Simplifying Value-Based Primary Care by Reducing Administrative Burdens

Executive Summary

Administrative burden on primary care adds costs to the entire health care system

There is strong evidence and a growing consensus that greater investment in primary care through value-based models provides teams the resources they need to deliver proactive, whole-person primary care. Prospective, regular payments provide the stability and predictability that practices need to expand teams and adopt technology.[1]

But the transition from fee-for-service to alternative payment models (APMs) has been bumpy. Most are built on fee-for-service payments. Too often, the models provide small monthly care management payments that may be paid in addition to visit-based payments, with practices eligible for a performance bonus or shared savings paid long after care is delivered.[2] This half-hearted approach perpetuates a broken payment system that has repeatedly failed primary care teams and the communities they serve.

These payment challenges are compounded by inefficient and cumbersome administrative tasks that make it difficult (if not impossible) to shift to effective alternative payment models.[3] This burden is especially high for practices that have multiple payer contracts and APMs, such as accountable care organizations (ACOs).[4] Practices struggle to keep up with variation across models, payers, programs and technology; documentation and usability issues in electronic health records (EHRs) also weigh down primary care teams.[5]

DEFINITION

Primary Care Administrative Burden

Administrative burden in primary care is defined as the costs associated with external documentation and information sharing requirements. The costs may come from complying with complex regulations or payer requirements.

Potential costs to the team often includes lower care team productivity, lower practice satisfaction and unreimbursed time and technology needed to document, organize and share information. When participating in APMs such as ACOs, primary care often faces additional administrative burdens associated with variation across payers and payment models.[6]

Potential costs to patients include shorter visits and fewer available appointments, undermining access. These burdens can also harm quality of care by disrupting care journeys, such as when primary care is not notified of a hospital discharge or a health plan requires more information before authorizing care.

"Provide help – provide community health workers, provide schedulers, provide actual help."

– **Response to PCC Survey on Administrative Burden**

IMPACT

The Costs of Primary Care Administrative Burden

A study of office-based physicians found almost 50% of their time during the office day was spent on EHR and desk work, with only 27% of their time spent on direct clinical face time with patients. In addition, physicians reported one to two hours of after-hours work nightly, spent mostly on EHR-related tasks.[7] Another study found that primary care physicians in the U.S. spend $20.49 in administrative costs to receive payment for every service that generates roughly $100 in revenue.[8]

The consequences of these administrative burdens are high. They discourage primary care participation in new care models that can improve primary care access and comprehensiveness.[9] They contribute to the decline in independent practice[10] and to clinician burnout. And they risk eroding trust from primary care clinicians who seek better practice models that enable them to deliver comprehensive care to all types of patients and communities.

By engaging its multistakeholder community, the Primary Care Collaborative (PCC) has developed a policy framework and strategies to reduce primary care administrative burden in APMs. This framework identifies the sources of administrative burden, categorizes them and prioritizes the costliest ones associated with alternative payment models. Using this framework, the PCC has identified multiple options and opportunities for reducing administrative burden and provided recommendations for different stakeholders on how they can help reduce the impact on clinicians and patients.

In addition to drawing on the feedback of its members and the broader primary care community, the PCC also engaged key thought leaders in this space. The PCC is especially grateful to Ann O'Malley, MD, an expert in primary care health services research, who served as an advisor to the project.[11]

Clinician and stakeholder feedback and recommendations

Below are major takeaways from a PCC survey of the primary care community (including clinicians, support teams, consumer advocates and others):

- As described by a survey respondent, the administrative burden on primary care is "staggering."
- Primary care is bearing the brunt of administrative tasks with systemwide benefits, including quality measurement and electronic data exchange. These costs should be spread across the entire system to ensure that data is exchanged securely and with minimal effort from clinicians.
- Industry stakeholders and policymakers, including Medicare and Medicaid leadership, can and must play a larger role in efforts to lower administrative burden.
- Payers should align on fewer, more meaningful quality measures in payment models. They should align to simplify and modernize systems for information exchange and standardize certain payment model features.
- Policymakers and stakeholders should consider more deeply whether the benefits of a new policy or regulation are worth the drawbacks of putting more administrative work on primary care teams.
- Technology and enabling vendors need to be transparent about the full costs and capabilities of their tools upfront, so primary care can make informed, proactive decisions about what resources they can rely on at their practice.
- The cost of technology and digital infrastructures needed to provide high-quality care should be accounted for in payment models.

Solutions require alignment, standardization and patient-centric innovation

The PCC grouped administrative burdens into broad categories based on stakeholder input. We considered them as use cases as we developed a framework for finding solutions and stakeholder champions.

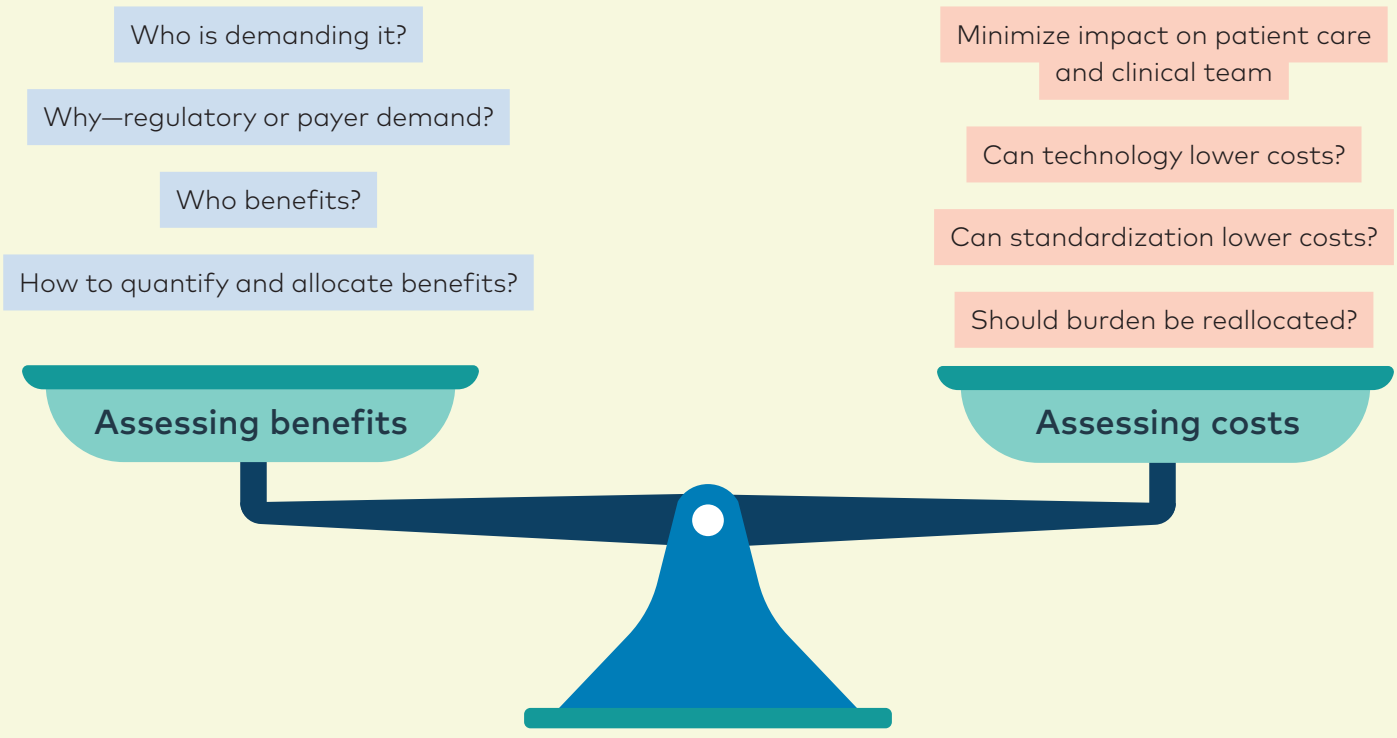
Below are the four largest, priority categories of administrative burden:

- Quality measure collection and reporting
- Excessive documentation (including for prior authorization) and coding demands
- Time-consuming, costly clinical data sharing due to lack of interoperability and other barriers
- Variation and complexity in payer contracts

The PCC stakeholder engagement process resulted in **a proposed framework for reducing administrative burden**:

- Describe the burden and its costs
- Identify the sources and intentions that create burden
- Consider any benefits and who benefits from activities that produce burden
- Consider alternatives to minimize impact on care teams and patient care
- Review the roles and responsibilities of key stakeholders in lowering burden
- Leverage opportunities to standardize processes across payers, stakeholders
- Use a cost-benefit analysis frame to inform decisions
- Incorporate administrative burden considerations upfront in policies and models

Administrative Burden Cost-Benefit Analysis



Background, Method and Findings

Background

Payment reform has contributed to administrative burdens

Federal and state policymakers have tried testing approaches for achieving comprehensive primary care while transitioning payment away from fee-for-service. Unfortunately, these efforts have not yet scaled,[12] despite strong evidence that more primary physicians in ACOs[13] and physician-led ACOs drive better performance.[14]

Studies suggest that **APMs have added to primary care administrative burdens**.[15] Most primary care practices that participate in APMs also continue to care for patients in traditional fee-for-service, creating more complexity as practices must navigate multiple payment systems.

The PCC engaged its multi-stakeholder community through multiple convenings and discussions with workgroups and committees to understand the size and sources of administrative burden. Based on literature review and stakeholder feedback, the PCC hosted two webinars exploring different approaches to reduce administrative burdens. One webinar focused on multi-payer alignment[16] and one focused on improving technology for documentation, data flow, decision support and patient engagement.[17] The PCC also conducted a survey of the PCC community that provided more insight and areas for improved alignment.

Finally, the PCC reviewed how public and private sector stakeholders can reduce the largest categories of primary care administrative burden and proposed a related framework. Use cases and case studies of promising efforts to lower aspects of administrative burden are included in the report.

WEBINAR

Teams, Tech and Tools: Takeaways from PCC Webinar

Joining ambient AI scribes are AI agents which can be trained and deployed as semi or fully autonomous chatbots or other automated agents to review and triage or delegate inbox messages. Dr. Yair Lewis of Navina joined a PCC webinar in October 2025 that discussed some of the implications and applications of fast-emerging AI generated health care tools. He predicted that these agents will be "commonplace" in primary care. Many of these AI applications appear promising for reducing AB burden and offloading tedious tasks from overburdened clinicians. Lisa Bari of Innovaccer and Dr. Sara Pastoor of Elation Health expressed some concerns about unintended consequences that might arise from taking a "let a thousand flowers bloom" approach to introduction and adoption of AI in health care.[18]

Panelists from Elation Health, Innovaccer and Navina discuss how technology can be used to alleviate burdens during a PCC webinar in October 2025.

"Today, with AI, I think all EHRs have exciting new opportunities to magically erase tedium and toil, giving time back to clinicians to focus on the things that actually matter to patients and to health outcomes."

– Dr. Sara Pastoor, Elation Health Head of Primary Care Advancement, during a PCC webinar

Developing a Framework for Reducing Primary Care Administrative Burden

• Engaging key stakeholders to inform solutions

The stakeholder engagement process and a review of the literature found that **administrative burden is hindering primary care participation in APMs**.

• Identify the sources of the administrative burden

Given the complexity of the health system, administrative burdens may arise from (and have) a variety of sources.

For example, one potential source of administrative burden may be Medicare or Medicaid requirements on participating health plans that are passed on to primary care. Variation in policies and processes like credentialing and prior authorization add to administrative burden. The CMS decision to align prior authorization processes in Medicare Advantage could be a model for Medicaid and commercial plans.[19]

• Probe, prioritize the biggest sources of administrative burden

Below are the four categories of activities contributing the most to administrative burden, according to stakeholders and a review of recent research.

Quality measure collection and reporting:

- Lack of standardized measures across payers and models
- Proliferation of measures across payers and programs
- Measures can distract from patient and clinical priorities

Excessive documentation and coding demands for payment purposes:

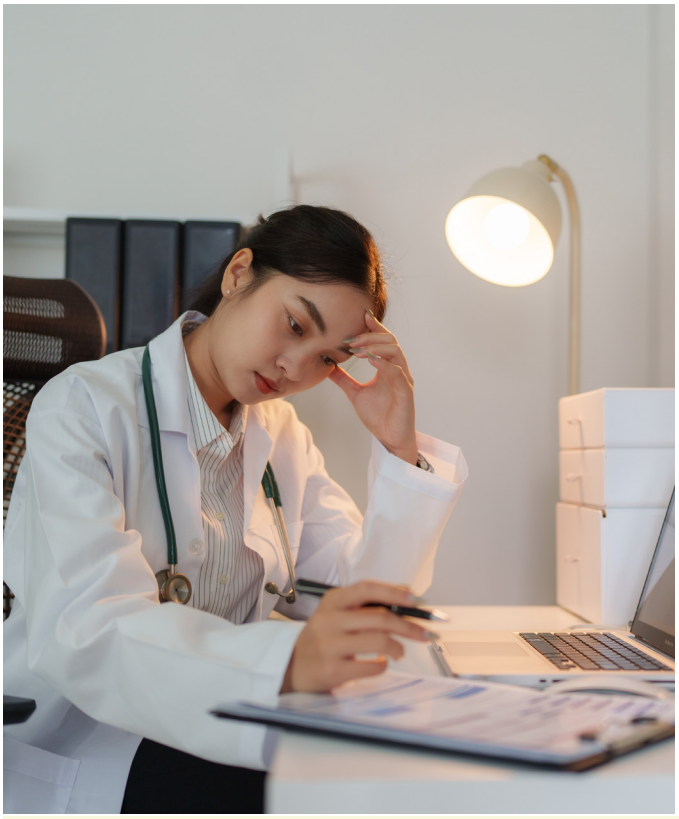
- Information in EHR serves revenue cycle instead of driven by care needs
- Duplicative requests from payers
- Practices face high friction prior authorization systems
- Primary care faces a deluge of patient requests to complete forms

Time-consuming, costly clinical data sharing and exchange:

- Slow progress in achieving electronic data **interoperability** (limiting electronic quality measure collection)
- High financial and workflow costs to buy, switch, add and integrate new tech tools
- Few tools track individual outcomes and across coverage, plans and programs
- Few tools engage patients effectively due to data siloes

Variation and complexity in payer contracts:

- Lack of standard terms, definitions and plan reports to practices in APM contracts
- Duplicative, high-friction processes for credentialing and provider network listing
- Poor payer collaboration and data sharing for patient attribution
- Lack of financial upside from payers relative to administrative burden in APMs

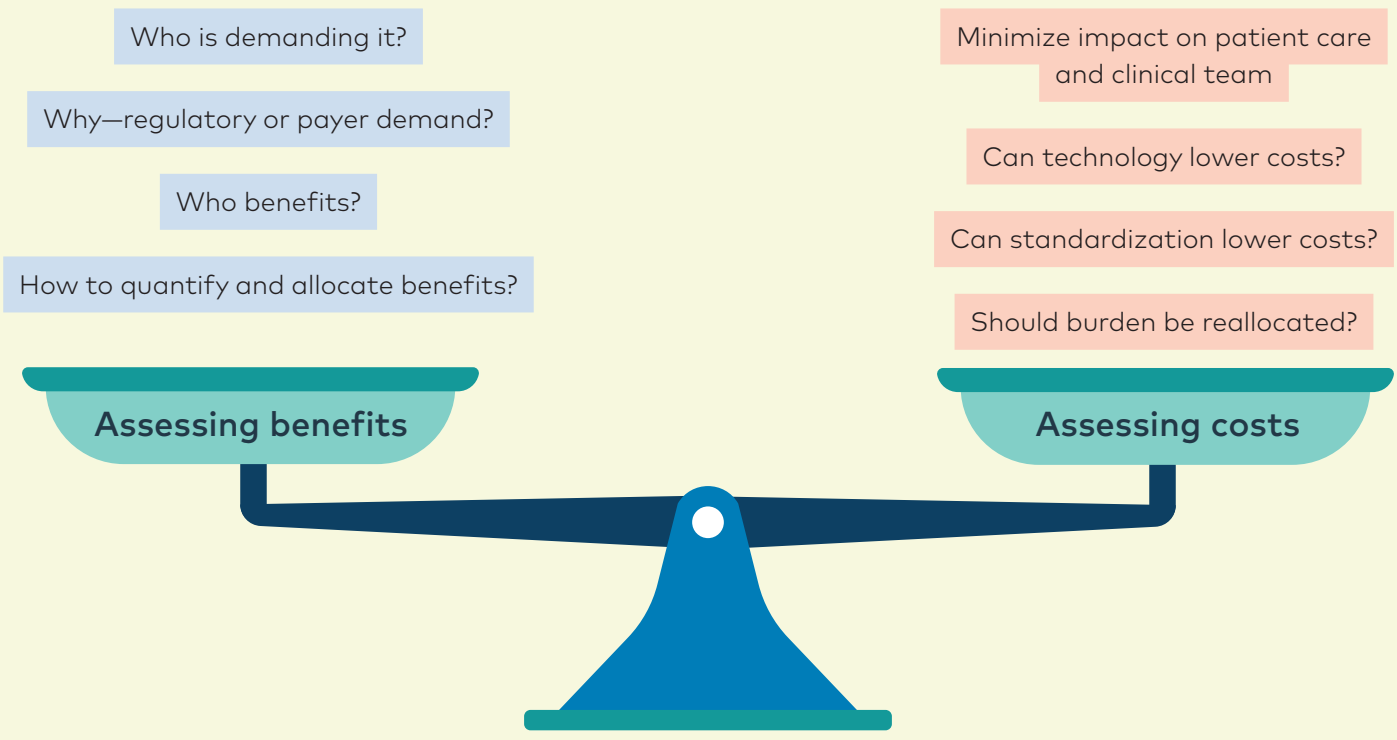


PCC's Framework: Stakeholder roles and responsibilities

The PCC proposes a **cost-benefit framework** decisionmakers can use to analyze and reduce administrative burden:

- Describe the burden and the costs associated with the burden
- Identify the sources and intentions that create the burden
- Consider benefits, including systemwide benefits, from activities creating burden
- Consider alternatives, modifications that lower the burden
- Review the roles, responsibilities of key stakeholders
- Anticipate administrative burden upfront in policies, models before going forward

Administrative Burden Cost-Benefit Analysis



Examples of the roles stakeholders could play to reduce administrative burden.

Burden	Sources of Burden	Possible Public Sector Solutions	Possible Private Sector Solutions
Quality reporting; too many measures, wrong measures for performance; too many payer portals; feedback reports slow, inaccurate	Too many measures across programs (some progress made in Meaningful Measures effort[20]); tech barriers to electronic, all-payer quality reporting (eCQM); pay for performance (P4P) measures can distort care	Align measures across Medicare, Medicaid and ACA on fewer, outcomes-focused and patient-reported measure sets; waive MIPS if in APM or adopting advanced primary care management (APCM) codes; use Medical Loss Ratio (MLR) quality dollars for practice level costs; reform MA Quality Stars to measure local performance	Voluntary payer alignment on fewer measures; payer financing for practice level measure collection reporting (MLR quality dollars), plans adopt shared portals, standardized reports to practices; health plan accreditation grades plans on efforts to lower administrative burden, improvements in plan systems for credentialing, provider network listing
Excessive coding documentation, such as multiple, duplicative requests for information for payment purposes and growing volume of forms from patients	Risk adjustment payments in APMs, Medicare Advantage (MA) encourage excessive coding of diagnoses; Health plans require more documentation to support higher level E&M codes, may auto-downcode; specialists refer patients back to primary care for form completion	Identify non-EHR data sources for RA; Medicare APCM codes (2025) reduce primary care documentation;	Artificial intelligence (AI) being tested, rolled out; ambient voice tools and agentic AI can reduce documentation burden; private sector follows CMS tech standards across all lines of business; Plans align on common sources of clinical evidence for prior auth (PA); limit services, therapies subject to PA; Health systems, large practices provide more admin support for primary care
Misaligned payment models across payers and excessive variation in administrative systems	Variation in payment model features such as patient attribution algorithms, duplication of processes such as credentialing, provider network listing, quality reporting; High-friction prior health plan authorization processes	CMS could require more reporting of APMs in MA, encourage standardization of APM models in MA; CMS could remove barriers in Medicaid managed care that inhibit APMs; Leverage MA to standardize, streamline PA process[21]	Voluntary payer alignment around primary care payment model types; align key terms and definitions, metrics, support common infrastructure for credentialing, network listing, allowing primary care practices to opt-in to APM contracts; public employee plans could lead transparent commercial effort for establishing standards for whole-person primary care
Lack of interoperability across EHRs and health plan systems; costly health information exchange (HIE) for getting patient level data; no ongoing financial support for practices to join HIE networks, upgrade tools, etc.	No financial consequences for stakeholders slowing pace of interoperability, engaging in info blocking; lack of trust among stakeholders around ownership, use of data, data security; no ongoing financial support for practices to join, use HIEs	Government sets penalties for info blocking; uses standards setting organization to evolve tech standards; Medicare pays practices for tech to help build market for primary care, patient-centric tools (see CMMI ACCESS model)[22]	Technology tools that facilitate quality reporting, create primary care dashboards across EHRs, support team-based care; connect patients for engagement, self-care; safe introduction of agentic AI for tasks such as inbox management, portal messages[23]

Solutions and recommendations to consider for reducing administrative burden

Medicare and Medicaid should lead by example and leverage their influence

Medicare is one of the biggest sources of administrative burden; fortunately, it has begun to reduce that burden by reducing documentation demands. For example, the new Advanced Primary Care Management benefit, is a care "bundle" paid monthly to practices for eligible beneficiaries with chronic conditions.[24] Billing requirements are streamlined in comparison to other billing codes related to chronic care management.

Medicare is also using its influence as a convener to accelerate data interoperability and lower administrative burden. This report identifies other areas, described below where Medicare could leverage its roles as payer, regulator and industry convener to reduce administrative burden. Other reductions may require legislation.

But both programs can and should do more to address administrative burden.

While commercial payers are also sources of unnecessary complexity and administrative burden, these payers now participate in Medicare and Medicaid at high rates. If Medicare and Medicaid **use their authorities to require more standardized and streamlined health plans processes**, commercial plans should follow suit and adopt simplified and standardized features in the commercial insurance market.

An entity like the Health Care Payment and Learning Action Network (HCPLAN) could be tasked by CMS, for example, with aligning payers and stakeholders on core contract terms and definitions for a set of model prototypes (i.e., shared savings, hybrid, partial capitation). Streamlining and standardizing terms and models would make it easier to compare outcomes, increasing competition and generating economic benefits for commercial stakeholders.

CASE STUDY: CALIFORNIA

Aligning payers to reduce burden of APM participation

The Integrated Healthcare Association (IHA) is "standardizing how payers, providers, and regulators measure and reward high-value care" and "building a single source of provider data in California with our Symphony Provider Directory."

IHA is a multi-stakeholder organization governed by representatives of California's health plans, health systems and physician groups. It includes Covered California, the State's ACA insurance exchange, and CalPERs, a large purchaser of health care benefits for public employees.[25]

IHA's success reflects California's long tradition of Health Maintenance Organizations (HMOs) in commercial, Medicare and Medicaid coverage. IHA designs payment models with stakeholders to align payers around common definitions and methodologies. A commitment to transparency and minimizing administrative burden helps build trust among participants.[26]

In 2024, Purchasers Business Group on Health's (PBGH) California Quality Collaborative and IHA launched the Advanced Primary Care (APC) Initiative to align payers and primary care practices to build a common advanced primary care model. The joint effort leverages IHA's infrastructure with a common reporting platform and uses a shared value-based payment model. The demonstration reflects a commitment from several large employers to invest in APC. Blue Shield of California, Aetna and other payers have agreed to facilitate the model.[27]

Other states where health plans and primary care leaders convene to increase alignment, lower administrative burden and invest in APMs include Arkansas[28], Oklahoma, and Kansas City[29], Michigan[30] and North Carolina.[31] State efforts may include Medicaid and commercial plans. Medicare has also participated in multi-payer models sponsored by the Centers for Medicare and Medicaid Innovation (CMMI).[32]

Consider greater standardization as a solution

Voluntary or mandatory solutions may be effective in bringing standardization to industry practices. Past industry alignment efforts can inform which approach to take. Stakeholders identified the government's roles as convener, purchaser and regulator. Medicare, for example, can influence the commercial market when it requires standardization in MA and across MA and traditional Medicare.

Medicare and Medicaid could play an essential role in aligning industry players around common electronic formats and processes. The current federal effort to establish a national provider directory, for example, could lower practice costs of updating multiple plan provider directories and aid consumers and employers.[33] Recent federal leadership on a broad set of priorities for a "patient-centric health care ecosystem" could build alignment to reduce pain points in administrative burden.[34] However, some stakeholders believe that certain sources of administration burden, such as failure to engage in data exchange and remove frictions, may require stronger federal regulatory action.

"Payers could do more to help. More active role with onboarding patients to primary care, for example. Data sent by payers is often not helpful in the form it is sent, and not always accurate. Often, a payer sends information on patients never seen by the practice."

– **Respondent to PCC Survey on Administrative Burden**

CASE STUDY: ARTIFICIAL INTELLIGENCE

On the brink of better tech tools that reduce administrative burden?

AI applications have the potential to reduce administrative burden for clinicians. Ambient AI scribes are being introduced and used for clinical note documentation. They are currently unregulated by the FDA. The scribes are taught to listen to a clinical encounter, transcribe, assimilate and compose a document for human review. Some are integrated in the EHR and perform billing and coding tasks.

A small study conducted in 2024 at six academic and community-based practice settings reviewed the impact of ambient AI scribes on self-reported burnout and other outcomes such as note-related cognitive task load, focused attention on patients and time spent documenting after hours. Use of ambient AI scribes was associated with a significant reduction in burnout, cognitive task load and a modest reduction in time spent documenting. Clinicians (roughly one-third were primary care) perceived that patient access to care could improve, along with more attention on patient concerns.[35]

In an invited commentary, Kaustav P. Shah and Kevin B. Johnson noted key unanswered questions. such as:

- Is the investment in AI scribes worth it?
- Will it be used primarily for revenue generation rather than improving patient-clinician interactions?
- While patient consent has been part of adoption thus far, as AI applications increase will patients be comfortable and trusting in the interactions?[36]

CASE STUDY: WISCONSIN

Promoting electronic quality measures, reducing "chart-chasing"

Most states have health information exchanges (HIEs) that serve as shared infrastructure for information sharing across providers, plans and patients. They support care coordination, public health reporting, safety and work to avoid duplication of services. HIEs have potential to lower administrative burden for primary care and health plans and build trust across the health care ecosystem, but they must be accessible to users and widely adopted to generate systemwide benefits.

One valuable use case for HIEs is streamlining quality measure collection and supporting the transition to electronic clinical quality measures . Wisconsin's HIE, a nonprofit organization known as WISHIN, has earned a National Committee for Quality Assurance designation, Data Aggregator Validation (DAV).[37] The designation means certain data streams have been tested end-to-end to ensure they can be considered primary source verified for HEDIS™ measure reporting purposes. DAV is intended to reduce the administrative burden of "chart chasing."[38]

Allocate administrative costs that can generate systemwide benefits broadly, fairly, transparently

In recognition of the systemwide benefits produced by standardized, publicly reported quality measures, Medicare and Medicaid already share in the costs of quality measure development and public reporting. It seems fair to ask these **large public programs to help reduce the practice level costs** associated with *collecting* quality measures.

Standardized patient surveys, which do not impose direct administrative burdens on practices, **should also be paid for by Medicare and Medicaid**. **Large public payers** (including states) should **reduce the number of quality measures** that primary care is asked to collect and increase their validity and meaningfulness for population health and informing patient choices.

HIE also generates systemwide benefits and can contribute to improvement in public and population health, yet its costs are not shared broadly. Today, information sharing costs to support better population health outcomes and better management of health care resources are often pushed down to the practice level without being acknowledged and incorporated in payment rates.

Conclusion

Primary care is bearing a staggering weight in the form of administrative burden. The weight of administrative burden is discouraging primary care participation in alternative payment models where primary care's participation has proven to drive better outcomes and lower costs. Unless administrative burden is reduced and its costs shared more broadly, primary care's full potential to improve health outcomes will not be realized. In light of the staggering price tag Americans are paying for health care, it is urgent that health care leaders, policymakers and stakeholders come together to lower administrative burden.

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About the Primary Care Collaborative

*The Primary Care Collaborative (the PCC) is a national nonprofit that unifies voices from across the health landscape to advocate for better health of all Americans by strengthening primary care. The PCC and its members promote policies and share best practices that encourage the growth of high-quality, whole-person primary care. Learn more at **thepcc.org**.*

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