DISCUSSION PAPER

Implementing High-Quality Primary Care in 2025: Key Policy Priorities

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Primary care is commonly the first point of contact for patients and is pivotal in the prevention and management of chronic disease. Yet despite primary care's essential value for the health of the nation, more than 100 million people across rural and urban communities in the United States are experiencing a calamitous lack of access to primary care (National Association of Community Health Centers, 2023; Jabbarpour et al., 2025). Even among those fortunate to have a regular source of primary care, the average wait time to schedule a family medicine appointment is 20.6 days, a delay that puts the health of individuals at risk and can increase costs through use of more expensive care, including emergency rooms (Jabbarpour et al., 2024). For the 60 percent of Americans who live with a chronic illness and the 40 percent who have two or more chronic illnesses, delays in care can lead to worsening underlying conditions and missed opportunities for early detection of preventable diseases (Buttorff et al., 2017; Gertz et al., 2022). Pressure on practices is driving many primary care clinicians to move to part-time practice, retire early, change which insurance plans they accept, or pursue membership-based models (e.g., concierge, direct primary care), leaving patients in a bind (Rosenthal, 2023). This access crisis is especially concerning given that life expectancy in the United States is lower than other Organisation for Economic Co-operation and Development nations, and primary care is the only component of the health care system that has been shown to increase life expectancy of the US population (Woolf, 2023; NASEM, 2021).

To meaningfully and measurably improve the health status of the US population, addressing primary care access challenges should be a top priority for the new Congress and administration. While some local, state, and federal efforts have attempted to address this crisis, current restructuring in the US Department of Health and Human Services (HHS) and reductions in workforce threaten to undermine some of the primary care support currently in place (Krist et

al., 2025). More federal-level leadership and action is needed to strengthen primary care to efficiently and effectively improve the nation's health.

A Federal Primary Care Policy Roadmap

In May 2021, the National Academies of Sciences, Engineering, and Medicine (NASEM) released *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* (NASEM, 2021). This report presented the abundant evidence that primary care improves life expectancy, and it identified primary care as a common good, detailing evidence-based recommendations across five domains essential to ensuring high-quality primary care is accessible to all in the United States:

1. **Payment.** Pay for primary care teams to care for people, not for doctors to deliver services.
2. **Access.** Ensure that high-quality primary care is available to individuals and families in every community.
3. **Workforce.** Train primary care teams where people live and work.
4. **Digital Health.** Design health information technology that serves the patients, family, and interprofessional care team.
5. **Accountability.** Ensure that high-quality primary care is implemented throughout the US.

The report offers detailed recommended actions for each domain that can serve as a roadmap to inform Congress and the Administration as they advance work on health and primary care priorities.

In response to the primary care report, NASEM launched the Standing Committee on Primary Care (Standing Committee) in 2023 with the purpose of providing objective, evidence-based advice to the federal government on primary care policy issues. Twenty-one experts serve on the Standing Committee, including primary care physicians and nurse practitioners, health systems leaders, other clinicians, patients, and researchers. The Standing Committee's work currently focuses on primary care payment, workforce, and digital health; these three domains from the 2021 NASEM report are essential to mitigating access challenges and to scaling and sustaining high-quality primary care.

Since its inception in late 2023, the Standing Committee has hosted seven public meetings on a variety of primary care topics, including workforce, rural health, payment, and access. The Standing Committee has also released three consensus reports, two of which responded to congressional and Centers for Medicare and Medicaid Services (CMS) requests for information about primary care payment (NASEM, 2024a; NASEM 2024b). The third consensus report recommended processes and data sources for CMS to consider when assessing primary care valuation for the Medicare Physician Fee Schedule (NASEM, 2025).

Between participation at public meetings, including federal agency leadership, and the number of report downloads, the Standing Committee efforts have had a broad reach, spanning policy makers, clinicians, scientists, and patients. Consistent with its statement of task, the Standing Committee is available to engage with federal officials and offer Federal Advisory Committee Act (FACA)-compliant expertise and guidance on a range of primary care policy issues.

Sustaining Efforts to Improve Primary Care

Since 2021, the federal government has taken action to improve primary care and the nation's health, yet recent changes could threaten this progress. Following the release of the 2021 NASEM report, HHS established the Initiative to Strengthen Primary Health Care, an agency-wide effort to coordinate, develop, and implement primary care activities across the federal government (HHS, 2023). HHS initiated critical actions needed to implement some of the NASEM report's recommendations, including changes to the physician fee schedule for primary care and expanded funding for training primary care residents in community settings (CMS,

2023; HRSA, 2023). This response by HHS also entailed the launch of three primary care payment demonstrations: ACO Primary Care Flex, Making Care Primary, and the AHEAD Model (CMS, 2025a; CMS, 2024b; CMS, 2024d).

In 2024, Senators Bill Cassidy (LA) and Sheldon Whitehouse (RI), introduced the Pay PCPs Act that would task CMS with creating hybrid payments for primary care, reduce cost-sharing for Medicare beneficiaries, and establish a new advisory committee to help CMS determine payment rates more accurately. After its introduction in the 118th Congress, it was referred to the Committee on Finance. Whether this bill will be re-introduced in the 119th Congress is yet unknown. Last May, the Agency for Healthcare Research and Quality (AHRQ) released "Measuring Primary Healthcare Spending," a technical brief that examines the heterogeneous ways primary care spending is calculated across the country; and in September, AHRQ issued a funding opportunity notice for the State-based Healthcare Extension Cooperatives to create state-level resources to build and support high-quality primary care with a focus on its role in addressing mental health (AHRQ, 2024; AHRQ, 2025). The National Institutes of Health introduced the CARE for HealthTM initiative in June 2024 with the goal of extending research opportunities into clinical care and community settings including recognition of the need to design research to address clinical conditions important to primary care practitioners and patients (NIH, 2025). In September 2024, the HHS Primary Care Dashboard was presented to the Standing Committee by the Office of the Assistant Secretary for Health, and, after announcing it last fall, it is unclear if the dashboard will continue given the recently announced reorganization of HHS (HHS, 2025). CMS also launched new advanced primary care management codes on January 1, 2025, which clinicians can now use (CMS, 2025d). It is worth noting that the future of some of these initiatives is uncertain with the new HHS restructuring efforts. Even if maintained, more federal leadership and policy changes are needed to strengthen and sustain primary care in the US. Recent federal policy changes appear to be crosswise with this forward momentum. In March 2025, HHS announced its plan to restructure its operations by combining the Office of the Assistant Secretary for Health (OASH), the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Agency for Toxic Substances and Disease Registry (ATSDR), and the National Institute for Occupational Safety and Health (NIOSH) into one entity—the Administration for a Healthy America. Although the restructuring promises $1.8 billion per year savings to taxpayers, it comes with a dramatic reduction in workforce across agencies (HHS, 2025). Also in March of this year, the CMS Innovation Center announced that it would end four demonstration models early, including Primary Care First and Making Care Primary (CMS, 2025b). The impact of these changes is not yet known.

Priorities for Policy Action

Payment

The *Implementing High-Quality Primary Care* report recommended that CMS, states, and private payers meaningfully increase the proportion of health care dollars going to primary care and shift from the dominant fee-for-service system to hybrid payment models that include a population-based, prospective payment component. The report also called for multi-payer collaboration to ensure the scale of payment change is sufficient to truly enable changes in practice. Furthermore, it recommended that payment models be evaluated based on their ability to promote the delivery of high-quality primary care and not on their ability to produce short-term cost savings. Unfortunately, despite some positive steps by CMS in payment reform, primary care spending as a percentage of total health care expenditures is falling rather than increasing (Jabbarpour et al., 2025). Transparency

and accountability are both needed to ensure any increase in primary care investment reaches frontline primary care practices.

Why It Is Important

Despite providing nearly 50 percent of all ambulatory services, depending on the state and method of measurement, primary care receives just under 5 percent of total health care spending (Willis et al., 2021). Disproportionately low spending on primary care results in care teams being insufficiently resourced to optimize patient health outcomes and fewer health professions students choosing primary care as a career (Jabbarpour et al., 2025). The 2025 national primary care scorecard demonstrated an increasing gap between students choosing primary care and those choosing specialty careers (Jabbarpour et al., 2025). Even among trainees who choose primary care residency programs, many do not remain in primary care post-training. Even more striking in this most recent scorecard is the disproportionate investment in graduate medical education in hospital settings that produce the fewest primary care physicians. The scorecard further showed that the widening income gap between primary care physicians and other specialties contributes to medical students choosing specialties other than primary care, ultimately contributing to decreased primary care access for consumers. These factors are disincentives for joining the primary care workforce and support the general assertion that not investing in primary care hampers its ability to improve the nation's health and worsens workforce shortages. Increased primary care financing and payment are needed to expand the primary care workforce, build interprofessional teams, and ensure adequate infrastructure (e.g., informatics) to support primary care.

Additional Policy Opportunities

Redefine success: The CMS Innovation Center has the authority to test and evaluate alternative payment models on a limited basis as demonstration projects. For a demonstration model to be subsequently adopted and scaled nationally, it must either reduce cost and maintain quality or improve quality without increasing cost. Greater investment in primary care will improve ultimate health outcomes and thus likely reduce future costs; however, it is unrealistic to expect cost reductions in the short term. **What is needed:** To align with what the *Implementing High-Quality Primary Care* report recommends, the definition of success for alternative payment models in primary care should be shifted to improved value over time for patients, society, and the primary care workforce. This change would require federal legislation.

Promote transformation: CMS Innovation Center demonstration projects have supported primary care innovation in some states or regions but not in others, and some demonstrations have shown some success (Perman et al., 2020). Primary care practices participating in demonstration projects hire additional interprofessional team members or deliver care in new ways only to find they are no longer able to maintain their transformations in care after the demonstration project ends. Other payers rarely participate, and changes can only occur for some patients in the system. This prevents full transformation and limits the ability to realize benefit for all patients. **What is needed:** For demonstration models that do not show overall benefit, the Secretary of HHS could consider implementing specific program components that have evidence to support benefit. Demonstration projects must cover sufficient time periods and have plans for sustainability to ensure improvements to care can be maintained (e.g., AHEAD is designed for a 10-year evaluation). Multi-payer alignment is essential for demonstration projects to have the potential to realize benefits.

Improve valuation of primary care: In February 2025, the Standing Committee released the consensus study report *Improving Primary Care Valuation Processes to Inform the Physician Fee Schedule*. The report concluded that the existing processes and methods for valuing services

under the Medicare Physician Fee Schedule are fundamentally broken, resulting in persistent undervaluing of primary care services (NASEM, 2025; Berenson and Hayes, 2024; MedPAC, 2024). The authors agree that delegating much of the valuation process to the Relative Value Scale Update Committee has resulted in a process with insufficient transparency, representativeness, and objectivity using methods that lack adequate reliability and validity. Moreover, this approach fails to accurately measure the work of interprofessional team-based primary care (NASEM, 2021; NASEM 2024b; NASEM, 2025). **What is needed:** The consensus study reports on the Pay PCPs Act and primary care payment valuation recommended that CMS should establish a new technical advisory committee to conduct independent analyses of service valuation for the Medicare Physician Fee Schedule and consider more rigorous, objective methods to inform measurement of clinical work and resources that include data sources such as electronic health record data and advanced analytic tools (e.g., large language models, time-driven activity-based costing) (NASEM, 2024b; NASEM, 2025).

Transition to hybrid payment: Much of the work done by primary care practices occurs outside of billable office visits. Common tasks like responding to patients' questions, coordinating care, identifying patients overdue for preventive or chronic care, or supporting self-management all occur outside of office visits. Plus, many services are delivered by extended care team members with no way to bill a fee-for-service visit. CMS has started transitioning to hybrid payment, with the G2211 code to pay for longitudinal care and the monthly prospective GPCM1-GPCM3 codes to pay for advanced primary care management. In its reports, the Standing Committee noted that these are important advances in hybrid payment, and more will be needed depending on their success (NASEM, 2024a; NASEM, 2025). **What is needed:** The consensus study reports on the Pay PCPs Act and physician payment valuation recommended congressional consideration of legislation to open the path to broad implementation of hybrid payment for primary care that includes a prospective payment component (NASEM, 2024a; NASEM, 2025).

Address cross-cutting primary care payment issues: Implementing primary care payment reform requires attention to several additional key issues that will influence successful uptake of new payment models and achievement of the goal of patient access to high-quality primary care. These issues include:

1. Budget neutrality: Current statute requires that changes in valuation of certain codes or addition of new codes to the Medicare Physician Fee Schedule projected to increase Medicare Part B spending by more than $20 million must be accompanied by offsetting reductions (42 U.S.C. § 1395w-4). Budget neutrality has produced friction impeding progress on enhanced primary care payment due to resistance from stakeholders who would find their payments reduced (NASEM, 2025).
2. Patient cost-sharing: The Standing Committee has expressed concern that Medicare requirements for beneficiary cost-sharing will pose a major barrier to uptake of new billable services such as the Advanced Primary Care Management codes and hybrid payments if copayments are required for the prospective payment component (NASEM, 2024a).
3. Accountability for enhanced payment: Increased payments for primary care bring payer and public expectations for accountability among primary care clinicians for enhanced services provided to their patients. In its three reports on payment reform, the Standing Committee emphasized the importance of metrics for accountability focusing on the fundamental functions of primary care (i.e., access, continuity, comprehensiveness, coordination, and person-centeredness)

rather than an array of reductionistic disease-specific measures. Qualifying for hybrid payment might be made contingent on primary care practices demonstrating their capacity for delivering advanced, team-based primary care, with prospective payment rates tiered based on the comprehensiveness of services offered.

4. Patient attachment and attribution: The current CMS policy for Advanced Primary Care Payment billing, and plans for possible prospective payment models, require beneficiaries to voluntarily agree to participate and to designate their primary care clinician or team (CMS, 2025d). Advanced payment models will need to be accompanied by considerable education and outreach to beneficiaries about the importance of having and reporting a regular source of primary care. This should ultimately lead to more longitudinal, trusting relationships between primary care clinicians and beneficiaries.
5. Equity: The Standing Committee has highlighted the need for payment reforms to be implemented in ways that promote equitable access to and quality of care. This might include approaches such as risk adjustment for prospective payment that supports patient and community social factors associated with a higher need for primary care services, and start-up funds for under-resourced practices to build their capacity for high-performing primary care.
6. Multi-payer participation: Although a highly influential payer, Medicare cannot drive transformative revitalization of primary care on its own. Achieving a tipping point in primary care investment requires alignment among all payers.

What is needed: CMS and Congress should carefully consider each of these issues when addressing primary care payment reforms, including facilitation of strong beneficiary connection to a regular source of primary care, selection of appropriate measures for tracking success and monitoring for unintended consequences, promotion of multi-payer alignment to achieve a tipping point for primary care investment, and removal of impediments to successful implementation such as budget neutrality and beneficiary cost-sharing.

Workforce

The *Implementing High-Quality Primary Care* report stated that high-quality primary care should be available to every individual and family in every community—that all individuals should have the opportunity for a usual source of high-quality primary care. As the report documented, an adequate primary care workforce is essential to achieving this goal. The primary care workforce includes core team members (e.g., clinician, nurse, patient and family), extended health team personnel (e.g., behavioral health, social worker, pharmacist, care manager), and extended community care team professionals (e.g., home health aides, community health workers, certified peer support specialists, school-based support, social services agencies). These teams need to be stable and consistently care for the patient and their families through sustained relationships and should be designed to meet the specific needs of the populations they are serving. To achieve this, the report recommended increased federal funding to train primary care teams and that this training should occur in the communities these teams serve.

Why It Is Important

The ability to access high-quality primary care depends on the availability of clinicians who are essential members of the primary care core team, including physicians, nurse practitioners, and physician associates (Phillips and Bazemore, 2010). The US has a lower proportion of primary care physicians as a percentage of total physicians than other nations that have better health outcomes (FitzGerald et al., 2022). According to the HRSA, which is proposed to be combined into the new Administration for a Healthy America, there are just over 7,700 primary care health professional

shortage areas in the United States—accounting for approximately 40 percent of all US counties—and more than 13,000 clinicians would be needed to alleviate the shortages (HRSA, 2025). Other research suggests the need is far greater than 13,000 clinicians (Basu et al., 2021). As a result, people in the US are less likely to have a long-standing relationship with a primary care clinician compared with people in other countries, which has shown empirically to promote health (FitzGerald et al., 2022; Bazemore et al., 2023). This is largely driven by an inadequate and poorly distributed primary care workforce, and an insufficient number of interprofessional team members, which are needed to support the health of patients. While the number of nurse practitioners and physician assistants has grown considerably in the past 20 years, the proportion of them working in primary care is relatively low and is shrinking (Jabbarpour et al., 2025). There are also signs that the overall number of primary care clinicians (i.e., physicians, nurse practitioners, and physician assistants) per capita is shrinking (Jabbarpour et al., 2025).

Additional Policy Opportunities

Expand community-based training: Of the approximately $20 billion of federal funding for residency training, about two-thirds comes from CMS through Medicare Direct Graduate Medical Education (DGME) payments and Indirect Graduate Medical Education (IME) (CMS, 2025c; CMS, 2024a; Wagner et al., 2024). These payments are made to teaching hospitals. This method of funding training is inconsistent with where people receive primary care (i.e., in the community) and neglects many communities not located near a teaching hospital, unintentionally creating primary care deserts (Green et al., 2001). **What is needed:** As recommended in the *Implementing High-Quality Primary Care* report, HHS should redesign GME to support training primary care clinicians in community settings and refocus the distribution of training sites to better meet the needs of communities and populations, particularly in rural and underserved communities.

Grow the interprofessional primary care team: The historical undervaluing, under-resourcing, and overburdening of primary care has reduced the proportion of physicians choosing careers in primary care (Hoffer, 2024). In addition to a shortage of primary care clinicians, there are also insufficient numbers of other interprofessional team members to support patients' complex chronic, social, and behavioral needs. **What is needed:** To help replenish and grow the interprofessional primary care workforce and make it a desirable career choice, *Implementing High-Quality Primary Care* recommended that HHS redesign and implement economic incentives, including loan forgiveness and salary supplements to encourage a more diverse, interprofessional workforce to train in primary care (NASEM, 2021). The report also recommended that HHS and the US Department of Education partner to expand pipeline models to increase opportunities for students who are underrepresented in health professions. How agency restructuring within HHS and the US Department of Education will affect these efforts is unknown.

Digital Health

Digital health is an essential component of health care. It broadly refers to a range of technologies used to improve the delivery of primary care services including online scheduling, electronic check-in, mobile applications, telehealth, wearable devices, and more. Health information technology (HIT), including the use of electronic health records, health information exchanges, and practice management software systems, is an essential component of digital health as it provides the infrastructure that enables the storing, sharing, and access to patient data. Artificial intelligence is increasingly being used in diagnosis, treatment planning, health care analytics, workflow optimization, and more. As recommended in the *Implementing High-Quality Primary Care* report, primary care needs digital health to make it easier to deliver the right care to the right people by the right team members at the right time. This includes

establishing digital health standards in primary care to (1) support relationship-based, continuous, person-centered care; (2) simplify the technology experience for patients, clinicians, and health systems; (3) ensure access to technologies, including by patients, clinicians, and health systems in rural areas with limited resources; and (4) hold technology vendors accountable to Meaningful Use standards (CMS, 2024c). The committee also recommended adopting a comprehensive, coordinated data infrastructure across systems.

Why It Is Important

Primary care requires high-quality digital health to effectively deliver its core functions of comprehensive, first-contact, continuous, coordinated care. Effective digital health is a common good that benefits both the primary care clinicians and patients who use it. Yet nationally, the HIT infrastructure needed to support digital health has fallen short due to poor interoperability, complex user interfaces, poor data quality, and lack of standardization resulting in inefficient clinical workflows creating burden for clinicians. Only one-quarter of primary care physicians report that they are very satisfied with their electronic health record, and fully a third say that they are "somewhat dissatisfied" or "very dissatisfied" (Hendrix et al., 2024). This highlights how technology is contributing to primary care burnout, interfering with the clinician-patient relationship, and adding burden to daily primary care providers' lives.

Additional Policy Opportunities

Make HIT certification meaningful: Electronic health records are certified by the Assistant Secretary for Technology Policy / Office of the National Coordinator for Health Information Technology (referred to as ASTP) (ASTP, n.d.). The certification process assesses interoperability, meaningful use, and impact on patient quality and safety. **What is needed:** ASTP could expand the meaningful use certification of HIT to assess whether systems fully support the functions of primary care (e.g., supporting relationships, providing access and continuous contact over time, collecting and understanding each patient's health and other relevant information, and having a person/patient/family-centric focus rather than a disease focus), while at the same time reducing the workload of the primary care team. Vendors should also be held accountable to ensure their systems satisfy and support primary care (Krist, 2024). These actions align with recommendations from the *Implementing High-Quality Primary Care* report. Tracking clinician satisfaction with electronic health records could also be considered as a way to hold vendors accountable (Krist, 2024).

Ensure interoperability: While HIT certification does promote interoperability and information blocking is forbidden, health information remains siloed. Clinicians frequently cannot access all of a person's health information in real time at the point of care, or the process to access and review the information is cumbersome and time consuming. Patient information remains a competitive advantage for both health systems and technology vendors, which further inhibits information sharing for clinical care. **What is needed:** As *Implementing High-Quality Primary Care* recommended, a coordinated national approach to share and protect data while holding vendors accountable for point-of-care information sharing is needed for all clinicians and patients. This falls within the existing authority of both CMS and ASTP.

Remove barriers to artificial intelligence: Executive Order 14179 seeks to remove barriers for America to design, implement, and use artificial intelligence (AI). The use of AI in health care holds great promise for digital health by supporting care teams, reducing workload for redundant and repetitive tasks, making sense of complex clinical data, and promoting the core functions of primary care. The current executive order calls for the Assistant to the President for Science and Technology, Special Advisor for AI and Crypto, and the Assistant to the President for National Security Affairs to develop and submit to the president an AI action plan. This responsibility could be extended to ASTP. **What is needed:** A national

effort is needed to advance the science of how to use AI to improve health. This includes research to develop and implement the use of AI, as well as policy and regulations to ensure the ethical use of AI to improve health without unintended consequences or misuse for gain (Matheny et al., 2025). The increasing use of AI in child and adolescent primary care settings underscores an urgent need to address privacy concerns with the use of this technology. Interoperability will also facilitate AI in that it will allow for it to be based on more complete data (Rehburg et al., 2024).

Maintain access to telehealth services: During the COVID-19 pandemic, the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 significantly expanded Medicare's telehealth policy. It allowed patients to remotely access a wider range of health care services, including non-mental health consultations, and eliminated geographic restrictions on where the services could be received. While some of these expansions have become permanent policy changes, many are set to expire September 30, 2025. **What is needed:** The telehealth expansions allowing all eligible Medicare providers to deliver services to people in their homes using video or audio modalities with no frequency limitations are needed to improve person-centered access to primary care. Making the COVID-19 era telehealth policy permanent would align with the 2021 *Implementing High-Quality Primary Care* report recommendation on the topic.

Addressing the Primary Care Access Crisis

Despite some progress that has been made on implementing the 2021 NASEM report recommendations, the ongoing—and worsening—primary care access crisis highlights that much more remains to be done. The *Implementing High-Quality Primary Care* report can be used by the new Administration and Congress—which has signaled that primary care will be a priority—as an evidence-based policy roadmap to improve payment, workforce, and digital health, which are key strategic priorities for expanding primary care access.

For example, Senator Mike Crapo, the Chairman of the Senate Finance Committee, outlined his priorities on health care for the 119th Congress, including his desire to continue bipartisan efforts to improve primary care through efforts such as augmenting access in rural areas, expanding the availability of mental health services and telehealth capabilities, and preventing clinic and hospital closures in rural and frontier communities (United States Senate Committee on Finance, 2025). Senator Crapo noted, "We must improve primary care, support chronic-care benefits in Medicare and provide Medicare doctors with long-term payment stability" (United States Senate Committee on Finance, 2025).

The Standing Committee's purpose is to advise the federal government as it tackles primary care access challenges. Its expertise is grounded in the health needs of families and communities and the ability of primary care teams to meet those needs. The Standing Committee has and will continue to be available to respond to federal questions, analyze new evidence as it emerges, and serve as a venue to discuss objective, evidence-based solutions to improve primary care access.

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