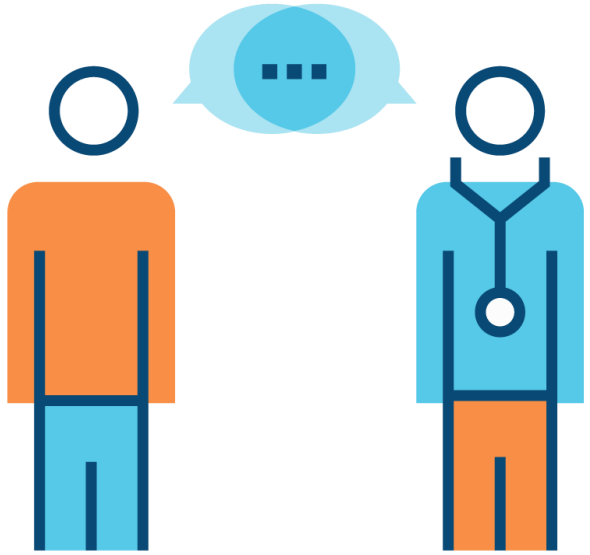

Primary Care Access, Delivery, and Payment Task Force

June 17, 2025

MASSACHUSETTS HEALTH POLICY COMMISSION

EOHHS

Agenda

WELCOME BY CO-CHAIRS

Approval of Minutes: April 16, 2025 (VOTE)

Recent Workgroup Meetings

- Data and Research Workgroup
- Workforce Workgroup

Guest Presentation: *Increasing Primary Care Spending Rates in Massachusetts: Lessons from Other States* – Christopher Koller, President of the Milbank Memorial Fund

Upcoming Primary Care Task Force Meetings

Agenda

Welcome by Co-chairs

APPROVAL OF MINUTES: APRIL 16, 2025 (VOTE)

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Upcoming Primary Care Task Force Meetings

VOTE

Approval of Minutes from April 16, 2025, Primary Care Access, Delivery, and Payment Task Force

MOTION

That the Primary Care Access, Delivery, and Payment Task Force hereby approves the minutes of the Primary Care Access, Delivery, and Payment Task Force meeting held on **April 16, 2025**, as presented.

Primary Care Access, Delivery, and Payment Task Force Membership

Kiame Mahaniah, MD, Undersecretary for Health, Massachusetts Executive Office of Health and Human Services

David Seltz, Executive Director, Massachusetts Health Policy Commission

Senator Cindy Friedman, Chair, Joint Committee on Health Care Financing

Representative John Lawn, Chair, Joint Committee on Health Care Financing

Michael Caljouw, Massachusetts Commissioner of Insurance

Lauren Peters, JD, Executive Director, Center for Health Information and Analysis

Ryan Schwarz, MD, MBA, Chief, Office of Accountable Care and Behavioral Health, MassHealth

Wayne Altman, MD, FAAFP, Founder, MAPCAP (MA Primary Care Alliance for Patients); Professor and Chair of Family Medicine, Tufts University School of Medicine; Vice President, Massachusetts Academy of Family Physicians; President, Family Practice Group (The Sagov Center for Family Medicine)

Laura Black, DNP, FNP-C, President, Massachusetts Coalition of Nurse Practitioners; Nurse Practitioner, BrightStar Health and Wellness; Owner, Integrated Health Partners

Jennifer Blewett, DSW, LICSW, DCSW, CGP, Clinician and Assistant Director for Community Outreach and Engagement, West End Clinic, Department of Psychiatry, Massachusetts General Hospital; Member, Massachusetts State Board, National Association of Social Workers

Alyson Bracken, PA-C, MPH, Senior Manager, Primary Care Center of Excellence, Brigham and Women's Hospital

Renee Crichlow, MD, FAAFP, Chief Medical Officer, Codman Square Health Center; Vice-chair of Health Equity, Department of Family Medicine, Boston University

Suzanne Curry, Director of Policy Initiatives, Health Care For All

Eric Dickson, MD, MHCM, FACEP, President and CEO, UMass Memorial Health; Former Board Chair, Massachusetts Health & Hospital Association

Mark Friedberg, MD, MPP, Senior Vice President, Performance Measurement & Improvement, Blue Cross Blue Shield of Massachusetts

David Gilchrist, MD, MBA, FAAFP, Executive Chair of Primary Care, Atrius Health and Reliant Medical Group; Past President, Massachusetts Academy of Family Physicians

Jon Hurst, President, Retailers Association of Massachusetts

Stephen Martin, MD, EdM, FAAFP, FASAM, Professor, Department of Family Medicine and Community Health, UMass Chan Medical School; Staff Physician, Barre Family Health Center; Medical Director, Greylock Recovery

Judith Melin, MA, MD, FACP, Governor, Massachusetts Chapter of the American College of Physicians; Internal Medicine, Beth Israel Lahey Health

Sarah Mills, MPH, Vice President of Government Affairs, Associated Industries of Massachusetts

Lora Pellegrini, JD, President and CEO, Massachusetts Association of Health Plans

Brenda Anders Pring, MD, FAAP, President, Massachusetts Chapter of the American Academy of Pediatrics; Pediatrician, Atrius Health and Beth Israel Deaconess Medical Center; Instructor, Harvard Medical School

Barbra G. Rabson, MPH, President and CEO, Massachusetts Health Quality Partners

Christina Severin, President and CEO, Community Care Cooperative

Barbara Spivak, MD, Past President, Massachusetts Medical Society; Internist, Watertown

Agenda

Welcome by Co-chairs

Approval of Minutes: April 16, 2025 (VOTE)

RECENT WORKGROUP MEETINGS

- Data and Research Workgroup
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Guest Presentation: *Increasing Primary Care Spending Rates in Massachusetts: Lessons from Other States* – Christopher Koller, President of the Milbank Memorial Fund

Upcoming Primary Care Task Force Meetings

Summary of Data and Research Workgroup Meeting, May 20, 2025

- The Center for Health Information and Analysis (CHIA) presented an overview of their process and methodology for defining primary care and measuring primary care spending.
- **Key Highlights**
  - The methodology developed includes a **broad, inclusive definition of primary care** so that it can be adapted and adjusted based on the analytic need.
  - The data collected is **summary-level claims data reported from almost all insurance types**, representing most Massachusetts residents.
  - CHIA can **stratify this data** by insurance category, payer and payer type, provider organization, service category, and patient age.
  - Claims data is allocated to primary care spending **based on a primary care service code and services provided by a primary care provider type**.
  - Provider types include **physicians** (family medicine, internal medicine, pediatrics, general practice, adolescent medicine, geriatric medicine, obstetrics/OBGYN) **and other providers** (Nurse Practitioner, Physician Assistant, Community Health Center/FQHC, Community Health Nurse Specialist Midwife, Women's Health Clinic)

Primary Care Service Categories:

Claims-Based: Office Type Visits, Home/Nursing Facility Visits, Behavioral Health Screening Preventative Visits, Other Primary Care Visits, Immunizations and Injections, Obstetric Visits

Non-Claims-Based: Incentive Programs, Capitation, Risk Settlements, Care Management, Other

Summary of Data and Research Workgroup Meeting, May 20, 2025

- The Health Policy Commission (HPC) presented their process for measuring primary care spending and utilization methodology using CHIA's All-Payer Claims Database (APCD).
- **Key Highlights**
  - HPC's definition for primary care closely aligns with CHIA's definition, with a few differences:
    - The HPC excludes obstetric services.
    - The HPC identifies providers using payer-reported assigned Primary Care Physicians (PCPs), provider types identified in the claims data, provider types as indicated in the HPC's Registration of Provider Organizations (RPO) program, and supplemental provider data from IQVIA.
    - The HPC is unable to capture non-claims-based spending.
  - Claims-based analyses complement CHIA's aggregate reporting process and allow for a more granular examination of primary care.

Examples of HPC analyses using this methodology:

- Statewide trends in primary care spending, utilization, and payment rates.
- Trends by patient demographics across years, including by patient age, geographic region, and insurance coverage status.

Key Discussion Themes: Data and Research Workgroup Meeting

- Workgroup members indicated that CHIA's work defining and measuring primary care services provides a strong foundation for the task force's recommendations.
- Potential next steps for the task force include identifying use cases to measure and apply CHIA's primary care definitions.
- Additional discussion and decision-making are necessary to determine recommendations regarding the inclusion or exclusion of pharmaceutical expenditures in primary care spend methodology.
- Workgroup members suggested that recommendations put forth by the task force should avoid including primary care service definitions in statute, but rather delegate continuation of this work to CHIA.

Summary of Workforce Workgroup Meeting, June 12, 2025

The HPC presented research from their report on primary care, released earlier this year, to provide background on current primary care workforce trends and challenges in the Commonwealth.

Key Discussion Themes

- **Increasing the Primary Care Workforce Pipeline**
  - Student loan forgiveness and Medicaid GME are drivers for attracting new graduates to primary care and should be expanded to Nurse Practitioner and Physician Assistant students.
  - Support for and expansion of residency programs for family medicine, nurse practitioners and physician assistance.
- **Investment in Team-based Care**
  - Reimbursement models that strengthen and support team-based care by broadening which roles can be included in care teams to reduce burnout (i.e., medical assistants, nurse-coordinators, and social workers), strengthen care coordination, and improve patient experience.
- **Regulatory and Policy Options to Reduce Provider Burnout:**
  - Review mechanisms for simplifying health plan credentialing, reducing/removing prior authorization requirements, and streamlining reporting requirements.

HPC Report: *A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action*, https://masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and

Summary of Workforce Workgroup Meeting, June 12, 2025

"If we want to look at the root cause of lack of physician access in this state for primary care…it is concerning that the two largest health care systems do not…have family medicine residencies."

- Dr. Renee Crichlow

"When it comes to residency programs, GME programs, remember there are zero dollars that go towards NP residency programs coming out of Medicare…so whatever we are thinking by way of having advance training residency programs, any investment that we want to make in continuing education, it's important to include all of the colleagues that are engaging in primary care."

- Dr. Laura Black

"If you want clinicians to chose primary care, you have to pay them more. So, I think we need to fix the job and fix the pay…Regarding the job, there are three major pieces…one is the administrative burden, we need to decrease that obviously…the second is we need to establish very robust teams and the funding to establish those robust teams within primary care…and then the third is switching from fee-for-service to prospective monthly payment."

- Dr. Wayne Altman

"I think we could expand our idea of who is on that [primary care] team by thinking about our colleagues in public health. We could think about community health coordinators and workers, town nurses, people who are experts in social determinants of health, so I'm not working on housing at the ground level to try to help someone."

- Dr. Steve Martin

Agenda

Welcome by Co-chairs

Approval of Minutes: April 16, 2025 (VOTE)

Recent Workgroup Meetings

- Data and Research Workgroup
- Workforce Workgroup

GUEST PRESENTATION: *INCREASING PRIMARY CARE SPENDING RATES IN MASSACHUSETTS: LESSONS FROM OTHER STATES* – CHRISTOPHER KOLLER, PRESIDENT OF THE MILBANK MEMORIAL FUND

Upcoming Primary Care Task Force Meetings

Increasing Primary Care Spending Rates in Massachusetts: Lessons from Other States

Massachusetts Primary Care Task Force

June 17, 2025

Christopher F. Koller

President, Milbank Memorial Fund

Milbank Memorial Fund

Agenda

- About Milbank
- Why Increase Primary Care Spending Rates
- State Strategies
- Lessons from Rhode Island and Oregon
- Implications for Massachusetts

About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve population health and health equity by collaborating with leaders and decision-makers and connecting them with experience and sound evidence.

We advance our mission by:

- Identifying, informing, and inspiring current and future state health policy leaders to enhance their effectiveness;
- Working with state health policy decision makers to advance primary care transformation and sustainable health care costs, leadership development and
- Publishing high-quality, evidence-based publications and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy.

What Is Primary Care?

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by **interprofessional teams** that are **accountable for addressing the majority** of an individual's health and wellness needs **across settings** and through **sustained relationships** with patients, families, and communities.

The Value of Primary Care

- Only part of the delivery system where the more we have, the better our population health outcomes and the fewer health disparities we have
  - (Not pharma and not hospitals)

Why Focus on Primary Care Spending Rates?

1. Evidence:
   - Relatively higher portions of health care spending going to primary care is correlated with better health system (country accountable delivery system) performance .
     - Examples: International comparisons. Integrated delivery systems, accountable care organizations
     - (MA heading in wrong direction – per MHQP/CHIA scorecard)

2. Organizing:
   - Need public support for policy change and its redistributive impact
   - Concept is easily grasped by public and contradicts public perceptions of primary care's value.
     - Example: Grumbach et al; Annals of Family Medicine; Survey of public perception of primary care spending rates (25-50%)

State Policy Strategies to Increase Primary Care Spending Rates

1. **Aspirational** – set a target for one or more payer groups
   - 20+ states in the past seven years with some form of legislation
2. **Directive** – use regulatory or contracting authority to require entities to increase and redistribute.
   - RI and OR.
3. **Specific Payments and Models** – increase directly or by consequence
   - All Medicaid
     - Payment programs like MA; raising Medicaid fees; Accountable care strategies

Increasing Primary Care Spending Rate: Design Questions

1. Target or Requirement
2. Numerator: How to define Primary Care and eligible payments
   - (how directive: What is being promoted: any primary care or “good” primary care?)
3. Denominator What is health care spending
4. Setting a target level
5. Accountable entity
6. Auditing, monitoring and policy accountability
7. Impact – “Breadth and Depth”
   - Are sufficient additional resources flowing to primary care practices themselves?
   - The multipayer and employed physician problems

Aspirational Example: California

- Health Care Affordability Board directed by statute to set targets for commercial health plans.
- Adopted definition and reviewed historical spending trends (@ 7%)
- Commercial health plan targets- increase primary by .5 to 1 percentage point a year, to reach 15 percent by 2034.

No state with aspirational targets has seen an increase in primary care spending as a result, or a move to more aggressive policy requirements.

Requirements Example I: Rhode Island

- 2010 – Required of Commercial Plans: part of “Affordability Standards” as a condition of getting rates approved.
  - Increase by a point a year. Explicitly redistributive.
  - Primary care defined by specialty
  - Allowed expenses included population health infrastructure, practice technical assistance and health information exchange support
  - Fully insured only (no Medicaid, Medicare, Self Insured)
  - Plan self-reporting
  - Written into regulation in 2013. Requirement of 10.5% . Met by plans
- 2025 – Regs rewritten – PC definition tightened; allowable expenses narrowed; denominator expanded (net effect of more dollars)

Requirements Example II: Oregon

- Spending levels set in statute in 2016 for Medicaid, Medicare, Commercial and Public Employee Plans.
- All required to reach 12 percent by 2023.
- Expansive definition of primary care (in statute and in regulation)
  - Not very directive as to how
- Monitoring by Oregon Health Authority
- Paired with Primary Care Transformation Center in Oregon Health Authority (Resources and Technical Assistance)
- Enforcement mechanism unclear

Oregon status - 2025

- As of 2022, Commercial carriers' primary care spending averaged 11.5 percent of total medical spending; Medicare Advantage carriers averaged 13.9 percent; PEBB and OEBB carriers averaged 11.3 and 13.3 percent; Medicaid primary care spending averaged 15.0 percent.
- The range of primary care as a percent of total medical spending varied.
  - Commercial carriers- from 6.9 to 19 percent
  - Medicare Advantage- from 4.1 to 17.7
  - Public Employee plans - from 9.5 to 19.3

Source: 2024 Oregon Health Authority Report

Specific Payments and Models

Many Medicaid agency efforts to change how much and how primary care is paid

.

- CT, NM and others adjust fee schedule
- OR and MA implement new primary care payment methodologies

Increase primary care spending rate in Medicaid is a desired outcome (MA) but not an explicit goal

Lessons from OR and RI – Partial Victories at Best

- Talk of “Primary Care Crisis” in both. Declining appointment access.
- **Rhode Island’s Magic moment** – period when primary care spending requirements compelled insurers to spend on population health capacity to allow ACOs to succeed in Medicare and Commercial.
  - Practice consolidation, high cost drugs, MA losses have threatened both these infrastructure payments and ACO arrangements. Will new regs mitigate?
- **Design flaws in RI**
  - Insufficient “breadth”, no Medicaid or public employees’ participation
  - No “depth” (employed physician) strategy
- **Implementation flaws**:
  - limited monitoring; no external accountability

Primary Care in AHEAD – the Next Frontier?

- "The overarching goals of Primary Care AHEAD are to …**increase investments** in primary care as a percent of the total cost of care (TCOC) …across all payers and to **support advanced primary care initiatives** through capacity-building efforts. "

- The (Primary Care in AHEAD) Model includes a strong focus on strengthening advanced primary care, promoting behavioral health integration, and improving care coordination.
  - Includes **enhanced payments** to practices to promote advanced primary care.
  - …(P)ractices must be participating in the state's … primary care alternative payment model and must meet certain care transformation requirements that will be **aligned across Medicaid and Medicare.**
  - **Performance goals** for practices on identified quality measures.

Source: From NASHP

Revisiting Design Questions for Massachusetts (I)

- ***Requirement*** – not target. Enforce in DOI, Mass Health and GIC
- **Numerator:** How to define Primary Care and eligible payments
  - *Learn from RI* – new regs are best of breed. Basis for comparison
- **Denominator** (What is health care spending) – *Copy and paste from CHIA*
- Setting a **target level** – *just get better*
- **Accountable entity** – *MA is well-positioned* Plans and health systems.
- **Auditing, monitoring and policy accountability**
  - Use *CHIA, HPC* reporting and monitoring
  - Need an accountable oversight entity. Keep issue at top of list

Revisiting Design Questions for Massachusetts (II) - Impact

- **Breadth: Getting to systemic impact**
  - Commercial+Connector+MassHealth+GIC
  - Must be aligned
  - Build on Mass Health (only payer with increasing primary care spend)
  - Look for Medicare opportunities

- **Depth (Employed clinicians problem)**
  - Note: If systems accept financial risk, no longer and issue
  - Does CHIA/HPC reporting mechanism give you platform for holding health systems accountable?
  - Would need to go beyond claims to financial reporting
  - Think carefully about enforcement.

Longer Run

- The US has an out of balance health care delivery system that is bankrupting our country and *harming* our shared aspirations for healthy communities with equal individual opportunities at long and fulfilling lives,
- To make progress, we must understand and address the economic and political forces that have created that imbalanced health care system
- Putting a thumb on the scale for primary care by increasing primary care spending rates is a high leverage way to begin.

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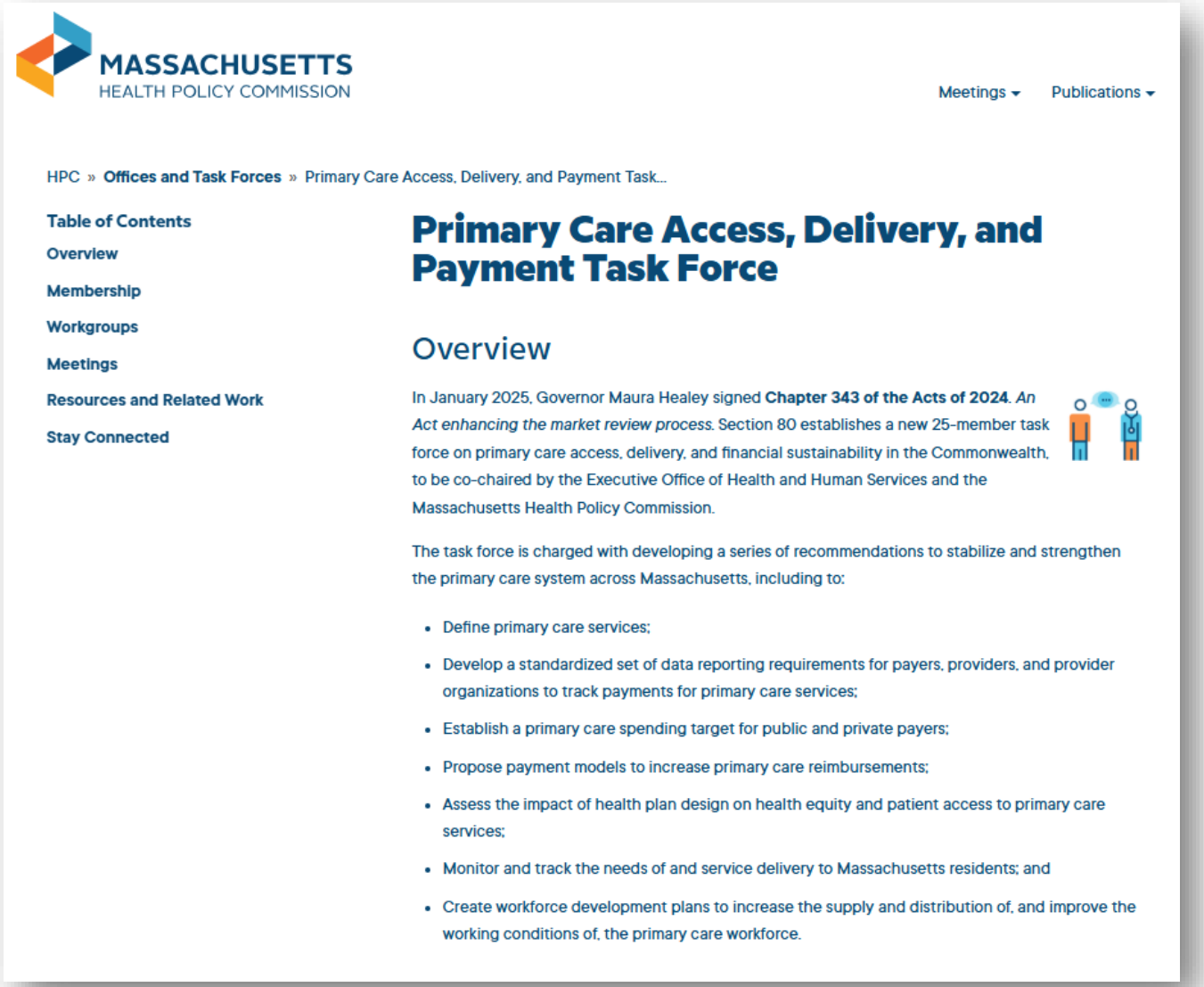
UPCOMING PRIMARY CARE TASK FORCE MEETINGS

The HPC maintains a webpage with all of the information pertaining to the work of the Primary Care Task Force.

[View membership details, upcoming meeting dates, and resources]



www.masshpc.gov/offices-and-task-forces/pctf

The Resources section highlights work related to the task force, including the HPC's primary care report and the new Primary Care Dashboard from CHIA and MHQP.

Table of Contents

Resources and Related Work

- Establishing Statute: Section 80 of Chapter 343 of the Acts of 2024
- **A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action**, 2025
- **Center for Health Information and Analysis (CHIA) and Massachusetts Health Quality Partners (MHQP) Massachusetts Primary Care Dashboard**
- Other HPC publications related to primary care

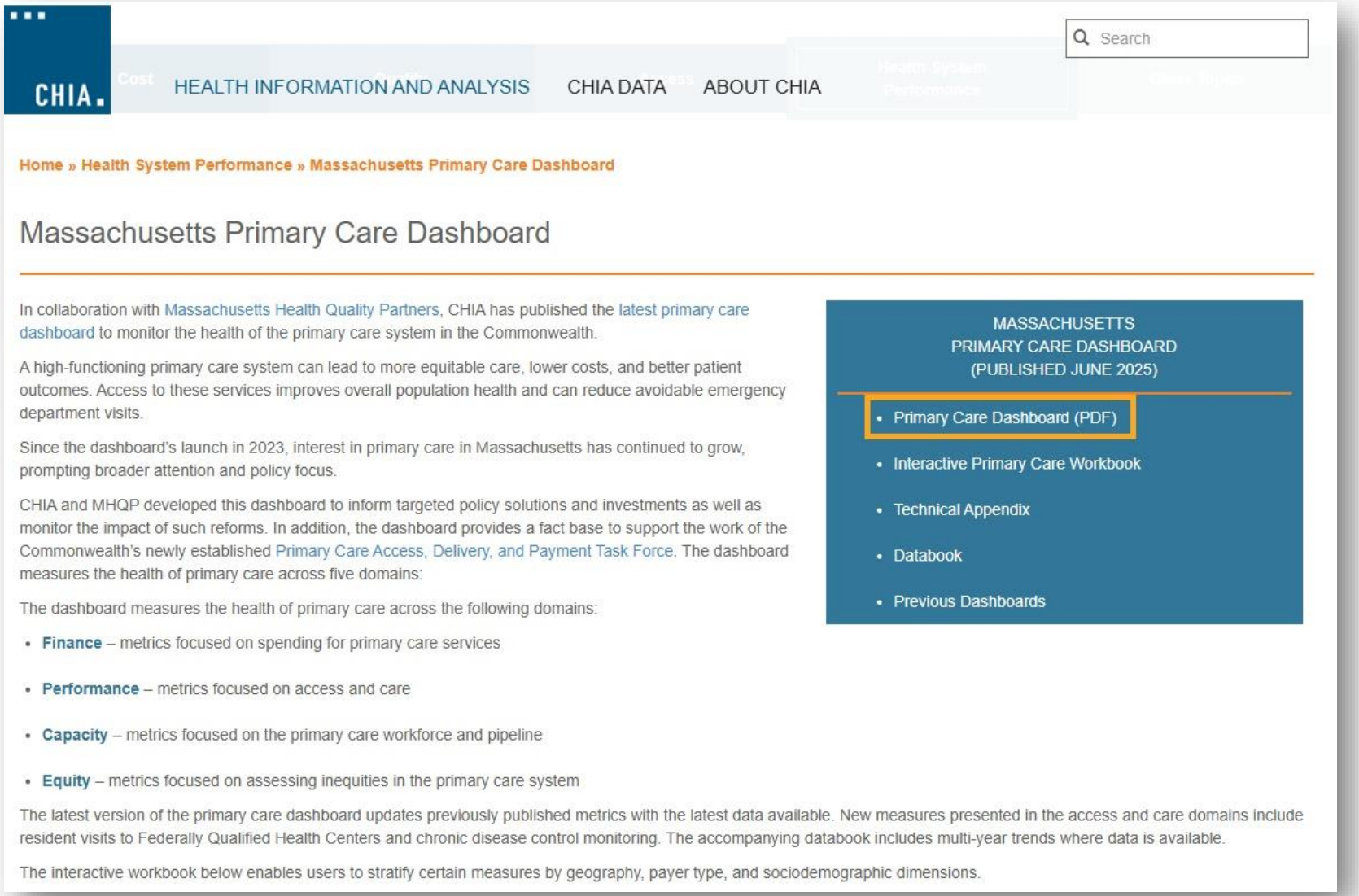
Resources Submitted by Task Force Members

Materials linked here have been provided by individual task force members for consideration and do not necessarily represent the views of the HPC, EOHHS, or other task force members.

- Gold S, Leggott K, Hemeida S, Karra L, Ram A, Hughes LS. **Advancing Primary Care Payment Reform in the Commercial Sector: A State Policy Playbook**. The Eugene S. Farley, Jr. Health Policy Center. April 2025.
- Gold S, Leggott K, Hemeida S, Karra L, Ram A, Hughes LS. **State Policies to Advance Primary Care Payment Reform in the Commercial Sector**. The Eugene S. Farley, Jr. Health Policy Center. April 2025.

https://www.chiamass.gov/massachusetts-primary-care-dashboard

Massachusetts Primary Care Dashboard



https://www.chiamass.gov/massachusetts-primary-care-dashboard

Upcoming Meetings

Data and Research Workgroup

Thursday, July 10

11:00 AM – 12:30 PM (virtual)

Primary Care Task Force

Tuesday, July 22

10:00 AM – 12:00 PM (in-person)

Workforce Workgroup

Wednesday, July 30

11:30AM – 1:00PM (virtual)

Primary Care Task Force

Wednesday, September 17

10:00 AM – 12:00 PM (in-person)