Many primary care practices are unable to benefit from innovative models because of challenges like insufficient infrastructure, low thresholds for risk and disqualifying practice characteristics, such as ACO revenue type.[29]

Primary care hybrid payment models

One of the most promising payment models under consideration by policymakers was introduced through the bipartisan Pay for PCPs Act, authored by Sen. Sheldon Whitehouse, D-R.I. and Sen. Bill Cassidy, R-LA. in the 118th Congress.[30] If enacted, this legislation would address the core causes of our primary care crisis by providing flexible and reliable funding to primary care providers and beginning to shift reimbursement away from fee-for-service payment incentives.

1. **First, the legislation would create a hybrid payment** — a mix of fee-for-service and population-based payment — through the Medicare Physician Fee Schedule. This type of payment approach would provide monthly, per enrollee payments to all primary care providers reimbursed through the Medicare program.
2. **Second, this legislation would establish a new physician payment technical advisory committee** that would help ensure payment rates to primary care providers reflect the true value and costs related to the care they provide to patients and their communities.[31] This advisory committee would function as a supplemental resource of expert recommendations for CMS to ensure that the RUC is not the only source of data being used to value and set payment rates for physician services, particularly for primary care.

The Pay PCPs Act would mark a significant step to shift primary care payment away from broken FFS economics and toward a payment and delivery system that better values primary care providers and drives high-quality and affordable care. Importantly, CMS does have the authority to implement hybrid payments within current models like the accountable care organization program (more on that below).[32] The Pay PCPs Act would give CMS the authority to offer hybrid payments to all primary care providers across the Medicare program.

Creating and streamlining billing codes

As models for comprehensive change to primary care payment in the U.S. are being explored, policymakers are also making a number of incremental improvements to the Medicare Physician Fee Schedule to better recognize the value of primary care. While these changes are not a panacea and do not make fundamental shifts away from FFS payment incentives, they take important steps to create new billing codes for primary care services that will increase reimbursement for providers and to streamline existing billing codes to reduce administrative burden that can often prevent primary care providers from being reimbursed for care they deliver.

In 2024, CMS finalized new payments for primary care providers through the creation of the G2211 billing code, an "add-on" payment that gives providers the ability to be reimbursed for delivering care to patients with complex and chronic conditions.[33] Because primary care providers frequently treat patients with complex and compounding chronic health conditions, this new code served as a new, albeit modest, revenue stream for primary care.[34]

In 2025, CMS finalized new bundled payments for advanced primary care management (APCM) services, which now allow providers to bill and be reimbursed for core primary care services on a monthly basis if they meet certain quality metrics and standards.[35] Adoption of the new APCM bundled payments not only helps to simplify the codes that primary care providers can bill to and be reimbursed for, but it also gives providers the flexibility to deliver the advanced primary care services that best meet patients' needs. The **APCM payments mark another important step in moving toward non-FFS based payments**, including bundled and hybrid or population-based payments, which show the greatest promise in driving the delivery of high-value care.[36] Despite this progress, billing codes remain incomprehensive and insufficient for the work of primary care physicians, and incentives continue to drive medical professionals to higher-paying specialty practices.

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Policymakers must take steps to strengthen our nation's primary care workforce and infrastructure through critical improvements to how primary care practitioners are paid.

Conclusion

High-quality and comprehensive primary care is central to an effective health care system and to promoting the health and well-being of people. Yet, the U.S. primary care system is in crisis. For too long, distortions in how we pay for health care and in particular physician services — which originate in the MPFS — have systematically undervalued and underinvested in high-quality primary care, leading to chronic shortages of primary care professionals that too often are unable to serve the growing health needs of our nation's families.

Policymakers must take steps to strengthen our nation's primary care workforce and infrastructure through critical improvements to how primary care practitioners are paid. It is essential that advocates work with policymakers to rebalance health care payment rates to more accurately value primary care providers and shift U.S. health care payment away from the inefficiencies of FFS economics and toward a system that enables and incentivizes health care providers to deliver high-quality, high-value care, including comprehensive and advanced primary care.

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