

Primary Care Access, Delivery, and Payment Task Force

July 22, 2025



MASSACHUSETTS
HEALTH POLICY COMMISSION



EOHHS

Agenda



Call to Order



UP NEXT: Approval of Minutes: June 17, 2025 (VOTE)

Statutory Deliverable #1: Proposal for defining primary care services, codes, and providers

Statutory Deliverable #2: Developing a standardized set of data and reporting requirements for private and public payers, providers, and provider organizations

Statutory Deliverable #3: Establishing a Primary Care Spending Target

Upcoming Primary Care Task Force Meetings

- PCTF Workforce Workgroup Meeting, Wednesday, July 30, 2025
- PCTF Meeting, Wednesday, September 17, 2025

Adjourn

VOTE

Approval of Minutes from the June 17, 2025 Primary Care Access, Delivery, and Payment Task Force Meeting

MOTION

That the Primary Care Access, Delivery, and Payment Task Force hereby approves the minutes of the meeting held on June 17, 2025, as presented.

Primary Care Access, Delivery, and Payment Task Force Membership



Kiame Mahaniah, MD, Secretary of Health and Human Services, 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

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

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	The task force shall develop recommendations to:	Statutory Deadline
1	Define primary care services, codes, and providers	September 15, 2025
2	Develop a standardized set of data and reporting requirements for private and public payers, providers and provider organizations	September 15, 2025
3	Establish a primary care spending target for private and public health care payers that reflects the cost to deliver evidence-based, equitable and culturally competent primary care	December 15, 2025
4	Propose payment models to increase public and private reimbursement for primary care services	March 15, 2026
5	Assess the impact of health plan design on health equity and patient access to primary care services	March 15, 2026
6	Monitor and track the needs of and service delivery to residents of the Commonwealth	May 15, 2026
7	Create short-term and long-term workforce development plans to increase the supply and distribution of and improving working conditions of primary care clinicians and other primary care workers	May 15, 2026

Statutory Deliverable #1: Defining Primary Care Services, Codes, and Providers

- Pursuant to Chapter 343 of the Acts of 2024, the Primary Care Access, Payment, and Delivery Task Force (PCTF) is charged with reporting findings and recommendations to the Massachusetts legislature to **define primary care services, codes, and providers** by September 15, 2025.
- The PCTF Co-Chairs have developed a **proposed draft** of this deliverable for discussion, including:
 - A Brief Introduction to the Issue
 - Policy Recommendation
 - Designated Agency
 - Transparent Methodology
 - Primary Care Advisory Body
 - Annual Review Process
 - Annual Reporting
 - Spending Target Measurement
 - A Summary of Current CHIA Methodology and Annual Update Process

- **Primary care represents one of the highest value categories of care**, yet is experiencing significant challenges, including reduced growth in investment compared to all other medical services.
- **Data-driven** policy changes, investments, and market reforms are needed to **support and improve the Commonwealth's primary care system**. Transparent, comprehensive expenditure data on primary care services in Massachusetts are essential to inform these reforms, and this **data measurement process is also critical for setting and tracking investment improvement targets**.
- As discussed at previous PCTF meetings, the **Center for Health Information and Analysis (CHIA)** is currently measuring primary care spending in Massachusetts and its methodology generally aligns with other states. Nearly 20 states have established methods to measure primary care spending, but there is **no national consensus for methodology to measure primary care spending**.
 - CHIA's methodology, developed in 2019 through a public listening session with stakeholders, leverages standard billing codes and aligns with other states' approaches.
 - CHIA has collected summary-level data from health insurers to measure overall spending on primary care and behavioral health services covered by insurance since 2020.

Primary Care Access, Payment and Delivery Task Force

Recommendation: Statutory Deliverable #1

- CHIA has already developed and implemented a **highly credible and robust process** for defining and measuring primary care spending in Massachusetts.
- **The PCTF recommends that Massachusetts rely on CHIA's technical expertise and experience** to continue this foundational measurement work, which is critical for informing policies to increase investment in primary care and other strategies to strengthen primary care access, delivery, and financial stability.

- **Designated Agency:** The Legislature should **codify CHIA as the agency responsible for defining, measuring, and reporting on primary care spending** in Massachusetts and authorize CHIA to require such reporting from payers and providers as is necessary for these purposes.
- **Transparent Methodology:** The Legislature should **require that CHIA develop and publicly post its detailed methodology and data specifications** for defining and measuring primary care spending based on summary level reporting from commercial and public payers.
 - The methodology should incorporate a **designated list of primary care services by codes, a list of provider types, and non-claims payments** to support primary care.
 - **CHIA should be informed by methodologies used in other states**, and to the extent appropriate, should align its methodology with those used in other states, particularly neighboring states, to allow for cross-state comparisons.
- **Annual Review Process:** The Legislature should require that **CHIA establish an annual process for reviewing and revising** as necessary its methodology for measuring primary care spending. The process should include consultation with the Primary Care Advisory Body, other states and relevant experts.

- **Primary Care Advisory Body:** The Legislature should establish an **ongoing primary care advisory body** to advise on primary care policy and rule-making across state agencies, including providing technical input on CHIA's data specifications, methodology, measurement, and reporting. The members of which should include primary care providers, behavioral health providers, health systems, health plans, and government agency representatives, including HPC, MassHealth, the Department of Public Health, and the Division of Insurance.
- **Annual Reporting:** The Legislature should require CHIA to report annually on primary care spending in Massachusetts, including as a share of total statewide expenditures, by member, by insurance type, by age group, by payer, and managing physician organization.
 - **HPC should include primary care spending trends in its annual cost trends report**, including complementary analyses based on data from the All-Payer Claims Database (APCD), and make corresponding policy recommendations.
- **Spending Target Measurement:** **CHIA's annual reporting should be used for the purpose of setting a primary care spending target** (to be further defined by the PCTF in deliverable #3).
 - CHIA should **consider the inclusion of pharmaceutical spending data as appropriate** in the calculation in order to **ensure clear incentives and accountability** for the state, market actors, and the public to be able to track meaningful progress on spending targets (as recommended by the PCTF).

In developing this recommendation, the PCTF discussed a number of **known limitations** with the current methodology as well as further considerations **which CHIA should explore and seek to address** in the future, to the extent feasible, including:

- Inclusion of Original Medicare Data
- Identification, measurement, and inclusion of services, such as behavioral health care services, that are delivered in a primary care setting but are not billed through insurance codes
- Consider inclusion of other professionals that provide services in a primary care setting
- Inclusion of spending on behavioral health integration and associated time spent on care delivery
- Measuring spending for primary care providers engaged in direct contracts with employers or who offer services that are not reimbursed through the health insurance plans (e.g., direct primary care, concierge)
- Inclusion of OB/GYN provider spending only for primary care services (e.g., wellness visits but not childbirth)

Measurement of Primary Care Spending in Proposed Legislation

- Two bills filed in the current legislative session direct CHIA to define “primary care expenditures” for the purpose of reporting and analyzing performance against a primary care expenditure target: **S.867, An Act relative to primary care for you**, sponsored by Senator Friedman, and **H.2537, An Act relative to primary care access**, sponsored by Representative Schwartz.
 - Both bills additionally direct CHIA to consider recommendations from the PCTF when defining primary care expenditures.
- **H.1370, An Act relative to Massachusetts primary care for you**, sponsored by Representative Haggerty, additionally defers to CHIA in defining “primary care expenditures,” with the specification that prospective payments for primary care services be included.

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Statutory Deliverable #2: Developing a standardized set of data and reporting requirements for private and public payers, providers, and provider organizations



- Primary care spending reporting includes fee-for-service payments for identified primary care services and provider types as well **as non-claims payments**.
 - Depending on the provider organization's structure, non-claims payments may be paid to the contracting entity, accountable care organization (ACO), or physician group and then distributed to participating groups and/or providers.
- Provider organizations **have different types of organizational structures** that contract with payers and distribute non-claims payments to employed or participating PCPs.
 - “**Funds flow**,” the method or formula for distribution of non-claims revenue or settlement, **is determined internally by each provider organization** based on the unique profile and goals of each organization and is proprietary and competitively sensitive.
 - Most provider organizations have a **management services organization (MSO) or administrative unit** that provides contracting, data and reporting infrastructure that is supported by fees from member practices or PCPs and/or a portion of non-claims payments.
 - Non-claims payments from multiple payers **may be pooled with other revenue** and distributed according to internal performance metrics.

Discussion of Deliverable #2 at the PCTF Data and Research Workgroup Meeting (July 10, 2025)

- At the PCTF Data and Research Workgroup meeting on July 10, members discussed **the need for additional information about and transparency of the flow of such payments** in order to promote accountability of provider organizations for increased spending on primary care.
- Members also acknowledged that the **complexity of different organizational structures and cost accounting approaches** to overhead and fees or retention for management and administrative services impact the ability to **“track the dollars”** intended for primary care.

Workgroup members discussed the need for additional information in **two dimensions**:

Funds Flow Formulas

- Some members called for **transparency of the specific formulas** used by provider organizations to allocate non-claims payments to PCPs in their organization as well as the distribution of those dollars.

Provider Organization Accounting

- Given that a large percentage of primary care providers in the Commonwealth are employed by or affiliated with large hospital-based provider systems, task force members identified a need for **more transparency of the financing of primary care practices and/or individual primary care providers** within a larger system.
- Members said it was important to track payments intended to support primary care and understand what **management and/or administrative services provided by the organization are “charged” or provided “in-kind” to primary care practices.**

Discussion: Considerations for Deliverable #2

- To whom should provider organizations report funds flow formulas/primary care funds accounting – to health plans or to the state?
- Should funds flow formulas and primary care funds accounting be confidential or publicly available?
- Should funds flow be reported by each payer or in the aggregate? How feasible is it for all organizations to report by payer?
- How feasible is it to develop standardized reporting of funds flow mechanisms applicable to different provider organizational structures (e.g., IPAs, hospital-based provider organization, multi-specialty practice)?

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Setting a Primary Care Spending Target: Design Questions

At the June 17, 2025, PCTF meeting, Christopher Koller, President of the Milbank Memorial Fund, outlined design questions for increasing primary care spending rates.

1

Should the spending target be aspirational or a requirement?

2

What should the spending target level be?

3

Who are the accountable entities?

4

Who are the oversight entities to enforce accountability?

5

How should total health care spending (denominator) be measured?

6

How should primary care spending (numerator) be measured?

7

How can systemic impact be ensured?

Setting a Primary Care Spending Target: Chris Koller's Recommendations for Massachusetts



- The spending target should be **required**.
- Use the Center for Health Information and Analysis (**CHIA**) **primary care spending definition and methodology**.
- Do not focus on setting a specific target level: “**Just get better.**”
- Hold both **health plans and health systems** accountable for increasing primary care spending rates.
- **CHIA and the HPC** should lead reporting and monitoring activities. An **accountable oversight entity** should be named.
- To **ensure systemic impact**:
 - All payers must be aligned
 - Continue to build on MassHealth's Primary Care Sub-Capitation Program
 - Look for Medicare opportunities
 - Think carefully about enforcement and accountability
 - Go beyond claims data to financial reporting

Primary Care Spending Target in Proposed Legislation

- Three proposals before the Legislature this session would direct the HPC to implement an **aggregate primary care expenditure target**:
 - S.867, *An Act relative to primary care for you* (Senator Friedman)
 - H.1370, *An Act relative to Massachusetts primary care for you* (Representative Haggerty)
 - H.2537, *An Act relative to primary care access* (Representative Schwartz)
- The three pieces of legislation define the aggregate primary care expenditure target as:
 - The targeted sum, set by the HPC, of all primary care expenditures, as defined by CHIA, in the Commonwealth in the calendar year in which the aggregate primary care expenditure target applies.
- The three proposals additionally permit the HPC to require a **performance improvement plan** (PIP) of entities identified by CHIA as failing to meet the aggregate primary care expenditure target and levy a civil penalty against those that fail to comply with the requirement for a PIP.

Massachusetts Primary Care Spending



Primary Care Spending (2022)

Spending on primary care services, and as a percentage of total medical spending by insurance category and on a per member per month (PMPM) basis.

COMMERCIAL

6.7% | \$995.2M | \$41.6 PMPM
2022

MASSHEALTH MCO/ACO-A

7.5% | \$208.1M | \$35.2 PMPM
2022

MEDICARE ADVANTAGE

4.2% | \$114.7M | \$46.8 PMPM
2022



Notes: Data for original Medicare was not available for this analysis. Analysis represents data from commercial payers that submitted CY2022 data: Aetna, BCBSMA, CCA, Cigna, Fallon, HPHC, HPI, MGBHP, THP, THPP, United, and United Medicare Advantage representing approximately 92% of the commercial market, 60% of the MassHealth MCO/ACO-A market, and 64% of the Medicare Advantage market in 2022. Totals may not sum due to rounding. Previously published data points are not comparable, differences are due to payer exclusions.

The three legislative proposals diverge in where the target is set annually.



The aggregate primary care spending target is set by each proposal as **equal to:**

S.867 – Sen. Friedman

- Eight percent in 2027,
- Ten percent in 2028,
- 12 percent in 2029, and
- At least 12 percent for all subsequent years.

H.1370 – Rep. Haggerty

- Ten percent in 2027,
- 12.5 percent in 2028,
- 15 percent in 2029, and
- Between 15 and 20 percent for all subsequent years.

H.2537 – Rep. Schwartz

- Eight percent in 2026,
- Ten percent in 2027,
- 12 percent in 2028, and
- At least 12 percent for all subsequent years.

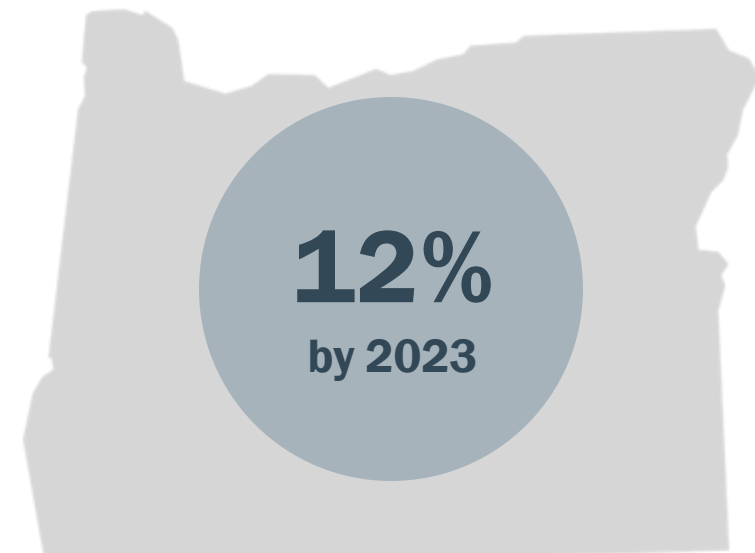
In each bill, the HPC is permitted to modify the aggregate primary care expenditure target for subsequent years, provided that (1) a **public hearing** is held and (2) the HPC Board of Commissioners approves the modification by a **vote of two thirds**.

An Act to Advance Health Equity



- S.901/H.1417, *An Act to Advance Health Equity*, was introduced by Senator Payano and Representative Williams and directs the HPC to establish aggregate **primary care and behavioral health expenditure targets**.
- The legislation directs the HPC to hold a **public hearing** prior to establishing the targets.
- CHIA is directed to include performance against the primary care and behavioral health expenditure targets in its **annual reports** going forward.

- In 2017, Oregon set a **primary care expenditure target of at least 12%** for all payers, to be reached by 2023.
 - By 2022, commercial carriers averaged 11.5% of total medical spending allocated to primary care.
 - Medicare Advantage carriers averaged 13.9%.
 - Oregon's public employee plans averaged 12.3%.
 - Medicaid coordinated care organizations averaged 15%.
- Defined primary care to include **family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics, and general psychiatry** and exclude vaccinations or treatment for acute illnesses.
- The benchmark is **not enforceable**, but the Oregon Health Authority can require carriers that do not meet this target to submit a plan to increase spending on payment for primary care as a percentage of total health expenditures by at least one percent each plan year.



- California set a **15% primary care spending target** for all payers, to be reached by 2034.
- Set an **annual improvement benchmark of 0.5% to 1%** increased primary care spending as a percentage of total health care expenditures through 2033.
- Defined primary care to **include the services of doctors, nurses, and pharmacists**. Obstetricians, gynecologists, and naturopathic providers were excluded.
- Benchmarks are incentivized through public reporting but are **not enforceable**.
- Increased **investment in the primary care workforce in parallel** to benchmark efforts.



Discussion: Setting a Primary Care Spending Target: Design Questions

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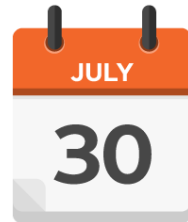


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Adjourn

Upcoming Meeting Dates



PCTF Workforce Workgroup Meeting

Wednesday, July 30th

11:30 AM – 1:00 PM (virtual)



Primary Care Task Force Meeting

Wednesday, September 17th

10:00 AM – 12:00 PM (in-person)