PRIMARY CARE FOR ALL (PCFA) TASK FORCE

FINAL REPORT (DECEMBER 2025)

CAFP
California Academy of Family Physicians

Interim Report of the CAFP Primary Care for All Task Force

January 2025

In April 2024, the CAFP Board of Directors established the Primary Care for All Task Force (PCFA), charged with recommending an organizational position on payment and health system models to expand and simplify access to, and investments in, primary care.

At AMAM, Delegates present will have the opportunity to provide verbal comment on behalf of physicians in their regions. Individual members who are not Delegates will not have the option for verbal comment at AMAM but will have the opportunity to provide written testimony. All testimony will be collated and considered by PCFA before making final recommendations to the Board. AMAM Delegates are asked to focus their testimony on the following questions:

1. Keeping in mind current CAFP policy, strategic plan, and the broader CAFP membership, what are the top three elements of primary care reform that the Task Force should prioritize?
2. What is the most exciting aspect of each of these two reform options? How does each option advance family medicine's ideal primary care delivery system?
3. What are the major hesitations around each of these options if they were to go to the Board for discussion and approval?

Task Force Recommended Options

The Task Force reviewed existing CAFP principles for health reform (universal, comprehensive, timely, high-quality, and sustainable), weighed outside research and evaluated current state-level efforts at reform. The Task Force also embraced the spirit of advancing bold reform, believing that the severity of the primary care crisis demands decisive action.

PCFA recommends that CAFP consider two options (not mutually exclusive) for major primary care policy reform in California that align with the needs of family medicine and are best poised to make a positive impact on current and future investments in California to advance continuous comprehensive primary care:

1. Implement regulations and/or enact legislation to **make the state 15 percent Primary Care Spend target a mandatory rather than voluntary benchmark** without changing health insurance financing and payment structures. A major limitation of the Office of Health Care Affordability (OHCA) primary care spending benchmark is that the statutory language authorizing this policy does not include enforcement mechanisms, making it a voluntary rather than mandatory spending goal. This reform option would convert the OHCA target from its voluntary status to a mandatory one, while leaving the current structure of health financing intact.
2. Enact a **unified financing model or single payer program for primary care** carved out from the remaining pluralistic health insurance system. This option would create a new universal, state-administered single payer program covering primary care services, essentially functioning as a state-sponsored direct primary care model for all Californians. The budget for the single payer primary care program would be statutorily indexed to 15 percent of total health care expenditures.

The following full report and its appendices provide detailed descriptions of these reform options, assessments of strengths and weaknesses of each option, and responses to Frequently Asked Questions about the two recommended options.

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Background: Primary Care for All Task Force

In April 2024, the CAFP Board of Directors (Board) established the Primary Care for All (PCFA) Task Force, charged with recommending an organizational position on payment and health system models to expand and simplify access to and investments in primary care. The PCFA Task Force is comprised of twelve physician members, including co-chairs Dr. Kevin Grumbach and Dr. Anthony Chong, diverse in gender, ethnicity, geography, practice type, and opinions. Members of the PCFA Task Force have expertise in health system financing, practice management, physician group financing, and/or health policy, and most are active in direct patient care.

The PCFA Task Force got started in earnest in June 2024 with an assignment of:

1. Reviewing current CAFP policy;
2. Researching and exploring health care and health insurance reform policy to develop evidence-based CAFP policy strategy;
3. Developing new policy on health system and health insurance reform, including, but not limited to, unified financing model;
4. CAFP member perspectives at the 2025 All Member Advocacy Meeting;
5. Making policy recommendations to the Board informed by research evidence, evolving state policy developments, Task Force discussions, and broader CAFP member input.

PCFA Task Force members committed to:

1. Participating in regular Task Force meetings, both virtual and in person;
2. Keeping an open mind to a multitude of policy options guided by shared principles about family medicine and the goals of health reform;
3. Committing to bold, innovative, collaborative work that achieves the goals of the Task Force.

Existing CAFP Policy

CAFP does not have policy that identifies a specific preferred model of health care reform but does have policy outlining CAFP's core principles of health care reform. Existing CAFP policy defines standards for health care delivery system and financing reform, guided by core principles:

- **Universal**: providing insurance coverage to every person.
- **Comprehensive**: providing insurance that includes all essential and needed health services.
- **Timely**: providing sufficient workforce and access to the appropriate health care clinician within reasonable time and distance standards.
- **Affordable:** ensuring cost is not a barrier to accessing needed services.
- **High Quality**: delivering health services according to medically- and culturally-determined standards of practice.
- **Sustainable**: accounting for overall system financing, as well as the financial sustainability of family medicine practices.
- **Physician independence**: supporting practice flexibility as well as independent patient/physician decision making.

The American Academy of Family Physicians (AAFP) also has policy, health care for all, which provides a framework for moving to a primary-care based health care system and health care coverage for all, with consideration of diverse reform options to achieve those goals.

The Primary Care Crisis

Decades of underinvestment have brought primary care in the US and California to the breaking point. The crisis is adversely affecting both patients needing primary care services and family physicians and others working in primary care. More than one in four Californians lives in a primary care shortage area. Patients in communities across the state face growing difficulty in finding a primary care physician open to new patients or scheduling timely appointments if they do have a primary care physician. Inadequate access to primary care contributes to deteriorating health among Californians, particularly among marginalized communities.

Demographic changes such as aging of the population, and epidemiologic changes such as increased rates of chronic diseases, are increasing primary care needs and exacerbating current shortages. Maldistribution of primary care clinicians amplifies these shortages, especially for

rural, low-income, and minoritized communities. Excessive workloads, exhaustion, and the aftermath of the COVID pandemic have increased burnout and moral injury among the entire healthcare workforce, but especially among primary care physicians. High burnout rates lead to attrition, early retirements, and mounting challenges recruiting medical students to primary care careers. These growing shortages contribute to a vicious downward spiral.

The National Academies of Sciences, Engineering and Medicine 2021 report Implementing High Quality Primary Care shined a spotlight on the fundamental cause of the primary care crisis: lack of adequate investment. Although primary care accounts for nearly half of all ambulatory visits in the US, only about 5 percent of health care spending goes to primary care. Reform proposals at the state and national level are increasingly focusing on policies to shift a greater share of health are spending to primary care. This additional funding would revitalize primary care by building the primary care workforce and improving the distribution of primary care clinicians; expanding practice capacities by adding staff members to provide team-based care; supporting innovation and application of new technologies; and reducing administrative burdens. Through these enhancements, clinicians are more likely to experience the joys of providing comprehensive primary care for patients, families and communities. More vibrant and successful primary care practice will attract more medical students to choose primary care specialties as a career choice.

Current Momentum for Primary Care Reform in California

In the past few years there have been unprecedented regulatory, legislative and other policy making efforts that signal significant momentum for reform in the state that prioritizes primary care, universal coverage, health equity, and affordability. Those efforts are summarized below. The November 5, 2024 election has likely changed the State's approaches and priorities. At the time of writing, the new Trump administration has not released any official health policy directives, however campaign signaling and his previous term provide an indication of some components of the new administration's health policy approach.

Universal Coverage and Unified Health Care Financing

In 2019, SB 104 established the Healthy California for All Commission to develop a plan that includes options for "advancing health care delivery through a unified financing system, including but not limited to a single-payer system." Some of the Commission's recommendations have already been enacted, including Medi-Cal eligibility expansion and establishment of the Office of Health Care Affordability (discussed further below). In January 2024 the state extended Medi-Cal eligibility to undocumented adults ages 26 to 49, making low-income individuals of all ages in the state eligible for Medi-Cal irrespective of immigration status. These reforms have added to Affordable Care Act coverage expansions such as federal subsidies for Covered California enrollment, resulting in steadily decreasing numbers of uninsured people in the state (6.2 percent uninsured in 2022). The Commission's final report in April 2022 provided a detailed analysis of the potential savings of implementing a single payer system and recommended that the state continue to move to implement a unified financing system, without specifying its exact features. In 2023, California enacted SB 770 (Weiner) directing the state to take concrete actions to advance the Commission's recommendations on unified financing by pursuing a waiver framework with the federal government for administering a state program that meets specified criteria, including universal coverage, equity, affordability, and comprehensive, continuous care. CAFP worked with the authors of SB 770 to successfully amend the bill to include language specifically calling out primary care; CAFP was the only major physician organization to support SB 770.

Office of Health Care Affordability and a Benchmark for Increased Primary Care Spending

California Senate Bill (SB) 184 (2022) established the Office of Health Care Affordability (OHCA) in the California Department of Health Care Access and Information (HCAI). SB 184 authorizes OHCA to set mandatory limits on total health care expenditures in the state. OHCA's governing

body, the Health Care Affordability Board, voted to approve a limit on annual increases in overall spending of 3.5 percent in 2025, decreasing to three percent annually by 2029. OHCA is also authorized to set targets for primary care investment in the state, measured as a percentage of total health care expenditures. CAFP staff and members participate in two OHCA advisory groups, the Investment and Payment Workgroup and the Advisory Council, providing input on methods for accurately defining and measuring primary care spending and an appropriate target for a primary care spending benchmark. In October 2024 the Health Care Affordability Board approved key elements of a primary care spending plan that CAFP strongly supported:

- **A benchmark for primary care spending of 15 percent of total health care expenditures.** This ambitious benchmark represents a more than doubling of primary care investment currently estimated at six percent. The California benchmark is higher than that set by other states that have adopted primary care spending targets. The plan calls for health plans to increase their primary care spending by one to 1.5 percent annually as a share of total spending to achieve the benchmark by 2034.
- **An appropriately narrow definition of primary care that reflects a comprehensive, continuous care model.** CAFP worked diligently to ensure that the spending that is counted reflects a family medicine approach to primary care (e.g., spending on services at retail clinics in pharmacies or by obstetrician-gynecologists is excluded).

The OHCA primary care spending plan has a few important limitations:

- It does not apply to health plans that do not fall under state jurisdiction; this includes not only Medicare but also self-insured employer "ERISA" plans (which constitute about one-third of the private insurance market).
- The health plan primary care spending targets are *voluntary*, unlike the mandatory nature of the total health care expenditure limits.

Managed Care Organization Tax-Funded Increases in Medi-Cal Payment Rates

The Managed Care Organization Tax (MCO Tax) is a tax on health plans that enables the state to draw down federal funding intended to support the state's Medi-Cal program. In 2023, the California Legislature committed to using some of the funds from the existing MCO tax approved by the federal government for long-overdue rate increases for physicians and other health care clinicians. The first increase went into effect January 1, 2024, increasing Medi-Cal rates to 87.5 percent of Medicare rates; this increase was preserved even amidst the fiscal year 2024-2025 budget deficit.

On November 5, 2024, California voters overwhelmingly passed Proposition 35, which establishes an MCO tax strategy in statute. The initiative levies a fee on managed care plans. This money is used to match and draw down additional federal money through the Medi-Cal program and is dependent on federal approval. The initiative is expected to generate $35 billion in new revenue. Per the initiative, California is required to spend the additional funds on designated health care programs, primarily an increase in Medi-Cal payment rates for primary and specialty care as well as support for emergency services, family planning, mental health access and prescription drug costs. There are also funds dedicated to supporting Graduate Medical Education. Importantly, the initiative will prevent legislators from using the tax revenue to replace existing state Medi-Cal spending.

Health Reform Priorities and Options

Consensus on the North Star for Primary Care Policy Reform

The first activity of the Task Force was to develop a north star set of criteria for the elements of great primary care that policy reform should support. The Task Force endorsed well accepted definitions of high functioning primary care as being affordable, accessible, equitable, comprehensive, continuous, and high quality. Other notable elements highlighted by the Task Force include trust, accountability, well-staffed (a well-resourced healthcare team), physician autonomy, and sustainability.

The Task Force fleshed out in more specificity several priorities for policies to achieve care transformation:

1. **Prioritize Equity**: System should recognize and address inequities in health care for the multitude of diverse communities across California.
2. **Support Physicians and their Health Care Teams**: The system should provide appropriate resources, with reduced administrative burdens for physicians and their teams to ensure that patients have convenient, sustainable access to patient care.
3. **Emphasize Continuity of Care**: System should meaningfully support and put resources behind processes that advance and preserve patient continuity of care, which includes continuity of insurance coverage.
4. **Involve Patients in their Care**: Patient should be in the driver's seat on their care alongside their physicians —including the ability to access care when they want and need it, in the setting that they need.
5. **Expand the Primary Care Infrastructure (workforce):** The system should prioritize and support pathways to primary care, especially family medicine, graduate medical education, and other infrastructure necessary to future-proof the California workforce and patient primary preventive care, especially in rural communities and,
6. **Implement Better Value-Based Payment Methods.** Payment methods should move away from only using fee-for-service and include a component of population-based prospective payment (i.e., capitation) to primary care practices.
7. **Incorporate Rural Perspectives.** Efforts to bolster primary care reform should always include the unique challenges that rural communities face and consider policy options and payment models that consider their perspectives on access and quality of care.

The Task Force also embraced the spirit of advancing bold reform, believing that the severity of the primary care crisis demands decisive action.

Evaluation of Health Care Reform Options

The Task Force assessed three health care reform options based on their likelihood of achieving north star goals. Task Force members researched, analyzed, and deliberated on each option focusing on key criteria, including the elements of an ideal primary care delivery system, the political and financial feasibility of each option, how the reform option would translate across practice types and within or across practice business constructs and operations, and option boldness for truly transformative change.

Ranging from most to least far-reaching, the **options included:**

1. Enact a **unified financing model or single payer program for primary care** carved out from the remaining pluralistic health insurance system.

This option would create a new universal, state-administered single payer program covering primary care services, essentially functioning as a state-sponsored direct primary care model for all Californians. The budget for the single payer primary care program would be statutorily indexed to 15 percent of total health care expenditures.

2. Enact an **all-payer program for primary care** that leaves the current pluralistic insurance system in place.
   This option would retain the current mix of private and public health plans in the state but require all plans (including Medi-Cal) to pay the same rates, using the same method (e.g., a hybrid capitation and fee for service method), for primary care. The payment rates would be set to achieve the goal of 15 percent primary care spend for the state as a whole.
3. Implement regulations and/or enact legislation to **make the OHCA 15 percent Primary Care Spend target a mandatory rather than voluntary benchmark** without changing financing and payment structures.
   This option would leave the current structure of health financing intact and convert the OHCA target from its voluntary status to a mandatory one. It would not require all payers to pay the same rates and methods for primary care but would require each plan to conform to the 15 percent target for primary care spending.

The Task Force, after analysis and discussion, decided to remove the second option, All Payer Health Care Reform for Primary Care, because it is less bold than the single payer option and more politically and practically complicated to implement than the single payer and mandatory spending target options. The Task Force recommends that CAFP consider the Unified Financing Primary Care Program and Enforceable 15 percent Primary Care Spend Benchmark as options that align with the needs of family medicine and are best poised to make a positive impact on the current and future investments in California to advance continuous comprehensive primary care. It is important to note that these options are not necessarily mutually exclusive; for example, CAFP might consider actions to make the OHCA 15 percent primary care spend target enforceable as a short-term strategy while developing a longer-term strategy to advance a single payer primary care program.

More details about the reform options are provided below in the appendices.

CAFP Member Input on the Two Task Force Recommended Health Care Reform Options

The Task Force puts forward these two reform options—single payer primary care and enforceable primary care spending benchmark--for consideration at the 2025 All Member Advocacy Meeting (AMAM).

We invite CAFP member input in advance of the AMAM meeting in March 2025. Prior to AMAM, please provide feedback on these two options by clicking on this link and completing the form. At AMAM, Delegates present will have the opportunity to provide verbal comment on behalf of physicians in their regions. Individual members who are not delegates will not have the option for verbal comment at AMAM but will have the opportunity to provide written testimony. All testimony will be collated and considered by the Task Force before making final recommendations to the Board.

Please consider the following questions when providing feedback:

1. Keep Keeping in mind current CAFP policy, strategic plan, and the broader CAFP membership, what are the top three elements of primary care reform that the Task Force should prioritize?
2. What is the most exciting aspect of each of these two reform options? How does each option advance family medicine's ideal primary care delivery system?
3. What are the major hesitations around each of these options if they were to go to the Board for discussion and approval?

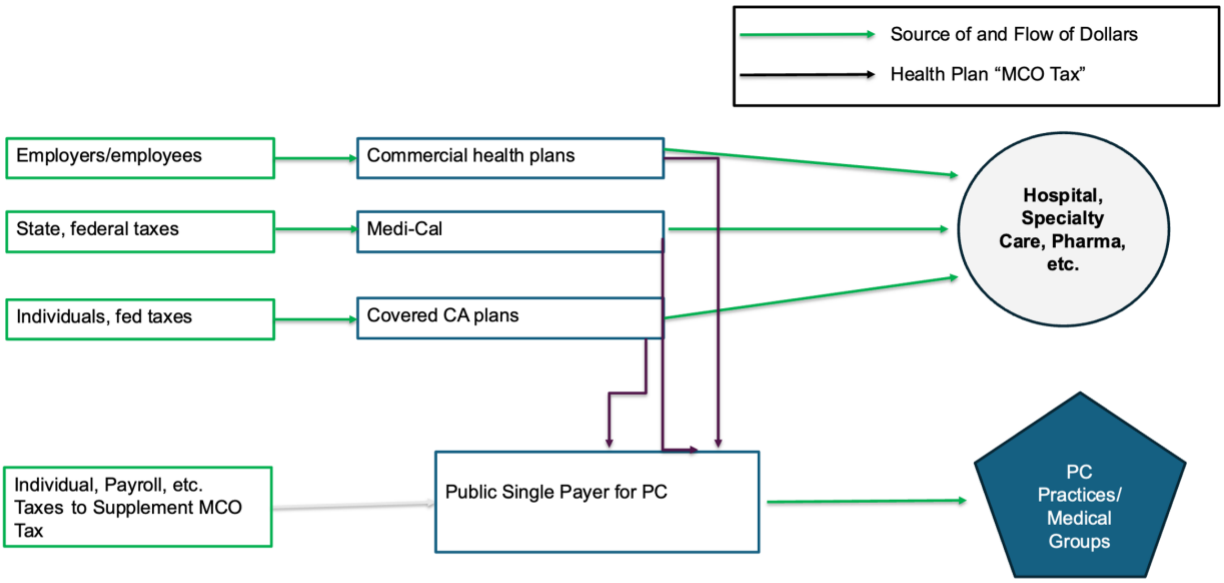
Appendix A: Reform Options

This appendix provides more description of the three options considered by the Task Force and its assessment of the strengths and weaknesses of each option.

1. Enact a **unified financing model or single payer program** for primary care carved out from the remaining pluralistic health insurance system.
   This option would create a new universal, state-administered single payer program covering primary care services.[1] This would essentially function as a state-sponsored direct primary care model for all Californians with an expectation for all patients to register with a primary care clinician/practice. Californians would retain their other health insurance (private or public plans) for coverage of non-primary care services. For primary care practices operated by large organizations, the plan would include measures to ensure that primary care payments reach front-line practices. The plan would ensure that payment is adequate and appropriate for different settings including rural communities. The budget for the single payer primary care program would be statutorily indexed to 15 percent of total health care expenditures in the state. Federal waivers would be required to incorporate Medicare and Medicaid into a state administered universal program. No such waivers for a state-administered single payer program currently exist in the US. Primary care physicians who do not wish to participate in this program would be at liberty to practice outside the program and bill patients directly.

   The Task Force recommended a financing approach to this program that is based on a model proposed by a single payer primary care program bill recently introduced in the Massachusetts legislature with the support of the Massachusetts Academy of Family Physicians. Rather than creating an entirely new tax to fund unified financing of primary care separate from the premium-based financing of private insurance, this model preserves the “front-end” financing of health insurance from employer and individual-paid premiums for private plans and tax-funding of existing government plans and introduces an MCO-tax on the “back-end” to pool funds from all payers into a single public trust fund to pay for universal primary care. The MCO tax would be set at 15 percent of total plan premiums. Some new taxes might be required to supplement the MCO tax to ensure sufficient funds for universal coverage and eliminating patient cost-sharing for primary care services.

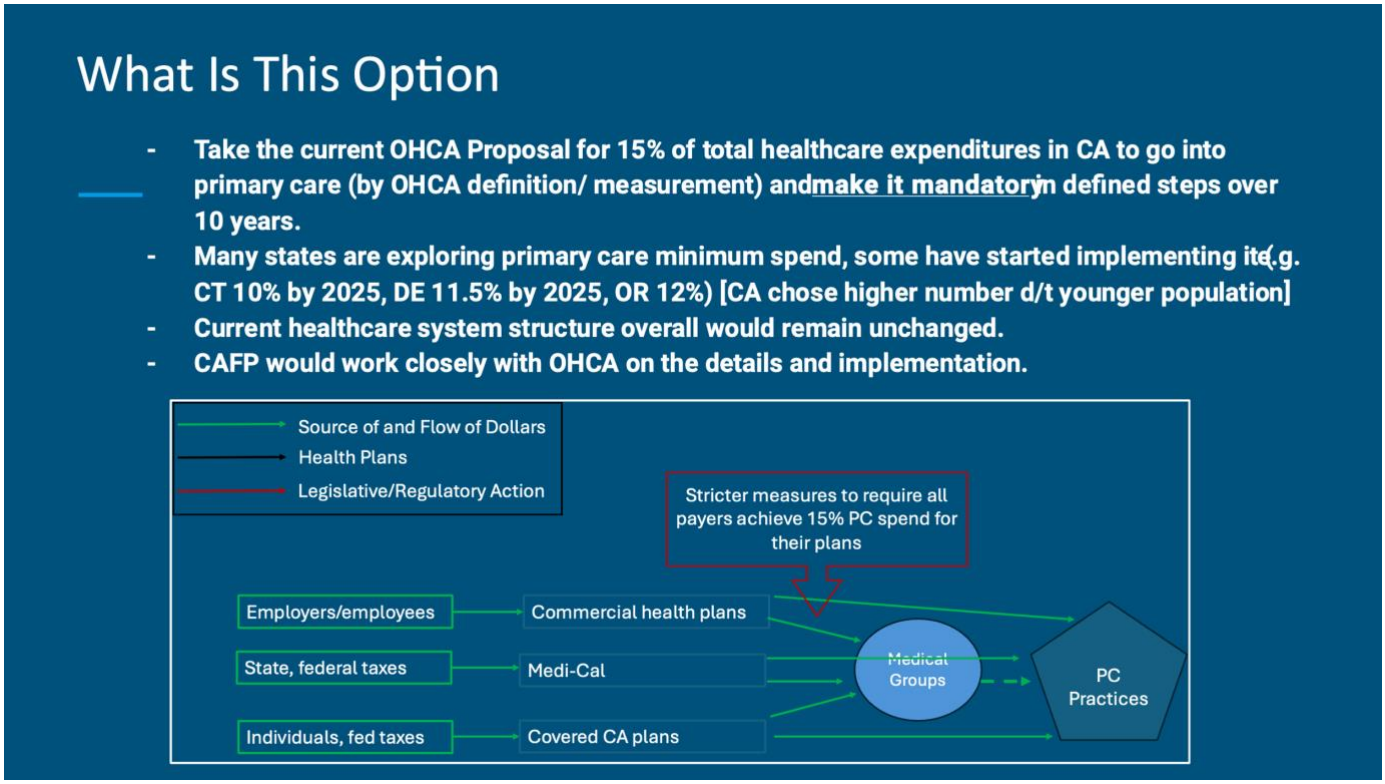
[1] A synopsis of a single payer primary care for all model appears at the end of this journal article.



- New universal public plan covering only primary care services
- Existing plans continue to cover other services

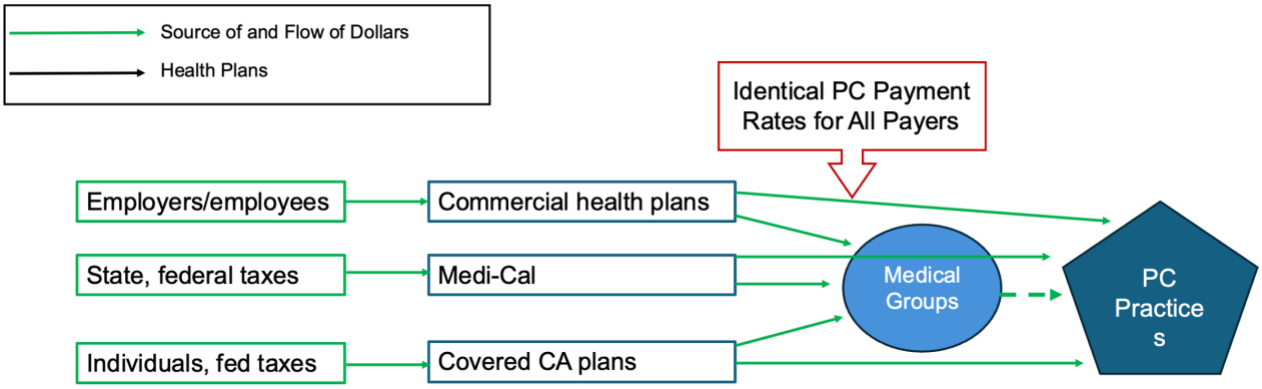
Strengths	Weaknesses
Universal, equitable insurance coverage for primary care	Politically challenging to enact; while less so that complete single payer system, likely to engender considerable special interest opposition
Continuity of coverage and primary care relationships; not disrupted by changes in income, employment, etc.	Risk of publicly financed and administered program being marginalized and underfunded if political retrenchment from 15 percent care spend benchmark
Administrative simplification and savings; for a practice, would function like direct primary care payment from a public sponsor	Potential disruption in coordination of and access to specialty referrals and other non-primary care services when primary care carved out from rest of insurance
Greater primary care payments if financed at 15 percent PC spend level	Potentially disrupts managed care organizations when primary care is funded separately
Could enhance practice options (potentially making small practices more viable)	Does not support patient direct pay practice models
Supports team-based care if not purely fee-for-service payment method	
Builds on momentum of SB770 and unified financing planning	

2. **Implement regulations and/or enact legislation to make the OHCA 15 percent Primary Care Spend target a mandatory rather than voluntary** target without changing financing and payment structures.
   This option would leave the current structure of health financing intact and convert the OHCA target from its voluntary status to an enforceable one. It would not require all payers to pay the same rates and methods for primary care but would require each plan to conform to the 15 percent target for primary care spending. A state mandate would not apply to Medicare or self-insured employer plans. The plan would include measures to ensure that increased primary care payments to large organizations reach front-line practices and provide appropriate compensation for rural and independent practices. This option would not include measures to provide insurance coverage of primary care for uninsured individuals.



Strengths	Weaknesses
California's adoption of a 15 percent PC spend target is a major accomplishment for primary care policy; achieving this level of primary care spending would be instrumental for revitalizing PC	Does not expand coverage to achieve fully universal coverage
Builds on existing state policy to strengthen it; politically and administratively more feasible than single payer program	Maintains payer inequities between government and private health plans, though all payers would increase spending on primary care
There may be regulatory approaches to enforceability that OHCA could implement without requiring new legislation to amend SB184	Maintains discontinuity in care that may occur when individuals change health plans
Ensuring higher primary care spend would bring greater resources to support primary care	Maintains administrative complexity of current system
Would not disrupt existing insurance and delivery system structures, which is a strength for patients and family physicians who are comfortable with these structures	If enforcement would require language to amend SB184, might engender strong opposition from CMA and other interests

3. Enact an **all-payer program for primary care** that leaves the current pluralistic insurance system in place. (*The Task Force decided NOT to recommend this option.*) This option would retain the current mix of private and public health plans in the state but require all plans (including Medi-Cal) to pay the same rates, using the same method (e.g., a hybrid capitation and fee for service method), for primary care. The payment rates would be set to achieve the goal of 15 percent primary care spend for the state as a whole. It would include measures to ensure that primary care payments to large organizations reach front-line practices. Federal waivers would be required to incorporate Medicare and Medicaid into a state administered all-payer program; Maryland is the only state that has a Medicare waiver for an all-payer program, which is for hospital payments. This program would not automatically include uninsured Californians since it only addresses payment under existing health plans; additional measures would be required to expand coverage to achieve fully universal coverage for primary care. The all-payer regulated payment rates would be binding for all physicians unless they did not participate in any insurance program and billed all patients directly.



- Pluralistic insurance system remains intact
- Key policy innovation: all health plans pay identical amount and method for primary care services
- To PC practice, payment indistinguishable for privately insured, Medi -Cal, etc.
- Payment method TBD, but recommend hybrid FFS+cap model
- Setting all payer rates: a) project $ value of 15% PC spend (total $ CA spend x 15%), b) divide by 12 = PC$pmpm, c) apportion pmpm into payment method components (cap, FFS, P4P, etc.).

Strengths	**Weaknesses**
Promotes equity by having same primary care payment rate for Medi-Cal and private plans	Would place disproportionate financial burden on Medi-Cal (and its tax financing) to "catch up" to much higher all-payer rate; in contrast, single payer program would allow Medi-Cal to contribute to unified financing pool at level proportionate to its share of total health care expenditures
Administrative simplification for practices by having all payers use the same payment method and pricing	Difficult to enforce payment rate regulation across diverse types of health plans with different models of payment to physicians and medical groups; more complicated to administer than single payer program
Would not disrupt existing insurance and delivery system structures, which is a strength for patients and family physicians who are comfortable with these structures	Maintains discontinuity in care that may occur when individuals change health plans
Potentially politically less threatening to insurance plans and other interests than single payer option	Does not expand coverage to achieve fully universal coverage
	Political resistance from health plans to this level of government rate regulation might be as high as for single payer option

Cross Cutting Issues for All Options

The Task Force identified several cross-cutting issues that will need to be addressed in all reform options to ensure that they are implemented in a manner that actualizes north star aims.

1. **Ensuring increased primary care spending reaches front-line practices.** Spending targets focus on measuring and regulating spending by health plans. There is a complicated flow of funds from health plan to front-line practices, particularly in California with many primary care physicians working in large health systems and with many plans using a "delegated" managed care payment model. There are often many steps in funds flowing from the health plan to a large medical group or IPA to smaller practice organizations to front line physicians and teams delivering primary care. Both the mandatory 15 percent primary care spend option and the single payer option with a 15 percent spending plan must include accountability mechanisms such as audits, criteria for drawing down additional payments, etc. to ensure payments to health care organizations reach front line practices.
2. **Including enough payers to reach a "tipping point" of practice-level investment.** Research indicates that payment changes must affect at least 2/3 of practice revenue to achieve the scale needed for practice transformation. The lack of state jurisdiction over Medicare and self-insured employer health plans challenges the ability of a state's stipulation of a 15 percent primary care spend benchmark to achieve this tipping point from a primary care practice perspective. The SB770 planning process might provide an opportunity to negotiate inclusion of Medicare in a state- administered unified financing program for primary care. Making the OHCA 15 percent benchmark enforceable might also include contemplation of waivers and other measures to extend the benchmark's authority to include Medicare and self- insured employer plans.
3. **Primary care infrastructure investment.** For increased primary care spending to achieve its goals of improving patient access to care and a more sustainable work environment for primary care clinicians, it must be coupled with measures to directly shore up the crumbling primary care infrastructure. Most importantly, policies must be implemented to rapidly increase the primary care workforce, including clinicians and other team personnel. These policies require front-loading primary care investment to enhance workforce and practice capacity, in addition to year-over-year increases in the share of health care expenditures flowing to primary care.
4. **Prioritizing equity.** All options for increasing primary care spending must be intentional in using the investment to address long-standing inequities based on geography, race-ethnicity, income, and other factors.
5. **Incorporate Rural Perspectives.** Rural areas are disproportionately affected by a lack of health care providers and tend to have higher uninsured rates than urban areas. Efforts to bolster primary care reform should always include the unique challenges that rural communities face and consider policy options and payment models that consider their perspectives on access and quality of care.

Appendix B: Reform Options FAQs

In this appendix the Task Force provides answers to frequently asked questions about the options of an enforceable primary care spending target and a single-payer primary care program.

1. **How would the option accommodate a diversity of practice types?**
    a) **Enforceable 15 percent Primary Care Spending Option**
    The enforceable 15 percent spend option does not restructure the current pluralistic model of health insurance and would not directly change the organization of medical practice. It is possible that increased primary care spend might disrupt the current trend of health care consolidation into large delivery organizations with employed physicians by improving the finances of smaller physician owned practices, including direct primary care models, making those practice models more economically viable. This would only occur if enforcement required the increased primary care spending to flow to front-line practices (see FAQ#3).
    b) **Unified Financing Option**
    A single payer model could promote smaller practice models but does not support direct patient pay models. A single payer authority could essentially function as a public, universal sponsor of direct primary care, paying a standard payment that is substantially higher than current payment rates for most payers. Under this scenario, funding would follow the patient, whether the patient elected a primary care clinician in the Permanente Medical Group or a solo family physician. This would prioritize patient choice, allowing individuals to select care that aligns with their needs. This, along with reducing administrative burden, may support more family physician practice options. A less favorable scenario would be the single payer imposing excessively rigid and restrictive criteria for practices to be able to participate in the single payer primary care program, disadvantaging clinicians who are not members of larger medical groups. Under either scenario, payment would not flow directly from the patient to the physician.

2. **How would the option incorporate existing CAFP policy?**
    a) **Enforceable 15 percent Primary Care Spend Option**
    A mandatory 15 percent spend on primary care would advance many of CAFP's payment policy objectives by increasing investment in primary care, addressing payment disparities, strengthening the workforce, and supporting health equity. Mandating that 15 percent of healthcare spending goes to primary care would ensure a significant and consistent financial commitment to family physicians and primary care practices. This approach could also help to strengthen the primary care workforce by attracting medical students to family medicine and helping to retain current family physicians by improving compensation. Family physicians would benefit from increased funding, enhancing practice sustainability and improved patient access. Insurers could invest funds directly into graduate medical education programs, expanding the pathways for an expanded rural primary care workforce. By increasing investment in primary care, this model would result in reduced health inequities; family physicians are often on the frontlines of addressing social determinants of health through screenings, care coordination, and referrals.

    Efficacy of the mandatory 15 percent primary care spend requirement in comporting with CAFP policy would depend in part on ensuring health plans do not become overly broad in what they include as clinical care (e.g., administrative costs, retail clinics, digital health platforms).

Mandating a percentage spend does not guarantee that payment methods will change to reflect the value of family physicians' work. For example, fee-for-service models may persist, perpetuating inequities in reimbursement without improving quality, care coordination, or patient outcomes. Practices serving rural, underserved, or high-Medicaid enrolled populations might not see equitable increases in funding if spending mandates are not coupled with payment reform to address existing disparities. Finally, to meet the 15 percent requirement, payers might reduce spending elsewhere, which could indirectly impact family physicians (e.g., cuts to integrated care programs).

b) Unified Financing Option

Accordance with CAFP policies depends largely on the details of how unified financing for primary care is designed and implemented. A unified healthcare system has the potential to achieve all major components of CAFP's health system reform and payment policies, from universal access and improving health equity to payment reform and reducing administrative burdens. CAFP policy supports healthcare as a fundamental human right and aims to work toward a system in which every individual has the right to comprehensive, high-quality health services that are delivered in a timely, culturally competent, and economically sustainable manner—regardless of age, gender identity, sexual orientation, geographic location, income, health status, or immigration status. A fundamental principle of a unified financing model is to include virtually all Californians in a less complicated system that is readily available and affordable for consumers, allowing all Californians to access primary care with no premiums and little to no co-pays. Creating more consistent, universal incentives should encourage a systemic approach to keeping people healthy, not just treating disease, including addressing social determinants of health. For family physicians, a unified financing system for primary care would aim to eliminate duplicative and independent administrative requirements, reducing physician system fatigue and freeing time for clinical work.

CAFP policy supports a diversity of practice types. A unified system could incorporate protections for small, solo, and low-earning practices and give patients more direct purchasing power by allowing them to go where they want for primary care. This has the potential to level the playing field between large groups and smaller practices. While a unified financing system could help support and promote independent practice, it would not allow for direct patient to physician payment and would add challenges to a physicians' ability to set their own rates.

Although unifying financing for primary care would provide transparency and clarity to an often-opaque system, it would also concentrate government authority over spending policy and payment rate setting. If done well, this approach could be more successful than a pluralistic financing model in achieving the goal of 15 percent of total health expenditures being spent on primary care. Accounting for primary care spending would be more straightforward when there is a single payer for primary care as compared with collecting spending reports from dozens of different health plans and trying to enforce spending targets for each plan. However, unified financing could also make the system susceptible to underfunding if state government rescinded a requirement for the primary care budget to be benchmarked to 15 percent of total health expenditures in the state.

Even if total spending on primary care increases, family physicians may have less ability to negotiate rates or incentives compared to the current system. Unified

financing may lead to top-down payment decisions that fail to account for diverse practice settings (e.g., rural, urban, FQHCs) and the unique needs of family physicians.

3. **How do we ensure that funding flows to frontline family physicians?**
Requiring that 15 percent of total health expenditures is spent on primary care must be coupled with measures to ensure that increased payments flow to frontline practices. Because of the complicated structure of funds flow for many physicians, with payments often going from a health plan to an integrated health system, ACO, IPA, or large medical group rather than directly to individual physicians, there is a risk that an inappropriate amount of increased health plan primary care spending is retained by intermediary organizations rather than reaching frontline practices and physicians. This would have a disproportionately negative impact on smaller and independent practices located in rural communities. The model would need to include a commitment to accountability that enhanced funding for primary care reaches frontline physicians. This could be achieved through audits and the marketplace.
    - Audits to ensure funds are supporting primary care might focus on cost allocation, practice capabilities, and practice outcomes. An audit may require the reporting of dollars allocated to particular services, staffing, salaries, benefits, and materials to determine the total spent on frontline physicians/practices. Another auditing method is assessing capabilities of a primary care practice through the supporting services available to physicians on the frontlines; addition or enhancement of services such as 24/7 call coverage, healthcare navigation, or social work services that support the practice can serve as an indicator of investment in primary care resources. Finally, an audit may be performed by looking at patient care outcomes as a performance indicator. For example, improvement in access, continuity, comprehensiveness, and quality in patient care can reflect the downstream effects of additional primary care funding in areas that increase productivity, staffing, and services (see FAQ #7).
    - A market approach to ensure flow of funds to frontline physicians would rely on transparency regarding compensation and benefits, practice capabilities (e.g., social workers, healthcare navigators), and practice outcomes such as access and continuity. This kind of transparency would allow consumers and providers to compare practices and vote with their feet. Recruiting/staffing firms and valuation firms could provide the data necessary to calculate share of premium dollar allocated to primary care compensation.

    A single payer for primary care has the potential to strengthen funds flow accountability if the single payer directly paid primary care practices rather than having primary care payments go to intermediary organizations (e.g., using a payment method modeled on Direct Primary Care).

4. **Where do we expect workforce to come from?**
Under both options, increasing primary care spend is expected to make the practice of primary care more attractive, sustaining the existing workforce and attracting a larger share of medical students and other health professional students to pursue careers in primary care. However, it takes many years for changes in incentives for people in training to translate into a meaningful increase in practicing family physicians and other primary care clinicians. It is possible that changes in incentives might have a more rapid effect on the workforce by repatriating family physicians, internists, and NPs/PAs currently working as hospitalists or in related focused practices into ambulatory primary care practice. However, additional short-term strategies will be needed in both options

to "front-load" increased primary care capacity so that greater investment translates into better primary care access and practice conditions. Help may already be on the way due to recent national and California state policies to substantially increase funding of graduate medical education with an emphasis on primary care (e.g., increases in Song-Brown funding). The number of family medicine residency positions in California increased by 33% between 2018 and 2023. Additional state funds are being invested in training programs in behavioral health and other fields that are critical for team-based primary care. Strategies to recruit and retain a sufficient primary care workforce to accommodate a single payer for primary care will need to incorporate policies targeted at the rural workforce needs in particular to ensure this patient population also has a sustainable source of primary care providers. CAFP will continue to advocate to protect and enhance state funding for family medicine residency positions and to ensure that investment is appropriately focused on training programs that produce graduates who truly practice primary care, especially in regions with the greatest need.

5. **How would systems be accountable for quality of care and performance measures while decreasing administrative burden for primary care practices?**
   Under both options, increased investment in primary care will need to be coupled with accountability for greater spending achieving the goal of high performing primary care. Traditional approaches to accountability have focused on reductionistic, disease specific measures (e.g., HEDIS metrics). However, there is growing recognition that the whole of primary care is more than the sum of dozens of disease specific measures. The Task Force recommends a paradigm shift to focus on a limited set of primary care measures that matter, motivate, and align with the quintuple aim for health improvement (better outcomes, patient experience, affordability, and equity and reduced health worker burnout). The trusted continuous, comprehensive patient-physician relationship is core to the quintuple aim. The American Board of Family Medicine's Center for Professionalism and Value in Health Care recommends four core primary care measures: 1. Continuous patient-physician relationship, 2. Person-centered Primary Care, 3. Comprehensiveness of Care, and 4. Trust in Physicians. Additional measures should focus on access and equity, as well as assessing administrative burden. As noted in FAQ#3, measures are also needed to ensure accountability at the health care organization level for increased funds flowing to front-line practices to pay for team staffing and other practice enhancements. Organizations should also be held accountable for providing facilitation for practice transformation. For example, the Advanced Access scheduling model, in which an individual clinician's panel is correctly sized (one measure being a patient's ability to see their personal trusted clinician within 3 days), is associated with both better continuity and access. Finally, approaches will be needed to identify the small proportion of practices who are significantly subpar on traditional HEDIS measures and may need focused support in quality improvement.

6. **How might the option be impacted by changes in federal and state politics?**
   a) **Enforceable 15 percent Primary Care Spend Option**
      The Office of Health Care Affordability (OHCA) currently does not have regulatory authority to enforce the 15 percent primary care spend. As such, this option would require legislative and administrative approval. Success would also be dependent on consistent state regulatory oversight and enforcement. This policy is not dependent on federal approval. However, Federal support for primary care through federal program payment incentives and structures could bolster California's efforts. For example, increases in reimbursement or funding structures in Medicare and Medicaid that support primary care could make implementation at the state level easier. Conversely, federal inaction or shifts in priorities away from primary care investment could create funding gaps and create obstacles.

There is likely to be significant opposition to an enforcement mandate. While insurers were generally supportive of the primary care spending benchmark framework, it will likely be less palatable if it is an enforceable mandate. Likewise, specialty physicians and hospitals may be concerned about a mandate that they worry could reduce spending on specialty care and hospitalization.

b) Unified Financing Option

This option would require both state and federal approval, including state legislative support and a federal Medicaid waiver. As such, this option would require significant political effort and support. The State Legislature and Governor's administration has shown significant support for primary care and health reform efforts (see report), including passage in 2023 of SB 770 (Weiner) directing the state to take concrete actions to a unified financing model by pursuing a waiver framework with the federal government. To date, the new Trump administration has not issued a direct policy statement on this issue.

A primary care unified financing option would likely also be subject to significant opposition from many health care industry organizations. CAFP was the only major physician organization to support SB 770.

7. How would the option impact access to care, continuity of care equity?

a) Enforceable 15 percent Primary Care Spend Option

Increased funding is expected to improve *access* to primary care by strengthening the primary care workforce and dedicating additional resources to expanding clinical services, adding vital staff members, innovating, and improving working conditions. As noted in FAQ#4, these investments would need to be coupled with an aggressive set of state policies to rapidly increase the training of family physicians and other primary care workers to create the additional capacity to increase access to care. These policies should promote diversity so that the composition of the health care workforce more closely reflects the demographics of the state. The increased primary care investment would also likely improve *continuity* of care. As noted in FAQ#5, accountability measures should include a strong focus on continuity and access. Although a general increase in primary care investment might improve *equity*, ideally the investment should be done in an intentional manner to prioritize additional investment in services for traditionally marginalized and under-resourced communities. Such intentionality might prove challenging if spending goals are set for health plans at a statewide level rather than using a regional or population-based approach for setting investment goals. While access and continuity can improve health outcomes, social and economic factors such as safe housing, nutritious food, and social support remain powerful drivers of health inequities. Increased funding could support and integrate community health workers into primary care systems to address the social drivers of health inequities.

b) Unified Financing Option

A single payer model, in addition to improving *access* through greater primary care spending, would have the added benefit for access by acting as a universal program for all state residents, regardless of their life circumstances. Patients could avoid interruptions in health insurance coverage and the challenges of Medi-Cal renewals because of job or family changes. On the other hand, there is the risk that access could be undermined if the state enacted a reversal of the 15 percent primary care spend requirement and underfunded primary care. A single payer primary care program would also enhance *continuity* of care. Patients would not need to change their primary care physician if they experienced a change in their employment, income, or life circumstances. Patients could enjoy the consistency of continuity and clinicians would experience less turnover of

patients joining or leaving their practices. Redistribution of resources to under-resourced and higher need communities to promote health equity is more feasible under a unified financing program which would give the state more control to direct more spending to where it is most needed. Funding could be used to provide incentives to build capacity to deliver primary care within under-resourced communities (e.g., creating more community health centers, tribal clinics, and similar entities). A single payer program would also enhance equity by eliminating payment differentials across payers. Medi-Cal would no longer reimburse physicians at rates much lower than commercial insurers. Under a single payer plan, there would be one payment rate for all enrollees.

8. **How would the option integrate specialty referrals and other aspects of care coordination?**
    a) **Enforceable 15 percent Primary Care Spend Option**
    This option is unlikely to substantially change access to specialists compared to the status quo. One risk in this model is spending more on primary care and less on specialty care may further tighten access to specialty care. On the other hand, creating the capacity within primary care to provide all the services family physicians are trained and able to deliver within primary care thereby alleviating the burden on specialists might expand specialty access.
    b) **Unified Financing Option**
    The purpose of this system is that it would create universal and continuous primary care service coverage without concern for deductibles or limited physician networks. Separating payment for primary care services from the rest of health care may be disruptive for narrow-network plans (primarily HMOs). A primary care single payer would not address issues around access to specialty care, the bureaucratic burdens of authorizations, and underinsurance/ lack of insurance for all services not provided in the primary care setting. It would also not likely make these issues worse. Specialty care access concerns may continue to drive discontinuity in primary care for patients with narrow-network insurance plans since they would likely choose to change their primary care clinician if their specialty access switched to a different system. On the other hand, little would change in referral issues for patients getting care in FQHCs, Direct Primary Care, or other settings in which specialty care is already organized outside of their primary care system. In many ways, direct primary care provides a precedent in how direct primary care practices currently handle specialty, imaging, lab, other testing and medication access, and could serve as a model of a currently existing system in which payment for primary care services is separated from other health care services.

Appendix C: Task Force Members

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