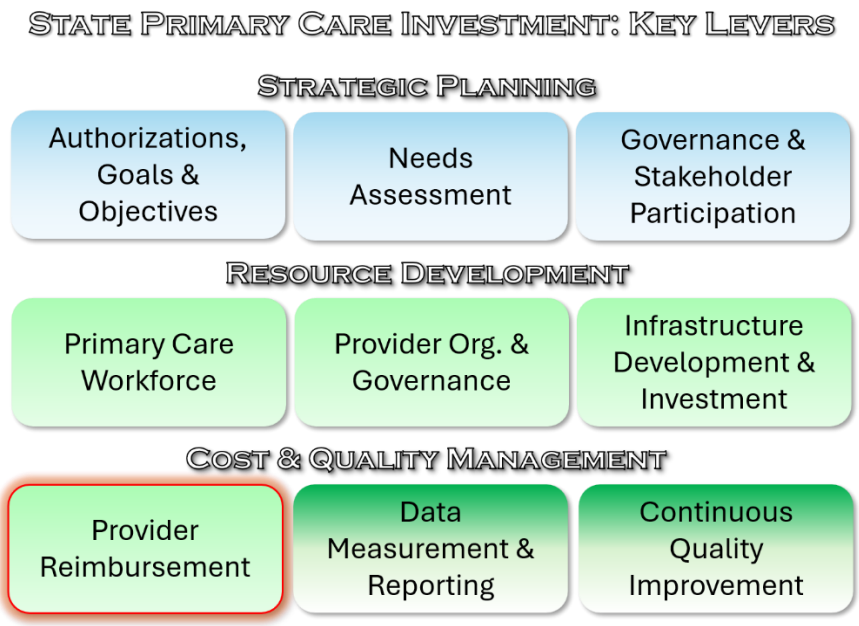
Key Lever 7 Primary Care Reimbursement: Overcoming the Challenges



The main purpose of the primary care investment "movement" is to distribute more healthcare spending to primary care in the belief that it is a more cost-effective way to care for people than the current system. A complementary belief shared by many healthcare professionals is that the most appropriate way to reimburse primary care practitioners and organizations is through monthly, risk-adjusted capitation (per member per month or PMPM) payments.

Several states have already set primary care spending targets that represent significant increases in primary care spending as a percentage of total state healthcare expenditures, typically in the range of 12 to 15 percent. CMS currently identifies six state participants, and AHEAD is considerably more than global budgeting.

But redirecting statewide healthcare spending to primary care and compensating primary care practitioners and organizations through risk-adjusted, population-based payments presents a number of challenges. That is the subject of this article.

Payer Participation

The first challenge that states face is capturing all of the additional revenue that would result from a primary care spending target because the state does not control all of its sources of revenue. Specifically, this is what it looks like:

PAYER/PROGRAM	% OF NATIONAL EXPENDITURES*	DEGREE OF STATE CONTROL
Medicaid	22.5%	**Least difficult.** The state can require MCOs or ACOs to make standardized prospective payments to attributed primary care organizations.
Employer fully insured	11.7%	**State insurance regulation can require** prospective primary care models and common standards.
State Employee coverage	(Insured or self-insured)	**State controls** whether insured or self-insured.
Individual/non-group insurance	4.5%	**Same** prospective payment & reporting rules **as for fully insured employer coverage**.
Patient out-of-pocket	13.1%	**Limited and indirect.** Most cost sharing is attached to another payer's coverage rather than independent self-pay.
Medicare Advantage	14.0%	**State authority limited.** Federally regulated plans control provider payment
Employer self-insured	21.6%	**ERISA generally prevents a state mandate**; participation depends on individual employers and plan administrators.
Medicare fee-for-service	12.6%	**The state cannot change payment unilaterally.** AHEAD or another federal-state agreement provides the current pathway to prospective payment.

***Percentages of National Expenditures** are based on 2023 federal health expenditure data adjusted to include only the payer categories shown.*

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The table suggests that states can directly govern payment for approximately two-fifths of the expenditures shown and can influence additional spending through their purchasing authority, cost-sharing regulation, voluntary payer alignment, and federal cooperation.

States participating in AHEAD will have a federal pathway for bringing Medicare fee-for-service into prospective primary care payment arrangements, although they will also encounter the broader requirements and challenges associated with hospital global budgets and total cost-of-care accountability. For states not pursuing AHEAD, the most difficult remaining problem is incorporating Medicare fee-for-service and self-funded employer plans, which together represent approximately one-third of national healthcare expenditures based on the estimates used above.

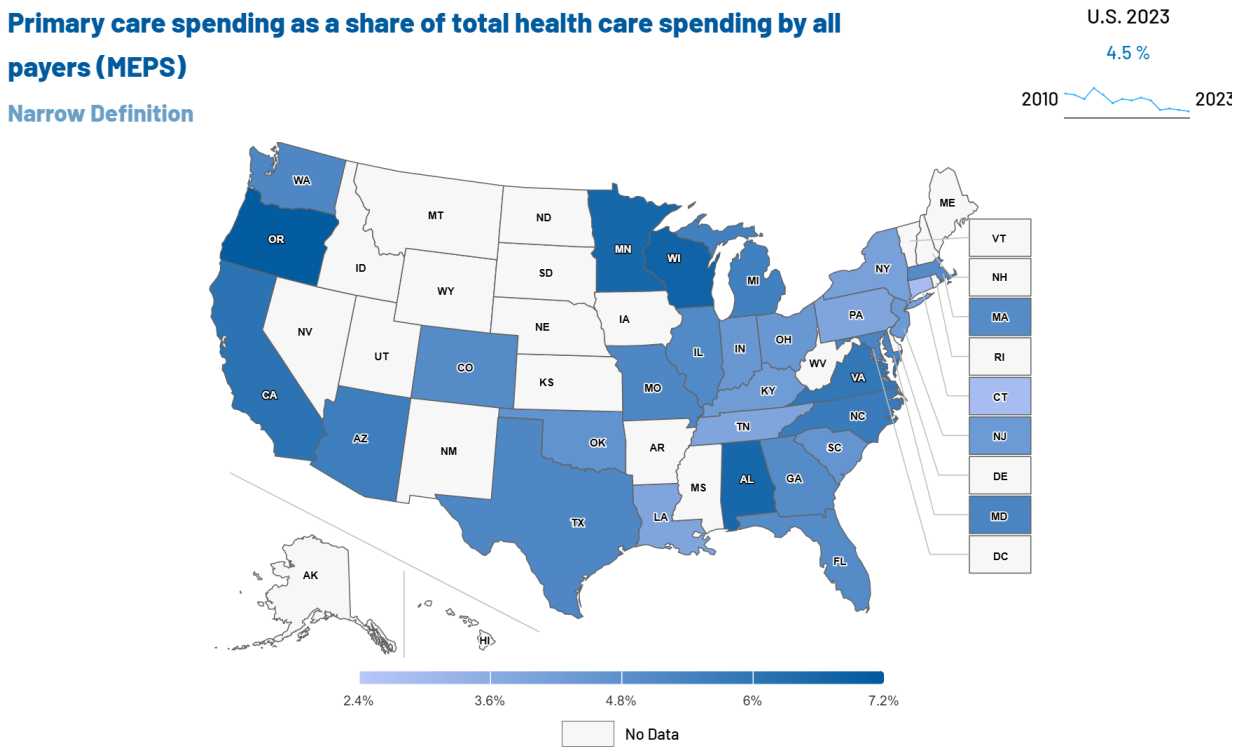
Federal cooperation will remain necessary to change Medicare fee-for-service payment. Self-funded employer plans present a different challenge because ERISA generally prevents states from regulating them directly. States should therefore examine whether provider-based regulation, analogous in concept to Maryland's hospital rate-setting system, could establish the forms and minimum levels of payment that state-qualified primary care organizations may accept. Such an approach might influence payment arrangements without directly imposing requirements on self-funded plans.

Provider-based regulation is not yet an established solution. It would require careful legal analysis, a workable rate-setting and administrative structure, and safeguards protecting patient access and network adequacy. Given the importance of the payer sectors that remain beyond direct state control, however, this approach deserves serious legal and policy development rather than being dismissed simply because direct payer regulation is unavailable.

Definition of Primary Care: A Major Divide

Although we have previously written about the issues relating to the definition of primary care, which can vary from state to state and even within states, this is a decision that can dramatically affect the amount of additional revenue being directed to primary care providers. To illustrate, the Milbank Memorial Fund reports that, using the narrow definition of primary care, national primary care spending amounts to 4.5 percent based on recent (2023) data. On the other hand, using a broad definition of primary care, Milbank reports national spending equaling 12 percent in 2023, down from 13.5 percent in 2021.

So, if a state sets a primary care spending target of 15%, the amount of additional primary care revenue will have to increase by 233 percent if it uses the narrow definition but only 25 percent using the broad definition.



Source: Milbank Memorial Fund 2026 Primary Care Scorecard Data Dashboard

Before establishing a primary care spending target, states must decide what expenditures count and which providers are intended to benefit. The choice involves an inherent tradeoff. A narrow definition would require more new money to flow to primary care organizations to meet the target, but could limit reimbursement for services and capabilities that are part of comprehensive primary care. A broad definition can appropriately include integrated behavioral health, preventive obstetric and gynecologic care, care management, infrastructure, and team-based services, but could make the target meaningless if existing spending already exceeds it. One solution is for a state to mandate two spending targets:

- **Core primary care spending:** Money reaching primary care clinicians, practices, and teams, subject to a meaningful minimum target.
- **Comprehensive primary care-related spending:** The broader set of integrated services, infrastructure, and organizational expenditures, subject to a separate comprehensive target and reported separately.

Capitation & Payment Adequacy

Risk-adjusted prospective capitation should be the principal means of paying primary care organizations. This approach most closely resembles LAN Category 4A, a prospective, quality-linked population

payment covering primary care services. It differs from LAN Category 3, which retains fee-for-service as its foundation, and Category 4B, which generally covers most or all healthcare spending. There are several requirements for making capitation work:

- Base payments sufficient to support the expected model of care.
- Adjustments for patient needs, practice capabilities, expanded services, and underserved locations.
- A limited performance component tied to access, quality, outcomes, patient experience, and appropriate hospital and emergency department use.
- Payment levels that allow primary care organizations to recruit and retain physicians, clinicians, and other members of the care team.

Capitation rates should recognize that primary care organizations differ in the range and sophistication of the services they provide. The MassHealth practice tiers offer one example of linking payment to progressively more integrated, team-based, and multidisciplinary care.

Hospital-employed practices require additional protections to ensure that most primary care payments reach and remain with the practice, that hospital compensation and other financial incentives do not conflict with primary care objectives, and that system charges imposed on the practice are appropriate and directly support its work.

Payment Adequacy

Payment adequacy means more than maintaining practice solvency. Payments should enable primary care organizations to increase clinician compensation to levels competitive with those offered by hospital employers and sufficiently competitive with specialist compensation to attract and retain the workforce primary care requires.

KFF's analysis of the 2024 HRSA Uniform Data System reports that health centers' aggregate net margin fell from 1.6 percent in 2023 to minus 2.1 percent in 2024. NACHC reported in May 2025 that 42 percent had 90 days or less cash on hand. These organizations are therefore particularly vulnerable to additional pressure on Medicaid reimbursement.

For a much more detailed analysis of community health center economics, visit the Kaiser Family Foundation's **COMMUNITY HEALTH CENTER PATIENTS, FINANCING, AND SERVICES** (KFF 2/4/2026).

Differing Scopes of Practice

Primary care organizations vary widely in size, structure, and scope, ranging from a few primary care practitioners operating under one roof to large, multi-location, multispecialty practices and fully integrated hospital-based practices. Rural communities may depend on relatively small practices, but those practices may require broad clinical capabilities and access to shared regional services. Larger integrated practices may be able to provide more services within a single organization. These differences affect the resources required to provide care and make a single payment level unlikely to be appropriate for every practice.

Massachusetts categorizes primary care practice sites into three Clinical Tiers based on their care delivery capabilities, staffing model, and level of integrated services:

> **Tier 1** Meets foundational standards including primary care delivery, referrals to specialty care, oral health screening/referral, behavioral health (BH) and substance use disorder screening, bi-directional BH tracking, and BH medication management.
>
> **Tier 2** Meets all Tier 1 requirements plus enhanced care delivery and staffing standards. Requires expanded access and specialized treatments, such as offering long-acting reversible contraception

(LARC), active buprenorphine prescribing/treatment availability, and alcohol use disorder (AUD) treatment.

Tier 3 Meets all Tier 1 and Tier 2 requirements plus advanced practice integration. Requires offering at least one specialized advanced capacity, such as clinical pharmacist visits, structured group visits, or a designated Educational Liaison for pediatric patients.

Higher clinical tiers receive higher per-member per-month (PMPM) sub-capitation enhanced payments to support advanced team-based care.

Performance, Incentives, and Accountability

A defined portion of primary care payment should be linked to performance, but the performance component should be limited so that practices have sufficiently predictable revenue to maintain staffing and services. Incentives should reward measurable improvements in access, quality, outcomes, patient experience, and appropriate utilization. Risk-adjusted capitation that includes performance incentives is central in a high-performing system. Incentives should include practice-level metrics that help determine quality of care and outcomes, such as:

- Appointment availability for established patients.
- Appointment availability for new patients.
- Growth in the number of attributed patients.
- Increased service to communities with primary care access shortages.
- Clinical quality.
- Patient experience.
- Avoidable hospital admissions and ED visits.

The performance measures should be publicly reported and benchmarked against local, regional, state, and national data where available.

Shared Infrastructure Financing

Because they serve the entire healthcare system, certain capabilities are more appropriately financed separately from primary care organizations' operating budgets, e.g.

- Statewide interoperability and health information exchange.
- Hospital and emergency department event notifications.
- Patient matching and provider directories.
- Data aggregation and common quality measurement.
- Population-health and performance-reporting systems.
- Shared clinical decision support, including medically oriented AI capabilities.

To do so, the state may sponsor or charter this infrastructure through a separate and transparent budget financed through some combination of payer assessments, participation fees, state appropriations, and federal funding. Primary care organizations would remain responsible for their internal systems and routine technology costs, with initial capital support potentially provided under Key Lever 6. This separation would preserve capitation revenue for patient care, reduce duplication, and help independent organizations compete with large health systems.

Summary of Recommendations

So, we have identified several potential obstacles for states wishing to unlock the full potential of increasing primary care reimbursement, from revenue capture to the very definition of primary care. To increase primary care investment and translate it into more effective reimbursement, states should:

- **Maximize payer participation.** Use direct authority over Medicaid, state employee programs, and state-regulated insurance while pursuing federal cooperation for Medicare fee-for-service and voluntary alignment by Medicare Advantage plans and self-funded employers.
- **Adopt two primary care spending targets.** Establish a meaningful minimum target for core investment reaching primary care clinicians, practices, and teams, together with a separate comprehensive target encompassing integrated services, infrastructure, and organizational support. Spending and progress toward each target should be measured and reported separately.
- **Make risk-adjusted prospective capitation the principal payment method.** Payments should provide predictable revenue based on the needs of the patient population rather than depend primarily on the volume of visits and procedures.
- **Ensure payment adequacy and competitive clinician compensation**. Base payments should support the expected model of care and enable primary care organizations to increase compensation for primary care clinicians to levels competitive with those offered by hospital employers and sufficiently competitive with specialist compensation to attract and retain the workforce primary care requires.
- **Adjust payments for differences among patients and practices.** Rates should reflect patient needs, practice capabilities, expanded services, underserved locations, and progressively more integrated and multidisciplinary models of care.
- **Protect primary care payments within hospital systems.** States should require transparency and safeguards to ensure that primary care funds remain with the practice, system charges are appropriate, and hospital financial incentives do not conflict with primary care objectives.
- **Link a limited portion of payment to performance.** Incentives should address access, continuity, quality, outcomes, patient experience, service to underserved communities, and appropriate hospital and emergency department use. Results should be publicly reported and benchmarked.
- **Finance shared infrastructure separately.** Statewide interoperability, event notifications, patient matching, common measurement, data aggregation, and performance-reporting systems should be supported through a transparent statewide budget rather than consuming primary care organizations' operating payments.

#PrimaryCare #PrimaryCareReimbursement #HealthcarePaymentReform #PrimaryCareInvestment #StateHealthPolicy #HealthcarePolicy #KeyLevers