



States Should Invest in Primary Care



States are facing growing pressure to improve health outcomes and constrain health care spending amid fiscal uncertainty and evolving federal policy. At a time when states need to do more with less, investing in primary care and population health is paramount.

THE ISSUE: Currently, Medicaid reimburses primary care providers in a way that leads to underinvestment in primary care. Fee-for-service (FFS) payments incentivize volume over value and discourage care coordination — and they are still the common payment approach for primary care, even in managed care states. Investment in primary care is associated with longer life expectancy, lower rates of chronic disease, and fewer hospitalizations. Yet, the U.S. continues to devote a small share of total health spending to primary care.

THE SOLUTION: States can redirect a share of their Medicaid dollars towards primary care by shifting how Medicaid reimburses primary care. As health care costs continue to rise, investing in primary care can equip states to better address patients' needs through prevention and comprehensive, coordinated care.

There are myriad ways states can pursue primary care payment reform depending on policy goals, legal authority, and stakeholder readiness.

INCREMENTAL APPROACHES

- **Fee-for-service + care management fee:** States can implement an additional care management fee that Medicaid prospectively pays to primary care physicians on a per-member-per-month (PMPM) basis. This fee helps cover and incentivize high-value activities that primary care physicians can provide but that traditional FFS does not reimburse, such as care coordination, patient outreach, medication management, and population health activities. This fee can also enable states to establish longitudinal care programs that are difficult to sustain under FFS payment alone. This approach is a good first step, but it does not fundamentally change underlying FFS incentives, which limits its ability to drive more lasting reform.
 - › **Best for:** States with limited payment reform experience looking to explore enhanced primary care investment without abandoning FFS.
- **Hybrid primary care payments:** States can expand the services under the care management fee to shift provider incentives further towards outcomes (both cost and quality) while enhancing primary care capacity through predictable, upfront funding. This approach expands the care management fee to cover most primary care services with additional limited FFS reimbursement for certain visits or procedures. Hybrid primary care payments take payment reform one step further than FFS + care management fees by further supporting care management and disease prevention and rewarding physicians for supplying needed care.
 - › **Best for:** States that want to advance beyond traditional FFS, but are not yet ready to adopt capitation or other advanced risk-based models.
- **Coordinated care organization + population-based payments:** States can leverage coordinated care organizations (CCOs) and population-based payments (PBPs) to not only incentivize cost and quality outcomes, but to hold providers accountable for them. Similar to Accountable Care Organizations (ACOs) in Medicare, CCOs are a group of providers (e.g., primary care physicians, specialists, hospitals, and behavioral health providers) who deliver care for a defined population, with a shared responsibility for cost and quality. This approach enables states to extend cost and quality accountability across settings (e.g., inpatient, outpatient, physician services, post-acute care, etc.) while offering a predictable, prospective revenue stream to providers. In managed care states, states leverage their managed care contracts to implement this approach. In FFS states, states can contract directly with the CCO provider organizations.





- › **Best for:** States looking to build on previous primary care investment by extending accountability for cost, quality, and population health outcomes across the broader health care system.

State Success Story: [Oregon](#) uses CCOs and population-based payments to coordinate care for Medicaid enrollees' primary, behavioral, and oral health care. The CCO model encourages providers to focus on preventive care and curbing cost growth.

COMPREHENSIVE APPROACHES

- **The CMS AHEAD Model:** For states that are well positioned to commit to multi-payer reform, the Achieving Healthcare Efficiency through Accountable Design (AHEAD) model is a Centers for Medicare and Medicaid Services (CMS) initiative that enables states to take on total cost of care accountability across Medicare, Medicaid, and commercial payers. The AHEAD model offers states a cohesive, statewide strategy to constrain health care cost growth across payers, rather than relying on fragmented, payer-specific approaches. The model maximizes all available tools and levers to constrain health spending and improve population health (e.g., primary care investment, hospital global budgets, ACOs). By aligning Medicaid, Medicare FFS, and commercial payers around shared benchmarks, AHEAD enables states to cast a wider net across the health system, improving population health for a much larger segment of residents while reducing chronic disease burden and reducing spending.
- › **Best for:** States with limited payment reform experience looking to explore enhanced primary care investment without abandoning FFS.

State Success Story: The Maryland All Payer Model (MDAPM), a predecessor to the AHEAD model, initially reduced Medicare spending by nearly [\\$1 billion over a 4.5-year period](#). The expanded version of the model, the Maryland Total Cost of Care Model (MDTCOC), included a care management payment to support advanced primary care. MDTCOC reduced total Medicare spending relative to national trends by [\\$689 million](#), reduced acute care hospital admissions by more than [16%](#) for the Medicare and commercially insured population, and improved several quality measures (e.g., reduced preventable readmissions, reduced emergency department visits). Building on the success of MDTCOC, Maryland transitioned to AHEAD in 2026, demonstrating how states can evolve from hospital-focused reform toward broader accountability for cost, quality, and population health.

INTERESTED IN LEARNING HOW YOUR STATE CAN INVEST PRIMARY CARE?

Arnold Ventures and our partners have a network of resources for states interested in engaging in payment reform. The [National Academy for State Health Policy](#) (NASHP) partners with states to develop innovative policies and strategies for systemic, multi-payer reforms to improve value over volume. Similarly, the [Medicaid Primary Care Population-Based Learning Collaborative](#), led by the Center for Health Care Strategies, offers support to state Medicaid agencies in transitioning primary care away from fee-for-service to enable greater flexibility in care delivery.

If your state is interested in learning more or connecting with one of the organizations mentioned above, please reach out to AV's Vice President of Medicare Sustainability and Provider Payment Incentives, Josh Gordon (jgordon@arnoldventures.org).

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