MEETING MINUTES

PRIMARY CARE ACCESS, DELIVERY, AND PAYMENT TASK FORCE

DATA AND RESEARCH WORKGROUP

May 20, 2025

CO-CHAIRED BY THE MASSACHUSETTS HEALTH POLICY COMMISSION AND THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Date of Meeting: May 5, 2025
Start Time: 1:00 PM
End Time: 2:30 PM

Primary Care Task Force Member	Present?
Dr. Kiame Mahaniah, Co-Chair	X
David Seltz, Co-Chair	X
Senator Cindy Friedman	A
Michael Caljouw	X
Suzanne Curry	X
Dr. Mark Friedberg	X
Dr. Judith Melin	X
Lora Pellegrini	X
Barbra Rabson	X
Dr. Ryan Schwarz	X
Summary	**10 Members Attended**

(A): Absent from Meeting

Proceedings

A meeting of the Primary Care Access, Delivery, and Payment Task Force (Primary Care Task Force) Data and Research Workgroup was held virtually on Tuesday, May 20, 2025, beginning at 1:00 PM. A recording of the meeting and the meeting materials are available on the HPC Website.

Participating Primary Care Task Force (PCTF) Data and Research Workgroup members who attended were Undersecretary of the Executive Office of Health and Human Services (EHS), Dr. Kiame Mahaniah (Co-Chair); Executive Director of the Health Policy Commision (HPC), Mr. David Seltz (Co-Chair); Mr. Michael Caljouw; Ms. Suzanne Curry; Dr. Mark Friedberg; Dr. Judith Melin; Ms. Lora Pellegrini; Ms. Barbra Rabson; Ms. Lauren Peters; Dr. Ryan Schwarz; and Dr. Barbara Spivak. Senator Friedman was absent from the meeting. Primary Care Task Force members. Dr. Wayne Altman and Dr. Laura Black also attended the meeting as non-voting participants.

ITEM 1: Welcome

Task Force Co-Chair Mr. Seltz began the meeting at 10:00 AM and welcomed the members of the PCTF Data and Research Workgroup, staff, and members of the public. Mr. Seltz explained the meeting will focus on how the Commonwealth currently measures primary care spending, policy decisions that have informed primary care measurement and methodology, and how other states have pioneered efforts around measuring primary care spending, with the future consideration of providing recommendations for setting a primary care spending target to increase investment in primary care in Massachusetts. Mr. Seltz recognized Co-Chair Undersecretary Dr. Manahiah, who acknowledged the challenging work ahead for the PCTF in making recommendations for improving and strengthen primary care.

Mr. Seltz explained the Co-Chairs' decision to establish two workgroups to provide an opportunity for task force members to meet on specific topics that will build towards deliverables and the ambitious timeline of the task force: a Data and Research Workgroup and a Workforce Workgroup, but additional workgroups may be established in the future as needed. Each PCTF Workgroup meeting will be public by livestream and membership information will be on the HPC website. The full PCTF will make final decisions on recommendations that will be reported to the legislature and policymakers. Mr. Seltz introduced and thanked the Data and Research Workgroup members and recognized Dr. Wayne Altman and Dr. Laura Black, two PCTF members who joined the meeting as non-voting participants.

Mr. Seltz described importance of measuring primary care spending to deliver high quality, equitable care, while noting that primary care spending in Massachusetts represents a small and declining proportion of overall healthcare spending. He noted that other states experiencing this issue began addressing the problem by determining their baseline primary care spending to be able to set targets for improved primary care investment and to monitor how investment impacts delivery of care.

Mr. Seltz reviewed three deliverables of the PCTF for which the Data and Research Workgroup will provide increased attention: 1) defining primary care services, codes, and providers for the purposes of measuring primary care spending and setting a spending target; 2) developing a standardized set of data and reporting requirements for private and public payers, providers and provider organizations; and 3) assessing the impact of health plan design on health equity and patient access to primary care services. He stated that the focus of the meeting would be related to the first deliverable and considers determining how primary care spending is measured to be the basis to the rest of the task force's work. He explained to meeting attendees that the Center for Health Information Analysis (CHIA) has developed a methodology and process for measuring primary care spending at a statewide level, as well as by managing physician group, health plans, and major market segment. He stressed that with CHIA's work, there is a strong foundation for the task force to adapt and build on for future measurements and goal setting.

Mr. Seltz reminded meeting attendees that all PCTF Workgroups are subject to Open Meeting Law (OML) and encouraged Data and Research members to engage in discussion and ask questions throughout the presentation.

ITEM 2: Center for Health Information and Analysis (CHIA) Presentation on Primary Care Definitions

Executive Director Lauren Peters provided background on CHIA's effort to define and measure primary care spending, which began in 2019, in part driven by proposed legislation that set primary care spending targets and the need to have data to understand the baseline spending. In response, CHIA developed the methodology to build the foundation for defining and measuring primary care, which they have been doing annually since 2019. Deputy Executive Director of CHIA, Caitlin Sullivan then presented on CHIA's process and methodology. The presentation slides can be viewed on the HPC website.

Ms. Sullivan explained that CHIA leveraged data specifications used and lesssons learned from other states and also held a public listening session to collect feedback from clinicians, payers, consumer advocates, measurement experts, and the general public to develop their approach. She said the methodology used a broad, inclusive definition of primary care so that it could be adapted and adjusted based on the analytic need. Expenditures are reported via mutually exclusive, hierarchical categories, with payer liability and member cost-sharing separated. The data collected is summary-level claims data reported from almost all insurance types, representing most of the Massachusetts residential population, with the exception of residents covered by original Medicare. CHIA is able to stratify this data by insurance category, payer and payer type, provider organization, service category, and, most recently, patient age.

Ms. Sullivan further described that health plans first identify claims for assignment to the behavioral category and to different subcategories, which are then reviewed for inclusion in the primary care services and those corresponding subcategories. After the claims are sorted through the hierarchical process, those that are not classified as either behavioral health or primary care are sorted into an "all-other" category, so they are captured along with CHIA's total health expenditure methodology, allowing CHIA to calculate primary spending as a percentage as total healthcare spending. CHIA asks payers to classify "non-claims" dollars paid to providers as either behavioral health, substance use disorder, primary care or "all other." Finally, prescription drugs are not included in the primary care methodology, but CHIA does ask that prescription drug claims are assigned to either Mental Health, Substance Use Disorder or "all-other" categories based on the national drug code (NDC).

Ms. Sullivan then reviewed the primary care service categories that payers report to CHIA as primary care. The claims are allocated to primary care spending based on a combination of a primary care service code and services that are provided by a primary care provider type. The dollars are categorized into claims-based and non-claims-based categories. CHIA provides the code-set to health plans so they are able to classify the claims, with provider types including individual practitioner taxonomies, such as pediatricians, advance practices nurses with pediatric specialties, and federally qualified health centers (FQHCs). Ms. Sullivan explained that the claims-based and non-claims-based categories are modular, meaning that CHIA can include or exclude them in the measurement as appropriate for the intended purpose, emphasizing that the methodology is that it is broad and inclusive so it can be flexible to support different purposes.

Commissioner of the Division of Insurance, Michael Caljouw asked Ms. Sullivan for more information on CHIA's process for determining what were ultimately recommended as the primary care service categories. Ms. Sullivan explained that in addition to holding public listening sessions, CHIA also released a data specification manual accompanied by an additional detailed code set, and collected feedback from carriers, health plans, and providers. In the first two years of data collection, updates were made, such as the addition of codes and provider types,

including FQHCs, to capture more of the MassHealth population and services, in order to be as robust as possible. Every year, when it releases its new code set and data specifications, CHIA provides a two-week comment period to solicit feedback and incorporate any changes before releasing their final code set.

Barbra Rabson, President and CEO, Massachusetts Health Quality Partners, asked how challenging it would be to separate behavioral health services provided by primary care providers from other behavioral health services. Ms. Sullivan stated that because of the modular nature of the data categorization, the methodology allows for this. She also specified that all behavioral health screenings and services, such as medication management, that are provided by primary care providers are included in primary care services. Behavioral health services that have a principle behavioral health diagnosis are categorized into the behavioral health care category.

Dr. Mark Friedberg, Senior Vice President, Performance Measurement & Improvement, Blue Cross Blue Shield of Massachusetts remarked that as the task force works on developing recommendations for a primary care spending target, adhering to federal mental health parity legislation is necessary. He then asked Ms. Sullivan to clarify how CHIA further defines non-claims-based payments to ensure they are being categorized as primary care spending. Ms. Sullivan clarified that non-claims-based payments count for less than 1% of primary care spending. CHIA has had discussions with health plans, as well as other states, to understand how best to capture non-claims-based payments. She clarified that in some cases, the health plan does know when payments are invested in primary care, such as with MassHealth primary care capitation payments, but in other cases CHIA does not know how to classify non-claims-based payments and has identified this as a potential area in their methodology in need of refinement.

Dr. Judith Melin, Governor, Massachusetts Chapter of the American College of Physicians, asked Ms. Sullivan if all services that have not been outlined in the presentation are categorized as “other” services and included in the denominator to calculate all primary care spending, to which Ms. Sullivan responded affirmatively. Dr. Melin asked for clarification on the reason that original Medicare is not included in the primary care spending methodology. Ms. Sullivan confirmed that Medicare Advantage members as well as dually eligible members are included in CHIA’s primary care spend methodology, but that primary care services covered by original Medicare is excluded due to data availability, acknowledging that this is an area that CHIA can explore sourcing from the Centers of Medicare and Medicaid Services (CMS) data sources, and agreed that primary care services covered by original Medicare is not a small portion of primary care spend in the Commonwealth. Dr. Melin asked if primary care services covered by Medigap plans are also included, and Ms. Sullivan answered she needs to bring that question back to team.

Suzanne Curry, Director of Policy Initiatives, Health Care For All asked Ms. Sullivan to provide examples of services that would be included in the “other primary care visits” or “non-claims: other” categories. Ms. Sullivan answered that “non-claims: other” is more of a “catch all” category for non-claims-based payments that do not fit in the other non-claims-based payment categories, and “other primary care” is primarily for community health center and FQHC billing.

Dr. Friedberg asked Ms. Sullivan to explain how CHIA’s process for classifying medical procedures, such as repairing a laceration in a primary care office would be classified. Ms. Sullivan explained that CHIA received feedback at the beginning of developing their process that some procedures completed in primary care settings be included in the primary care spend calculation, and that CHIA’s primary care definition is based on a consensus model that many other states have adopted, with the exception of areas for which there is not a lot of consensus, including how to define obstetrics and medical procedures completed in a primary care setting. For these areas, CHIA has relied on gathering information from health plans and providers to decide how to categorize these service areas in their methodology.

Ms. Rabson asked Ms. Sullivan if all births reported by a global code are included in CHIA’s primary care spend. Ms. Sullivan answered that all births that are reported by a global code are included in primary care spend, but births

that are reported separately from pre-natal services would not be included. She further explained obstetric services reported by a global code are about 8% of commercial primary care spending, and about 5% of MassHealth primary care spending, and certainly not all births in Massachusetts are included in CHIA's primary care spend methodology.

Ms. Sullivan then reviewed the primary care physicians and provider type categories that must be included for claims including a primary care services code to be allocated to primary care spending. Ms. Sullivan fielded questions from members asking how subclassification codes for nurse practitioners and physician assistants are utilized to ensure that services provided by these providers are correctly categorized. Ms. Sullivan specified that there is a primary care subclassification code for these provider types and acknowledged that she would ask her team if claims using a generic code for nurse practitioners and physician assistants can be disaggregated from primary care spending.

Ms. Sullivan continued her presentation to explain that CHIA is able to disaggregate behavioral health services provided by a primary care providers to include them in the larger primary care category in order to capture the integration of behavioral health services in primary care. She also highlighted that prescription drugs are not included in the numerator for calculating primary care spend, but that they are included in the denominator for total health care spending. She acknowledged that as the increase in retail prescription drug spending far outpaces the increase in primary care spending, CHIA would be supportive of removing prescription drug spending from the calculation for the purpose of setting a primary care spending target, noting that there is lack of consensus among states for whether to include prescription drug spending in primary care expenditures.

Dr. Friedberg commented that in developing a primary care service definition, primary care spending methodologies, and setting a primary care spending target, the goal of the task force should be to effectively improve patient health and the sustainability of our primary care workforce. He acknowledged that there may not be one primary care definition that completely satisfies all stakeholders and that there is uncertainty and continual learning that comes with setting spending targets. He then recommended the State Policies to Advance Primary Care Payment Reform in the Commercial Sector report published by the Eugene S. Farley, Jr. Health Policy Center of the University of Colorado, which recommends that states avoid defining primary care services in statute to allow for changes to be made as necessary.

Dr. Ryan Schwarz Chief, Office of Accountable Care and Behavioral Health, MassHealth, agreed with Dr. Friedberg's comment and stated that, from MassHealth's perspective, if pharmacy expenditures are included in the denominator for calculating total primary care spend, it would be preferrable to include the net pharmacy expenditures, rather than gross pharmacy expenditures. He explained that removing pharmaceutical spending from calculating primary care spend and setting a primary care spend target may be more mathematically advantageous for building a meaningful and accurate measurement of primary care spending, as primary care expenditures could never grow at the rate of pharmaceutical expenditures.

Dr. Altman stated that he understands this perspective and suggested modeling both methods to understand how inclusion or exclusion of pharmacy spending might impact the outcomes. Director Seltz agreed and stated these models are already being developed. He further explained that the purpose for which we are measuring health care expenditures helps inform methodological decisions. For example, to measure total healthcare expenditure, no spending should be excluded, whereas for the specific purpose of targeting investment in primary care with respect to other medical care, a different determination could be made for the measurement methodology. Finally, he raised that, in addition to states setting primary care spending targets for improvement, some have gone further to prioritize that additional investment be directed into specific areas under specific payment models, and referenced Rhode Island's decision to utilize non-claims-based payments to provide more comprehensive support to primary care practices, as an example.

Ms. Sullivan provided an overview of how CHIA updates its data specifications to add new codes or respond to feedback and stated that CHIA releases their primary care spending report and updated primary care dashboard in May. Finally, she provided a snapshot of the previous primary care dashboard to demonstrate how the data is reported. Commissioner Caljouw commented that in making recommendations for defining primary care services, measuring primary care spending and setting a primary care spend target to increase primary care investment, the task force should make sure to develop a process that promotes fair and reasonable actions from organizations. Director Seltz added that there may also be a consideration for recommending accountability mechanisms for organizations to meet specific requirements.

Dr. Friedberg asked Ms. Sullivan if CHIA is able to stratify their data by age, as primary care spending varies widely by age group, to which Ms. Sullivan responded they do have that capability but that their age groups may be too broad and more granularity may be needed. Dr. Altman asked if the total primary care spending by payer can also be compared to overall primary care spending, to which Ms. Sullivan answered that this can be done but with the caveat that original Medicare claims would be not included. Dr. Altman then asked Ms. Sullivan to clarify how cost-sharing is calculated into total primary care spending, and Ms. Sullivan clarified that it is collected separately from claims data but added into the total primary care spend calculation. Finally, Ms. Rabson commented that the task force may want to create separate use cases while developing recommendations for defining primary care services.

Director Seltz then acknowledged the work of Massachusetts Health Quality Partners (MHQP) on the primary care dashboard, thanked CHIA and Ms. Sullivan for the presentation, and stated that he was interested in researching how other states are handling original Medicare claims in their calculations of primary care spending.

ITEM 3: Massachusetts Health Policy Commission (HPC) Presentation on Primary Care Spending and Utilization Methodology

Director Seltz provided background about HPC's process for measuring primary care spending and utilization using CHIA's All-Payer Claims Database (APCD). He explained the advantage of using APCD is that it allows for a specific focus on patient and provider level experience of healthcare services, payment delivered to providers, and the patient demographics to conduct analyses of primary care spending, utilization, and payment. This work complements CHIA's work in our ability to target specific questions related to the primary care landscape. Director Seltz introduced Dr. Sasha Albert, Associate Director of Research and Cost Trends at the HPC to continue the presentation.

Dr. Albert reviewed HPC's definition for primary care, which mostly follows CHIA's definition with a few differences. First, the HPC excludes obstetric services. Second, 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. There may be slight differences in provider identification than with those used CHIA's payer-reported aggregate data. Finally, the HPC is unable to capture non-claims-based spending.

Dr. Albert then presented three examples of the types of analyses HPC can generate through this methodology, particularly with commercial claims: 1) showing the growth in primary care spending compared to all other medical services between 2017 to 2022, demonstrating that primary care sending has grown at a much slower rate (11.8%) than spending for other medical services (24.7%), and the proportion of primary care spending as part of overall healthcare spending has decreased over time; 2) showing the same trends, disaggregated by children and adults, which showed that primary care spending for children has grown about one third as fast as spending on other medical services for children and 3) . examples demonstrating how the HPC can measure disparities in use of primary care. Dr. Albert concluded the presentation.

ITEM 4: Discussion of Statutory Deliverable #1: Defining Primary Care Services, Codes, and Providers for the Purpose of Measuring Primary Care Spending and Utilization

Workgroup members discussed the primary care methodology presentations. Members commented on the importance of the task force keeping in mind populations from lower socioeconomic groups when providing recommendations for a primary care spending target, especially at a time when there is decreasing workforce capacity. Members also expressed concern that while the amount of out-of-pocket spending for primary care or direct pay for concierge medicine is currently small, it is a quickly growing trend and should be an area of consideration for the task force. Dr. Friedberg asserted that the task force should avoid recommending that primary care spend definitions be put into statute and believes that CHIA should lead this work in collaboration with the task force. Members also had questions about the degree to which behavioral health services are considered primary care and added to the denominator in calculating primary care spending. Director Peters explained that CHIA's data is modular and flexible enough to conduct specific analyses such to understand how much behavioral health is being delivered by primary care providers. Lastly, members expressed confidence in CHIA's definition as the standard for this work and agreed that the task force should be making recommendations for CHIA to continue to iterate their work, ideally not in statute, and also identify potential use-cases to apply this methodology.

ITEM 5: Adjourn

Director Seltz thanked Workgroup members for their input and encouraged task force members to continue sharing thoughts and resources. Dr. Mahaniah agreed that the task force should try to move as fast as possible to confirm its recommendations for primary care service definitions, based on CHIA's work, while providing a frame for apply changes that can be used by future decision makers. Director Seltz said that the next Data and Research Meeting is scheduled for Thursday July 10, 11:00 AM to 12:30 PM, and reminded Data and Research Workgroup Members that topics discussed during this meeting will be shared with the rest of the Primary Care Task Force at the next full Primary Care Task Force meeting on Tuesday, June 17th.

The meeting adjourned at 2:31 PM.