World Journal of Advanced Research and Reviews
eISSN: 2581-9615 CODEN (USA): WJARAI
Cross Ref DOI: 10.30574/wjarr
Journal homepage: https://wjarr.com/

(RESEARCH ARTICLE)

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From Cost Benchmarks to Care Architecture: Reconstructing Primary Care in Massachusetts for Access, Equity, and Cost Containment

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World Journal of Advanced Research and Reviews, 2026, 29(02), 659-670

Publication history: Received on 29 December 2025; revised on 03 February 2026; accepted on 06 February 2026

Article DOI: https://doi.org/10.30574/wjarr.2026.29.2.0318

Abstract

Massachusetts is known to be a leader in health policy innovation, especially its near-universal insurance coverage and national benchmark on health care cost growth. However, despite such an advanced policy infrastructure, the Commonwealth is still experiencing increased health care expenditure, limited access to primary care, and long-standing disparities in health outcomes. Current policy studies rightly identify the causes of cost increase, such as administrative complexity, price dispersion, unnecessary utilization, and endemic under-investment in primary care, but fail to go further to identify a structural failure underlying that: the lack of care delivery designs that can transform cost standards into operational change at the point of care.

This paper will contend that Massachusetts has exhausted reforms that are focused on measurement, accountability, and refinement of policies in small steps. The second step of reform needs to be a transition to cost benchmarks as retrospective control systems into the intentional design of primary care as an architectural form of care- one that coordinates legal authority, administrative form, workforce placement and payment models around access, equity, and cost containment all at the same time.

Based on health policy analysis, health law, health economics, and administrative realities guided by national medical group benchmarks, the paper illustrates why cost containment strategies have not increased access and reduced inequity despite a wide agreement on underlying causes. It determines the structural contradictions inherent in existing delivery models and demonstrates how administrative complexity, misaligned payment, and fragmented governance serve as hidden taxes on access.

The conclusion of the analysis is that a sustainable reform within cost growth limits demands rethinking primary care not as a collection of services or care locations, but as a care architecture. In the absence of this change, cost benchmarks will persist as diagnostic, but not system transformation tools, and the policy leadership of Massachusetts will not be connected to lived patient and provider experience.

Keywords: Architecture; Benchmark; Care; Cost; Equity

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1. Introduction

Massachusetts holds a unique niche in the American health policy. The Commonwealth has shown in the last twenty years that through a concerted legislative effort, regulatory supervision, and stakeholder involvement, it is possible to remodel the incentives of the health system. Since the spread of near-universal insurance coverage in Chapter 58 to the creation of the first statewide health care cost growth benchmark in Chapter 224, Massachusetts has been a test ground of reforms since adopted elsewhere.

However, policy leadership has failed to produce delivery-level equilibrium. Regardless of regulatory complexity, Massachusetts citizens have among the highest health care expenditures in the country, as employer-based family premiums hit 28,151 in 2024, the highest in the United States. Premium growth has exceeded both wage growth and inflation over several years in a row, and consumer cost sharing has increased more rapidly, with much of the growth being due to increasing deductibles. Approved premium increases in the combined individual and small-group market in 2025 and 2026 were at levels not observed in several years, further increasing household affordability.

Meanwhile, primary care access has been getting narrower and narrower. The inability of primary care practices to serve as the front door to the health system is constrained by delayed appointments, shortages of workforce, and administrative bottlenecks. The downstream effects of these access restrictions are predictable: higher emergency department usage, preventable hospitalization, and disjointed care of patients with chronic conditions.

Such co-existence of sophisticated policy architecture and chronic access failure demonstrates a paradox in the structure. Massachusetts has managed to quantify and track cost increases with accuracy, but it does not have structures that can influence the way care is accessed, provided, and financed in dynamic ways. Cost containment tools are mainly applied at the macroeconomic level, the benchmarks, reporting requirements, accountability processes, whereas the failure to access and equity is at the micro level of clinical operations. The outcome is a system that is able to diagnose cost growth but is unable to intervene at the stage where costs are created and care is experienced.

The diagnosis is supported by recent studies by the Massachusetts Health Policy Commission. The Commission has found administrative complexity, unnecessary price dispersion, low-value care, unnecessary utilization, and under-investment in primary care as enduring contributors to health care spending growth. It has also cautioned that affordability and access, which are two of the fundamentals health policy goals of the Commonwealth, are threatened by increasing costs unless collective action is renewed.

Notably, the results do not imply the ineffectiveness of policy intentions. Quite the contrary, the health policy framework in Massachusetts demonstrates an advanced cognizance of the drivers of cost increase and disparity. What is becoming clearer, though, is that policy intent is not enough. The current issue confronting the Commonwealth is no longer a matter of diagnosis or authority, but of execution, namely, how to translate policy objectives into delivery-level architectures that can be run within the real-world constraints.

This paper will further the thesis that the present stalemate in Massachusetts health reform is due to a mismatch in policy design and delivery system structure. Cost containment, access, and equity are discussed as related, but sequential goals, and dealt with by discrete interventions, not system design. Consequently, reforms tend to be half-successful and leave the dynamics intact. In order to escape this cycle, primary care needs to be reconsidered as a location of care, but as a strategically managed system in which the goals of cost, access, and equity intersect.

Massachusetts is the focal case not due to the uniqueness of its issues, but due to the visibility of its failures at the delivery level because of its data infrastructure, regulatory maturity and policy transparency.Cost growth benchmark and comprehensive analytic capability of the Commonwealth All-Payer Claims Database permit accurate diagnosis of misalignment between the policy intent and operational reality. The framework created here is state-portable on purpose. Although there are differences in legal authorities, market structures and payer mixes across states, legal variability is approached as a parameter and not a constraint. The fundamental lesson, that cost control demands delivery architectures that can control access in a constrained environment, is applicable in every situation in which health systems depend on primary care to absorb demand that would otherwise be incurred in more expensive environments.

2. Without Care Architecture: A Structural Contradiction Cost Containment Without Care Architecture

The Massachusetts health care cost growth benchmark is one of the most ambitious efforts in the United States to exercise macroeconomic discipline over health care expenditure. The benchmark aims at making sure that health care expenses do not crowd out wages, state investment, or family consumption by linking the growth in allowable spending with more general economic variables. Ideally, these benchmarks generate strong incentives to efficiency, coordination, and value-based care.

Practically, however, cost containment policies implicitly presuppose the presence of a strong and available primary care system that can absorb demand that has been driven out of more expensive environments. This supposition is becoming less and less true. Even in a state where there are high provider density and vast health system resources, access is limited by appointment delays, workforce shortages, and administrative friction.

This contradiction is recorded in the 2025 Cost Trends Report by the Health Policy Commission. Although the state of Massachusetts still spends a lot of money on health care in general, the expenditures are still concentrated on hospital-based services, specialty care, and pharmaceutical spending. Simultaneously, the lack of access to primary care is a direct cause of preventable emergency department visits, inpatient hospitalizations, and re-admissions, trends that push the overall medical spending upward instead of keeping it in check.

This dynamic is a fatal flaw to the existing reform logic. The cost containment structures are aimed at affecting aggregate spending behavior, yet they do not, in themselves, make capacity where none exists. In the event of limited access to primary care, cost pressures are shifted as opposed to being diminished. Emergency departments and hospital outpatient departments are the default access points not due to their clinical suitability or cost-effectiveness but due to their availability.

In this case, cost increase is not an anomaly; it is a foregone conclusion of system design. Accountability mechanisms and benchmarks can detect excess spending only in hindsight, but cannot be used to replace delivery architectures that avoid unnecessary utilization in the first place. Consequently, cost containment may turn out to be retrospective and punitive instead of prospective and transformative.

The Commission has reiterated several times that lack of access to primary care is linked to increased expenditure and poorer outcomes, especially in individuals with chronic conditions. However, access is poorly motivated in existing payment models. Fee-for-service reimbursement is volume-based instead of availability-based, and many value-based systems are still superimposed on encounter-based infrastructure. Making access more open in such circumstances frequently raises provider costs without revenue, which forms rational opposition to reform at the organizational level.

This tension brings out a more fundamental structural contradiction: policies of cost containment are based on the mechanism of access, yet access is underfunded, overburdened administratively, and operationally constrained. Cost benchmarks cannot have the desired impact without clear alignment between payment, access design and deployment of work forces.

Besides, the effects of access failure are not equally distributed. The increase in deductibles and cost sharing increases the effect of access limitations on low-income communities and people of color, resulting in delayed care, medical debt, and preventable complications. The Blue Cross Blue Shield of Massachusetts Foundation has calculated that preventable expenditure that can be ascribed to health inequities amounts to about 1.5 billion every year, highlighting the financial and the ethical implications of the existing system design.

Access, in this case, should be interpreted not as a secondary quality measure or consumer convenience, but as a fundamental cost containment strategy. In the absence of a consistent, prompt access to primary care, the downstream utilization is structurally inevitable, and the cost containment measures are brought down to the ground.

3. Law Authority without Integration.

In health law terms, the lack of legal authority is not the key obstacle to primary care reform in Massachusetts. The Commonwealth has one of the most liberal and advanced legal frameworks in the country to experiment with payment reform, redesigning delivery, and workforce innovation. Alternative payment models, global budgets, risk-bearing provider organizations, flexibility in the scope of practice, and massive data gathering and management are permitted

by statutes, regulations, and administrative precedents. However, in spite of this enabling environment, the provision of primary care is still divided, access-restricted, and inconsistent with cost-containment goals.

This disconnect is indicative of a critical legal-institutional disconnect: there is a large dispersion of authority, but little incentive to integrate.

3.1. A. Current Legal Authority of Reform of Payment and Delivery.

The Massachusetts law allows a wide scope of payment and delivery reforms that theoretically would allow a more affordable and accessible primary care system. These include:

3.2. Alternative Payment Models (APMs):

The commercial payers, Mass Health, and provider organizations are permitted to sign global budget arrangements, shared savings contracts, and per-member-per-month (PMPM) payment structures. Various levels of downside risk are regularly absorbed by accountable care organizations (ACOs) working under both public and private contracts.

3.3. International Budgets and Total Cost of Care Accountability

The statewide cost growth standard provided in Chapter 224 sets a macro-level limit within which payers and providers are supposed to control the total medical spending. Although the benchmark does not specify particular models of delivery, it leaves legal and political space to experiment with population-based payment.

3.4. Scope-of-Practice and Workforce Flexibility

Massachusetts allows team-based care models that include nurse practitioners, physician assistants, pharmacists, behavioral health clinicians, and community health workers, but they are licensed and supervised. New legislative and regulatory developments have increased the opportunities of non-physician clinicians to practice at the highest level of their license.

3.5. Data Transparency and Oversight

The Commonwealth gathers and examines a lot of data on expenditure, utilization, prices, and quality using the All-Payer Claims Database and other reporting systems. Massachusetts Health Policy commission has extensive powers to track trends, cost drivers, and policy interventions.

Combined, these powers form a solid legal basis of reform. They enable access and continuity rewarding payment models, workforce structures that increase capacity, and monitoring systems that measure system performance. Transformation is allowed in the law.

B. Fragmentation as a Legal-Structural Problem. Regardless of this lax structure, the attempts to reform have failed to come together to form a primary care structure. Rather, power is dispersed in a variety of dimensions: Payers: Each of the commercial insurers, Mass Health, Medicare Advantage plans, and self-insured employers has unique payment models, quality measures, and administrative needs. Although nominally aligned on the principles of value-based care, these models tend to vary in the rules of attribution, risk adjustment, reporting, and access incentives. Provider Organizations: The heterogeneous contracts and governance structures are applied to health systems, physician groups, community health centers, and independent practices. The same system may have primary care practices that are subject to various incentives based on payer mix and contractual arrangements. Regulatory Bodies: The responsibility of oversight is shared by various agencies that have different mandates such as cost monitoring, insurance regulation, workforce licensure, and public health. Although there is coordination, there is no one body that is in charge of integrating payment, access and delivery design at the point of care. This disintegration has significant legal implications. The payment reform, delivery innovation, workforce policy, and technology governance are developed in parallel and not in harmony. Consequently, reforms are often additive, as opposed to transformative, i.e. placed over the top of the existing structures without changing the logic behind them.

C. Authoritative Law, Weak Compulsion. The Massachusetts legal environment is characterized by the fact that it allows reform without requiring integration. Cost benchmarks bring about post-factum accountability, but not specific delivery architectures. APMs do not demand efficiency to be attained by expanding access or investing in primary care, but they do demand efficiency on an aggregate basis. Flexibility in scope-of-practice permits workforce innovation, but it does not guarantee that workforce innovation is implemented in a strategic manner to enhance access. There are benefits of this lax stance. It can be locally experimented and does not require one-size-fits-all requirements. It also, however,

generates a collective action problem. Individual payers and provider organizations might not have adequate incentive to invest in access-oriented primary care redesign when the benefits, which are reduced downstream utilization and reduced total medical spending, are system wide. Consequently, the legal permissibility does not imply the operational coherence. Innovation is not system-driven but compliance-driven. Organizations are maximized under tight contractual and regulatory limits, and the structural circumstances that generate access failures are preserved.

3.6. Typology of Legal Fragmentation.

In Massachusetts, legal fragmentation functions in three dimensions that are analytically different. Vertical fragmentation occurs because of the federal-state gap, especially where Medicare, Medicaid, and commercial regulation create parallel requirements which are not aligned regarding payment, quality measurement, and data reporting. Horizontal fragmentation indicates payer-payer disparity in the Commonwealth, with commercial insurers, MassHealth, Medicare Advantage plans, and self-insured employers implementing divergent attribution rules, incentives, and administrative procedures. Functional fragmentation is in the regulatory areas, such as payment policy, workforce licensure, health IT governance, and insurance oversight, which are regulated by distinct statutory and administrative authorities that have few coordinated design mechanisms. Although none of these dimensions alone is a preclinical to reform, their combination negates delivery-level integration at the point of care

D. The Loss Architecture of the Law. What is quite missing in the present structure is the legal framework that clearly connects payment reform with access performance and workforce deployment. Although cost growth benchmarks reflect aggregate performances, they do not directly influence the way access is funded, regulated, or operationalized. The assumption of the law is that the delivery systems will internalize cost pressures and react to them. There are indications that this assumption is misplaced. Without integration, primary care reform will be susceptible to the piecemeal implementation. Redesigning payment models without delivery; piloting delivery without long-term funding; workforce innovation without goal alignment; workforce innovation without goal alignment. The outcome is a multiplication of projects lacking a unifying architecture. Legally, the dilemma confronting Massachusetts is thus not the establishment of new authority, but the utilization of the current authority in a manner that will force integration in payment, access and administration. The law will not be able to allow transformation to take place without creating it without such integration.

Structural Inertia: Incentives, Dominance, Path Dependence. The continued existence of access restrictions in Massachusetts cannot be attributed to lack of information or policy negligence. System behavior is influenced by three reinforcing forces. To start with, payer incentives are still disjointed and retrospective and they reward aggregate efficiency without consistently funding prospective access capacity. Second, the dominance of hospital systems, in terms of economic and organizational aspects, still entrenches the primary care investment decision-making process in downstream revenue logic as opposed to access optimization. Third, path dependence constrains reform paths: decades of experience of encounter-based reimbursement, accretive regulatory pressures and overlays of policy have institutionalized primary care in forms that are ill adapted to the management of population-based access The combination of these forces forms structs.

IV. Administrative Reality: Primary Care as a Strategic Contradiction. Whereas legal frameworks define the limits of what can be done, administrative and financial realities define what can be sustainable. This tension is more evident nowhere than in primary care. In health systems, primary care is both supposed to be the basis of population health management and operate in a financial model that compromises its ability to do so. Such a contradiction is not incidental. It is the logical consequence of the mismatched incentives inherent in the current reimbursement and organizational systems.

A. The Role of Primary Care in Health System Strategy. Primary care has a broad mandate administratively. It is expected to: Offer access in time to acute and preventive needs. Treat chronic illness and organize care. Be the point of entry into value-based care and risk management. Promote equity through lessening care barriers. Minimize unnecessary emergency department and inpatient use. Strategically, primary care is said to be the front door of the health system and the driver of cost containment. However, this rhetoric is in sharp contrast to the way primary care is funded and run.

B. MGMA-Informed Financial Reality. The statistics on national bench-marking show that primary care has very thin margins, even in large and well-resourced systems. Although precise numbers depend on specialty and location, a few trends are well established and are in line with those reported by MGMA

Table 1 Illustrative Primary Care Financial Performance (MAGMA-Informed)

Metric	Median Primary Care Practice	Top Quartile Practice
Operating Margin	-2% to +1%	+2% to +4%
Total Cost per FTE Physician	High	Higher
Revenue per FTE Physician	Moderate	High
Visit-Based Revenue Share	>80%	<70%

This data demonstrates one of the underlying limitations: even high-performing primary care practices produce small surplus. Without external assistance or cross-subsidization, margins are not high enough to fund large-scale expansion of access, investment in technology, or expansion of the workforce.

3.7. Access Expansion as a Financial Risk.

Expansion in access like longer hours, same-day appointments, or improved care coordination has been well known to be clinically beneficial. They are however, in terms of administration, usually financially unstable according to the current payment models.

Table 2 Access Interventions and Financial Implications

Access Intervention	Operational Impact	Financial Effect
Extended clinic hours	Increased staffing needs	Higher labor costs
Same-day appointment slots	Reduced no-show flexibility	Revenue volatility
Team-based care models	Improved continuity	Upfront investment
Virtual-first access	Faster triage	Misaligned reimbursement

In the fee-for-service reimbursement, revenue is based more on encounters than availability. Consequently, the costs tend to rise without a corresponding rise in revenues as access is expanded. Shared savings are uncertain, retrospective and even in many value-based arrangements, whereas the expenses of access expansion are fixed and immediate. In the context of health system financing, opposition to access expansion is thus logical, as opposed to a hindrance. Access is an unfunded mandate without aligned payment.

D. Primary Care as a Loss Leader. In integrated delivery systems, primary care is often used as a loss leader to facilitate downstream revenue generation. Although such a strategy can be economically rational on a system level, it generates perverse incentives on a practice level. The justification of investments in primary care is based on the effect on specialty and hospital use as opposed to the inherent value of access and continuity. This framing supports the strategic contradiction of primary care reform. Practices are supposed to absorb demand, risk management, and equity, but they are measured financially using productivity measures that are maximized on the volume of visits and not on access or outcomes.

E. Workforce Attrition as a Rational Response. The workforce implications of the financial and administrative stresses on primary care are predictable. Burnout, turnover, and early retirement are not exceptions; they are logical reactions to a system which requires more access and coordination without offering the structural support to maintain them. MGMA data continuously indicates the progressive increase in staffing ratios, rising non-clinical workload, and the growing dissatisfaction among the primary care clinicians. The trends also limit access by decreasing effective capacity, which forms a feedback loop where workforce shortages contribute to access failures, which increases downstream utilization and cost increases.

F. Administrative Complexity as Capacity Erosion. These are compounded by administrative burden. Authorization beforehand, documentation, payer variance, and disjointed information systems waste clinician time and staff resources.

Table 3 Administrative Burden and Access Capacity

Administrative Function	Time Burden	Access Impact
Prior authorization	High	Fewer appointment slots
Documentation	High	Burnout risk
Payer-specific rules	Moderate–High	Staffing inefficiency
Fragmented IT systems	Moderate	Slower throughput

Administratively, complexity acts as a latent tax on access. It decreases effective capacity without decreasing demand, further compromising the capacity of primary care to act as the front door of the system.

G. The Strategic Implication Combined, these administrative facts explain why incremental reform has not worked. Primary care is being requested to undertake system-level roles with organizational and financial instruments that are intended to support episodic and visit-based care. Even good reforms will still yield marginal gains without structural payment alignment and integrated access design. The administrative statistics do not imply a leadership or effort failure. They instead point to a design failure

V. Administrative Complexity as a Tax of Access. Administrative complexity has long been known to contribute to the increasing health care costs. The excessive administrative burden is a consistent finding in policy analyses in Massachusetts that have identified it as a source of spending increase with little or no clinical benefit. However, the prevailing idea of administrative complexity as a cost problem does not fully capture the systemic impacts of that problem. In addition to adding overhead, administrative burden is a stealth tax on access- it is eating up the effective capacity of primary care and compromising the very cost containment measures it is supposed to reinforce.

- Beyond Dollars Complexity: Time as the Scarce Resource. The conventional measures of administrative burden are financial in nature: billing expenses, staffing ratios, or overhead percentages. Although these measures are significant, they mask a more significant limitation, time. In primary care, access is determined by the binding resource of clinician and staff time. Any extra administrative need decreases the time to care of patients, whether in terms of numbers or physical capacity. Hours are wasted on prior authorization, documentation, payer-specific policies, and disjointed information systems that could be spent on clinical encounters, care coordination, or proactive outreach. These time losses are not easily seen on balance sheets as opposed to direct financial costs. They appear through the form of fewer appointment slots, increased wait times, and decreased continuity. In this respect, the administrative complexity creates a tax on access. It pulls out capacity in the system without decreasing demand, compelling primary care practices to allocate available capacity rationally by increasing wait times or decreasing scope.
- Administrative Burden and Capacity Erosion. This dynamic is supported by empirical evidence in Massachusetts. Although the clinician density is relatively high compared to other states, residents still report that they cannot find primary care appointments in time. This disparity cannot be attributed to the number of workers. Rather, it is a manifestation of erosion of effective capacity through administrative friction. The administrative climate that Massachusetts primary care practices are confronting is: •Payers and service-specific prior authorization requirements. •Billing, quality reporting and compliance documentation standards. Even ostensibly aligned value-based contracts have payer heterogeneity. •Disjointed digital infrastructure, which necessitates the entry of data twice and hand reconciliation. All these factors use up incremental time. Together, they transform the functioning of primary care. Clinicians use large portions of their workday on non-clinical activities, and support staff are pulled off the front lines to administrative management.
- The Consequences of Administrative Design of Access. The implications of this burden in terms of access are underestimated. Administrative complexity is not only cost-increasing, but it limits throughput and flexibility. Practices lose the capacity to support same-day appointments, address unscheduled demand, and actively engage high-risk patients. Effectually, complexity transforms latent demand to unmet need. The cost containment has direct implications in this dynamic. In case of limited access to primary care, patients resort to other sources of care, which in most cases are emergency departments or outpatient services in hospitals. Not only are these sites more costly, but they are also less efficient in treating chronic conditions and preventing complications. Therefore, administrative load leads to indirectly preventable utilization and increased overall medical spending. Massachusetts Health Policy Commission has highlighted many times the interconnection between administrative complexity, provider burnout, and access issues. The Commission in its 2025 recommendations recommended that policies should be reduced, standardized, centralized and/or automated

of common administrative tasks, especially those that overburden primary care clinicians and hinder timely access to care.

- Complexity as a Consolidation and Burnout Driving Force. The organizational structure of care delivery is also influenced by administrative burden. Smaller and independent practices are more susceptible to consolidation because they typically do not have the resources to address payer variation and compliance requirements. Although consolidation can create administrative economies of scale, it can also create new layers of bureaucracy that further alienate clinicians to patients. Administrative overload at the workforce level is one of the primary sources of burnout and attrition. Clinicians who are trained to deliver care are more and more being called upon to act as data managers and compliance officers. Such a discrepancy between professional identity and day-to-day job contributes to increased turnover and premature retirement, which further limits access. These are counterproductive in terms of the system. Cost containment efforts, which transfer administrative accountability to providers, end up cutting capacity, driving downstream utilization, and worsening workforce shortages.
- As an access tax administrative complexity. The policy issue is redefined as the administrative complexity as a latent access tax. Simplification is not just an efficiency indicator, but it is a kind of access reform. Administrative friction can be minimized to increase effective capacity without necessarily increasing staffing or infrastructure. The reform strategy has significant implications of this reframing. The standardization of requirements, payer harmonization, and routine automation should be considered not only in terms of their potential to save costs but also in terms of their effects on access. Without such assessment, the good reforms may end up moving the burdens instead of reducing them.

Finally, administrative complexity demonstrates a theme that is repeated in Massachusetts health reform: policies aimed at controlling cost at the edges may unintentionally compromise the ability of the system to provide care. In the absence of an integrated design, complexity builds up, and access is lost.

3.8. Equity as an architectural product

Equity has emerged as a primary goal of modern health policy, and Massachusetts has been on the leading edge in trying to quantify and deal with health outcome disparities. However, even with this focus, disparities continue to exist in terms of income, race, ethnicity, and geography. The patterns are usually explained by social determinants of health or personal behavior. Although these factors are admittedly important, a sole emphasis on them clouds the contribution of health system design to creating inequitable results. In this section, a different framing is developed: inequity in access to primary care and primary care outcomes is often a structural consequence, influenced by the financing, organization and delivery of care at the point of care.

3.9. The Limitations of Incentive-Based Equity Strategy.

Numerous equity programs are run using incentives and reporting mandates. Providers are motivated to enhance performance in equity measures, social needs, or culturally competent care models. Although such efforts are worthwhile, they usually presuppose that the underlying delivery system can respond. In reality, though, the efficiency of incentive-based strategies is restricted by limited access, excessive cost sharing and staffing shortages. The administrative and financial burdens of practices that address high-need populations are the highest, limiting their capacity to invest in equity-oriented intervention. Through this, equity incentives can unintentionally increase disparities by rewarding organizations that are already in a good position to perform.

3.9.1. Access Friction as a Cause of Inequity.

The populations that are less resourceful are disproportionately impacted by access friction, which is a cumulative impact of administrative complexity, scarcity of appointments, and cost barriers. Patients who have rigid work schedules, restricted access to transportation, or lower health literacy have less capacity to use complicated access pathways. In situations where primary care appointments are limited or necessitate a lot of administrative maneuvering, such patients will tend to postpone care or use emergency care. This is depicted in Massachusetts data. Residents with high-deductible health plans are much more likely to forgo the care they need because of cost, and the effects are especially strong among low-income residents and residents of color. Deductibles have been a major source of medical debt, which has increased access barriers. . These trends are not due to individual choice alone. They are indicative of system design choices that overload the entry barriers financially and administratively.

3.9.2. Workforce Shortages and Geographic Inequalities.

Equity is further entrenched by workforce shortages. Distribution of primary care clinicians is not even and there are shortages which are most severe in communities already disadvantaged socioeconomically. There is administrative load

and financial strain that would cause practices in these regions to be unable to recruit and retain staff, and this creates a feedback loop where the access constraints would further entrench the existing disparities. Equity-wise, workforce instability is not just a labor problem; it is a structural determinant of access. As long as there are no specific plans to stabilize and sustain primary care in underserved regions, inequalities will remain in place despite the larger policy promises.

3.9.3. Equity as a Design Problem

The consideration of equity as a structural result puts the emphasis on the behavior of individuals to the design of the system. It highlights the point that inequities are not only due to external social conditions but also the manner in which health care systems distribute capacity, demand, and fund access. In this perspective, incentives are not sufficient to bring equity. It should be integrated into the structure of primary care provision. The access pathways should be developed to reduce friction; payment models should consider the cost of service to high-need populations; administrative procedures should be streamlined to ease access to services by patients and providers. The stakes of this design challenge are highlighted by the estimated $1.5 billion of avoidable spending that can be attributed to health inequity in Massachusetts. Inequity is not only a moral but also a financial failure. Systemic barriers that slow care and disintegrate care delivery create costs that have systemic ripple effects.

3.9.4. Implications to Reform under Cost Constraints.

The structural treatment of equity as an outcome has far-reaching implications on cost growth constraint reform. It implies that equity and cost containment are not competing goals, but rather they are dependent on each other. The systems with less access friction and stabilized primary care capacity have higher chances of avoiding unnecessary utilization and downstream expenditure. On the other hand, reforms that are too narrow in their incentives or reporting but do not deal with structural impediments are likely to institutionalize inequity and erode cost containment objectives. The existence of inequalities in the presence of sophisticated policy regimes shows that the incremental strategies are inadequate.

3.9.5. Equity and the Point of Care

Finally, equity is achieved or not at the point of care. It is influenced by the ability of patients to get timely appointments, afford services, and continuity. These are not the results of abstract policy commitments but the realities of the operation of primary care delivery. The acknowledgment of equity as a structural outcome strengthens the main thesis of this paper, which is that cost containment, access, and equity meet at the point of care. Unless integrated design is adopted, the quest to develop one goal will still be at the expense of the others.

VII. Innovation and Constructive Disruption: Where Change Is Now Possible. The continuation of cost increase, access limitations, and inequity in Massachusetts may indicate institutional inertia. But ironically, this is also the time of strange preparedness to change. There are several structural factors such as technological, financial, workforce-related, and regulatory factors that have come together to make primary care reform not only a necessity but also possible. The difficulty lies in leveraging these conditions to positive disruption, which in this case is not destabilization of the health system, but intentional redesign, which matches policy intent to operational reality.

- Digital Maturity and Reconfiguration Access. The development of digital infrastructure has changed the possibility of real-time control over access. Primary care organizations can triage demand, dynamically allocate clinical resources and keep continuity across settings using interoperable data systems, analytics, and decision-support tools. These functions undermine the belief that access should be structured in terms of fixed appointment times and episodic interactions. Notably, digital maturity does not solve access constraints in itself. In the absence of harmonized payment and governance frameworks, technology will become another administrative layer. Nonetheless, when used wisely, digital resources can minimize friction, increase effective capacity, and facilitate proactive care, which are exactly the functions that are needed in the context of cost growth limitations.
- Payment Flexibility and the Constraints of Encounter-Based Reimbursement. The Massachusetts payers are starting to recognize the weaknesses of encounter-based reimbursement. An increase in global budgets, shared savings plans, and PMPM payments is an indication that value cannot be achieved only by the volume of visits. Although these models are still heterogeneous and not perfectly aligned, they are a step away when it comes to assuming that access has to be rationed in order to maintain margins. This change leaves a gap in which primary care redesign can be implemented. Availability, continuity, and population management payment models can be used to invest in access without an unsustainable financial risk, in contrast to throughput-based models. The

difficulty is to incorporate these models across payers and to incorporate them in administrative practice, as opposed to overlaying them on fee-for-service infrastructure.

- Reconfiguration of the Workforce and Team-Based Care. The workforce constraints are one of the key obstacles to access, but they also have redesign possibilities. The development of scope-of-practice, team-based care models, and increased roles of non-physician clinicians provide avenues to increase capacity without corresponding increases in physician workload. Such models can be used to enhance access, burnout, and continuity when deployed strategically. Nevertheless, the payment and administrative systems are often misaligned to sabotage workforce innovation. Team-based care involves initial investment, role definition and enabling technology. In the absence of integration, the workforce reforms are likely to be merely pilots, not system-wide solutions.
- Regulatory Readiness Lack of Central Coordination. The regulatory climate in Massachusetts is characterized by the willingness to embrace innovation. Legal authority that currently exists allows exploring payment models, workforce structures, and digital care delivery. The oversight institutions have strong data and analytical ability. However, as has been shown in the previous sections, authority is not enough. The lack of a coordinating architecture implies that innovation is not evenly spread. There are organizations that progress at a fast rate and those that do not. The ensuing difference compromises system-wide influence and continues inequities. Constructive disruption thus does not need deregulation, but rather strategic coordination, that is, the alignment of existing authorities to common goals at the point of care.
- Constructive Disruption Defined. Here, constructive disruption does not mean market disruption or institutional replacement. It means instead redesigning primary care as a strategically managed system, not a group of loosely coupled services. This kind of disruption is healthy exactly because it aims to continue with policy objectives and to discontinue delivery models that do not serve them any longer. The digital maturity, payment flexibility, workforce innovation, and regulatory readiness converge to form a window of opportunity. The question of whether this opportunity will bring about transformation lies in the capability to bring together these components into a coherent architecture that realizes access, cost containment and equity at the same time.

4. Towards an Integrated Theory of Primary Care Under Constraint.

The conclusions drawn in this paper are united by a single point: primary care reform within the limits of cost growth cannot work in the framework of incremental or sequential interventions. Rather, it needs to consider an integrated theory, which considers payment, access, workforce design, administrative processes, and equity as constitutive components of one system.

A. The Feedback Loops That Determine System Performance. Primary care exists in a system of overlapping feedback loops: Payment models define access incentives: access is either rewarded or punished. Access design determines patterns of utilization, which can result in patients getting timely and appropriate care or opting to access services in more expensive environments. Patterns of utilization determine cost trends, which influence overall medical spending and benchmark performance. Cost trajectories determine the equity outcomes because the increase in costs and limited access has a disproportionate impact on vulnerable populations. The consideration of any of these factors separately interferes with the equilibrium of the system. Access redesign Payment reform leaves capacity constrained. Expansion of access without corresponding payment disrupts finances. Structural change equity programs do not target the neediest.

B. The Limitations of Sequential Reform. Much of modern health policy is implemented in a series: payment reform is launched, delivery models are tested, workforce initiatives are implemented, and equity measures are overlaid. This sequencing presupposes that every intervention will act separately and cumulatively. Massachusetts evidence indicates otherwise. Sequential reform generates partial benefits and does not change fundamental dynamics. The continuity of access limitation and disparity in the advanced policy regimes means that the missing factor is integration rather than sequencing.

C. Integration as a Design Imperative. A unified theory of primary care acknowledges that decisions made at the point of care are felt throughout the system. The payment should be designed to facilitate access; the access should be designed to discourage unnecessary use; administrative procedures should conserve capacity; and equity should be incorporated at every tier, as opposed to being added on the bottom. This theory does not dictate one type of organization. Instead, it offers a model to assess the alignment of incentives, capacity and accountability by reforms. It is the integration that becomes the measure on which innovation is evaluated.

D. Governance and Accountability Implications. The governance also has implications of integration. Mechanisms of accountability that are based on aggregate expenditure or retrospective performance are inadequate. Good governance should evaluate the practical operation of delivery architectures, including how access is controlled, how capacity is distributed, and how equity is implemented. The analytic study of the Massachusetts Health Policy Commission in Massachusetts has elucidated the nature of the problem. The second step of reform involves systems that will convert this transparency into design on delivery.

4.1. Co-ordination Failure and not Leadership Failure.

The lack of the delivery-level integration in Massachusetts cannot be taken as the lack of the leadership of a particular actor. Instead, it is a typical coordination failure of shared savings and diffuse benefits. Payers have fewer incentives to finance access capacity unilaterally whose downstream cost savings accrue to the system. Heterogeneous contracts and retrospective accountability limit provider organizations. Regulators have wide powers but no specific mandate to coordinate operationally payment, access and workforce design. Rational actors in this environment optimize locally and access and equity goals at the system level are underprovided. This discussion does not prescribe the order in which actors should take the first action, but rather identifies the structural circumstances that predispose first-mover action to be improbable without architectural alignment.

4.2. Political Economic Limitations.

The reform of primary care in Massachusetts is influenced by both the technical and legal factors, as well as the dynamics of political economy. Hospital systems, payers, employers, and labor interests are in a negotiated balance where cost increases are handled in small steps to prevent destabilization. Although rhetorically supported, primary care investment does not have a focused constituency with the market power to force architectural redesign. Cost benchmarks serve a political purpose as accountability tools, yet delivery reform needs redistributive decisions, across settings, organizations, and professional roles, that create opposition even in policy-progressive settings. These dynamics can be used to understand why the integration is still behind the measurement sophistication.

5. Conclusion

Massachusetts has hit the same inflection point in its health reform trajectory. The Commonwealth has unmatched policy acumen on the causes of cost increase, access failure, and inequity. The powers of reform are legal. Administrative data are abundant and more accurate. However, these assets have not been integrated into a system of delivery that can realize affordability, access, and equity at the same time. This paper has presented the argument that the current disconnect between policy intent and system performance is actually a failure of integration and not diagnosis. The strategies of cost containment rely on access, but access is structurally underfunded and administratively limited. Equity is accepted as a policy goal, but inequities have been generated since they are system-designed. The complexity of administration is the area of efficiency gains, but its effect on access and capacity is underestimated. It is not the beauty of policy frameworks that will decide the future of primary care reform in Massachusetts, but rather the capacity to create delivery systems that will coordinate law, finance, technology, and workforce at the point of care. In the absence of such alignment, cost benchmarks will be operating as backward-looking accountability instruments instead of forward-looking instruments of change. On the other hand, through integrated design, primary care will be able to play the long-held vision of a primary care as the cornerstone of a sustainable, equitable health system. It turns into a cost containment strategy and not a victim of it. Equity is a structural product and not a dream measure. Administrative simplicity is a restorative capacity and not a depleting one. The difficulty now is how to proceed to action--to system design rather than policy analysis. Massachusetts has preceded this. Whether it does so again will not only decide the future of primary care in the Commonwealth, but also the sustainability of the cost containment and equity as long-term health policy commitments.

This paper throughout differentiates between innovation within existing constraints, incremental pilots overlaid on encounter-based infrastructure, and innovation of constraints, which is defined as delivery architecture redesign that changes the interaction between access, payment and administrative capacity at the point of care.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

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