

Primary Care Access, Delivery, and Payment Task Force

October 29, 2025



Agenda



Call to Order



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

Statutory Deliverable #4: Propose payment models to increase public and private reimbursement for primary care services

Upcoming Meetings

Adjourn

VOTE

Approval of Minutes from the September 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 September 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, JD, 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, 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, Beth Israel Deaconess Medical Center; Chief Medical Officer, Essential Pediatrics; 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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UP NEXT: Statutory Deliverable #4: Propose payment models to increase public and private reimbursement for primary care services

- Alternative Payment Models for Primary Care Implemented in Other States
- MassHealth Primary Care Sub-Capitation Program
- Proposals in Massachusetts Primary Care Legislation
- Open Discussion: Principles for Advancing Primary Care Alternative Payment Models

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DELIVERABLE	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

- An April 2025 report from the University of Colorado’s **Farley Health Policy Center** examines approaches of five states that have initiated policies advancing **alternative payment models (APMs)** for state-regulated commercial plans for primary care.
- The report identifies **3 key features** of impactful primary care APM policy:
 - Move towards “advanced” APMs that truly **enable and incentivize change**, particularly those with meaningful amounts of **prospective payment**.
 - **Increase investment** in primary care.
 - Improve **multi-payer alignment** in both efforts, not only within the commercial sector but also across sectors.

STATES EXAMINED

- 1 Arkansas 
- 2 Colorado 
- 3 Delaware 
- 4 Rhode Island 
- 5 Washington 

Colorado

- Enacted law to increase investment in primary care and grant the Division of Insurance (DOI) authority to set affordability standards.
- DOI regulation establishes parameters to align primary care APMs across payers:
 - APMs must include quality measures, patient attribution, risk adjustment, and core competencies
 - Option to include prospective payment, shared savings arrangements, flexibility for carriers and providers, and behavioral health integration incentives

Delaware

- Passed stepwise legislation to create the Primary Care Reform Collaborative, increase investment in primary care, create the Office of Value-Based Health Care Delivery (OVBHCD) within the Department of Insurance (DOI), and establish mandatory minimums for payment innovation
- The OVBHCD is responsible for establishing affordability standards, targets for carrier primary care investment, and collecting data and developing reports to measure carrier primary care investment.
- Regulation required carriers to offer primary care incentive programs with non-fee-for-service (non-FFS) payment

Rhode Island

- Established the Office of the Health Insurance Commissioner (OHIC), with increased oversight and policy efforts in health care.
- OHIC established affordability standards for health plans, that, over time, have required increased investment in primary care, increased alignment, and focused on prospective payment and integrated behavioral health
- In 2023-2024 created a definition for Primary Care APM that includes prospective payment for a defined set of primary care services.
- This also sets a deadline for 60% of covered lives in primary care APMs by 2027.

APM Targets for State-Regulated Commercial Payers



State	Alternative Payment Model Targets
CO	<ul style="list-style-type: none">▪ Recommends 50% of total medical expenditures in APMs and 25% of primary care expenditures in prospective payments (Non-binding)
DE	<ul style="list-style-type: none">▪ 75% of primary care providers enrolled in an APM
RI	<ul style="list-style-type: none">• At least 10% of covered lives in a primary care APM by 2021• Stepwise increases to 60% of covered lives in a primary care APM by 2027• 8% of total medical expenditures in primary care APMs inclusive of both non-FFS and FFS dollars

Details of Prospective Payment in Voluntary or Regulatory State APM Efforts



State	Requirements Related to Prospective Payment
CO	<ul style="list-style-type: none"> ▪ Regulatory target (without a mandate) for 25% of primary care payments to be prospective
DE	<p>Regulatory requirement for carriers to offer:</p> <ul style="list-style-type: none"> • Non-FFS payment greater than or equal to a primary care incentive program offered by Medicare • A larger proportion of non-FFS payment similar to CPC+ track 2 (which shifted a portion of FFS payments to capitation) • A carrier-designed program that transitions a portion of FFS payment to non-FFS payment
RI	<ul style="list-style-type: none"> ▪ Regulatory definition of primary care APMs as relying on prospective payment for a defined set of primary care services



POLICY LEVERS

- MOUs and other voluntary agreements have limited ability to create change but can **provide an avenue for advancing stakeholder consensus.**
- **Legislation is needed to grant appropriate regulatory authority** to state agencies, including to implement affordability standards.
- Participation in **federal demonstrations** creates an ongoing structure to advance primary care APM policy and multi-payer alignment.



TARGETS TO SET

- **Primary Care investment targets** provide the foundation for primary care reform that can be tied to APM implementation.
- Targets for the **percentage of primary care providers or covered lives in APMs** can be set to scale implementation.
- Mechanisms to ensure primary care APMs meaningfully change how practices are paid include **clearly defining what qualifies as a primary care APM or setting targets for the proportion of non-FFS dollars in APMs.**

- Legislation should take in to account **possible loopholes** or **different interpretations** of policy.
- Legislation should **control costs** and **prevent cost-shifting** to patients.
- States should **require alignment of APM efforts across all payers under state jurisdiction** (e.g. state employee programs) to maximize impact and reduce administrative burden.
- **Primary care advisory groups** created through legislation or regulation provide a valuable platform to obtain feedback to inform the development of APM policy.
- **Equity considerations** (e.g., risk adjustment for social factors) should be incorporated in primary care payment innovations throughout the entire process..
- Adequate **funding for data and evaluation** activities is necessary.
- Payments intended for primary care should be **paid directly to practices or enhance supports** that benefit primary care practices.
- **Monitoring and enforcement mechanisms** should be included in regulation.

Farley Report Insights for Primary Care APM Design

- There is **no one-size-fits-all** primary care APM.
- States have generally encouraged **prospective payment** for overall model direction.
- Aligned APM components related to **practice transformation support, attribution, and risk adjustment**.
- Greater design standardization to ensure meaningful **alignment on APM approach and parameters** to decrease administrative burden while allowing for flexibility.
- Standardization of **quality metrics** focused on what providers can impact and what matters to patients.
- Aligned **care delivery requirements** (e.g., on team-based care).
- Allow **sufficient time** for practices to transform to advanced primary care.

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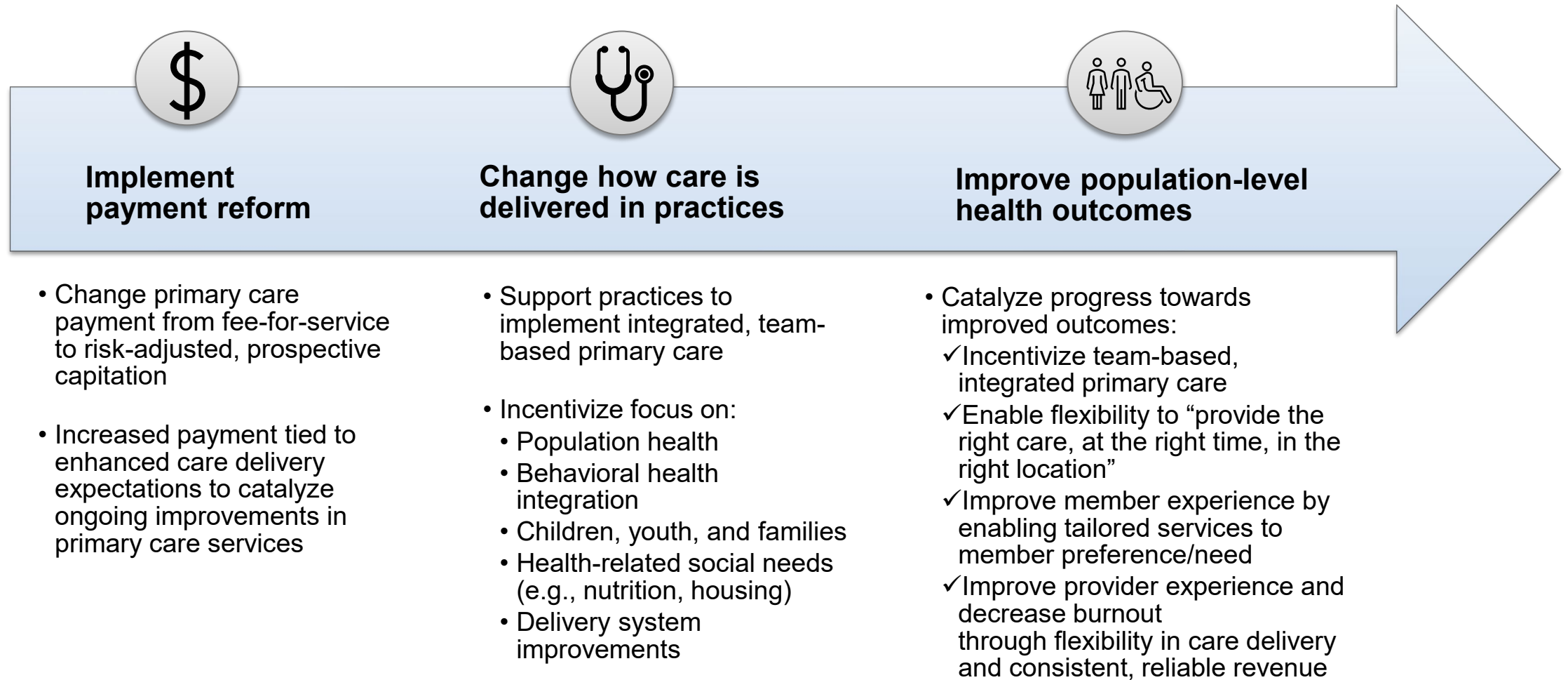
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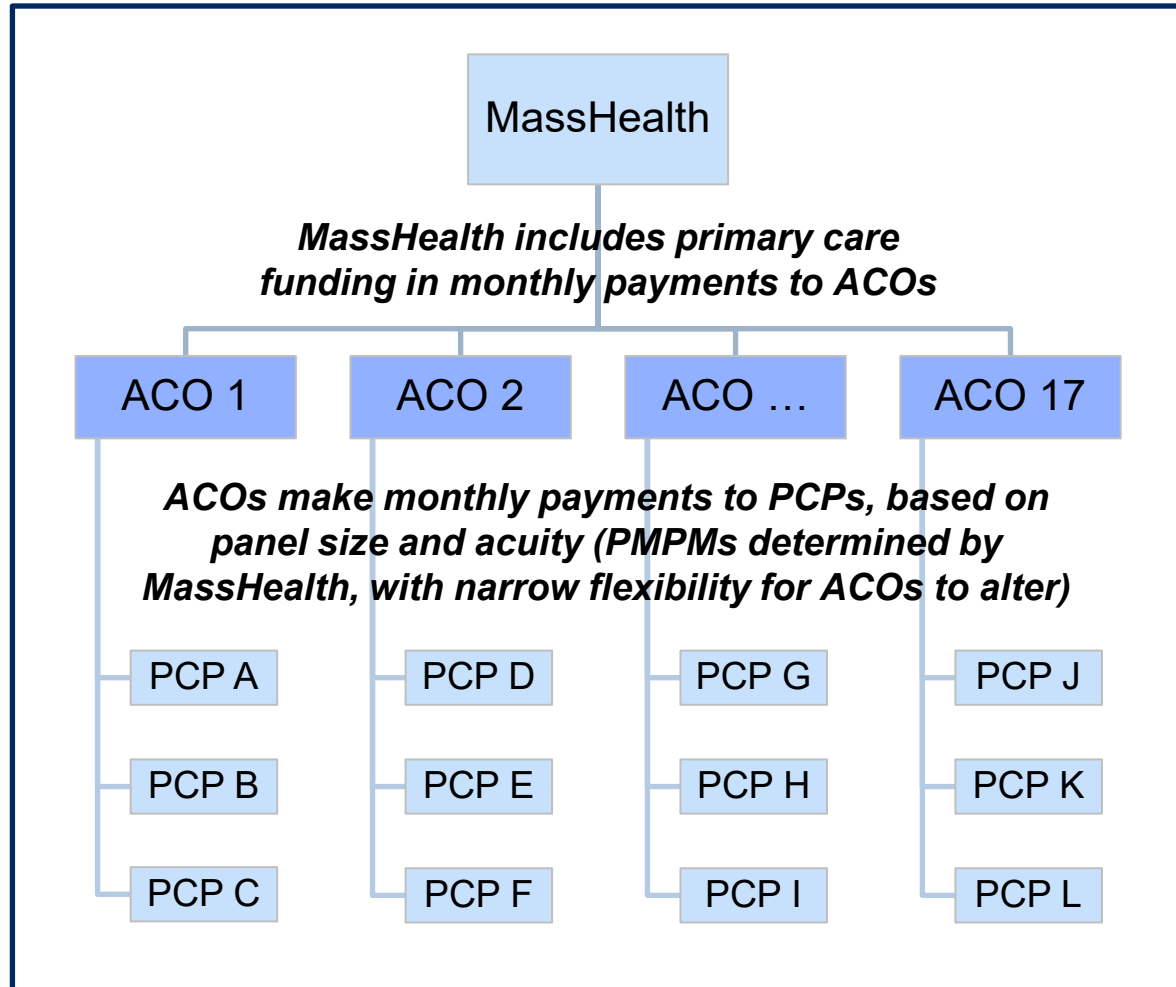
Upcoming Meetings

Adjourn

MassHealth Primary Care Sub-Capitation: Overview



MassHealth Primary Care Sub-Capitation: how it works, and early experience



For more information: <https://www.mass.gov/masshealth-primary-care-sub-capitation-program>



Market-wide participation

All ACO primary care practices (~900) are required to participate, reflecting 92% of eligible members (~1.1M). Every major health system and all Federally Qualified Health Centers participate.



Prospective, reliable capitation payments providers can rely on

Monthly capitation payments from ACOs to practices were 99.9%+ accurate and consistent



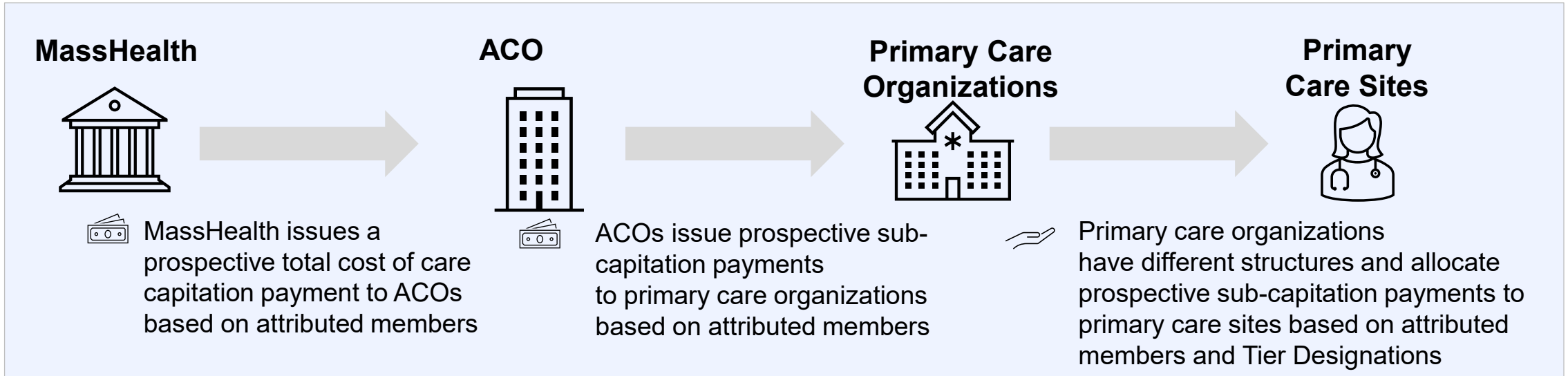
Care is improving

Of practices that continued in the program from 2023 to 2025, >200 practices (20%) “leveled up” their service offerings, including expanded after-hours care, behavioral health integration, and more

MassHealth tracks sub-capitation payments to participating sites and ensures all dollars are paid accurately and consistently



ACOs are required to make monthly, prospective sub-capitation payments to primary care organizations (defined by Tax Identification Number) and report payments to MassHealth. MassHealth conducts compliance checks using these reports.



- ACOs must submit **monthly reports** to MassHealth **detailing sub-capitation amounts paid**, including payment details by primary care organization, primary care site, and rating category
- **Primary care organizations must allocate payments** to primary care sites **based on Tier Designation**
- **MassHealth conducts compliance checks** using payment tracking data to ensure each primary care organization receives at least 90% of its sub-cap rate¹ and that 100% of sub-cap dollars are allocated to ACO primary care sites
- **Payments were 99.9%+ accurate and consistent** in the first year of the program

¹ Federally Qualified Health Center (FQHC) organizations must receive 100% of their sub-capitation rates

Considerations and Challenges in Implementing Primary Care Capitation

Rate setting in capitation

- 1 **How to define primary care** – what are the “right” services to include and how do you identify them?
- 2 **Where to focus investment across populations?**
 - Kids vs adults
 - SDOH
 - Provider type (FQHCs, independent practices, rural/urban, etc.)
- 3 **How to set prospective rates** – historical fee-for-service utilization vs risk-adjusted, market-based rates?
- 4 **Risk adjustment** – what are the “right” variables to incorporate?
 - Dx, Rx, SUD, SDOH, etc.
 - Different considerations for primary care versus Total Cost of Care

Multi-payer participation

- 1 **Practice-level payer mix varies widely across the Commonwealth**
 - MassHealth is only ~20% of the payer mix across practices¹
 - Commercial and Medicare payers are ~55% and ~19% of the payer mix across practices, respectively²
- 2 **“One foot in both canoes”** – FFS vs cap
 - Practices are only able to fully respond to value-based incentives if enough of their care is paid for in capitation
 - For all primary care practices, this means more than just MassHealth

¹ March 2025 data from CHIA's [Enrollment Trends Dashboard](#). Figure does not include SCO/PACE/One Care.

² March 2025 data from CHIA's [Enrollment Trends Dashboard](#), March 2025. Commercial includes private commercial (unsubsidized). Medicare includes Medicare FFS and Medicare Advantage.

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Legislation proposed in Massachusetts would develop an all-payer primary care capitation model with prospective, per-member per-month payments.



- Three proposed bills would codify a version of the PCTF as a permanent body within the HPC to continue primary care reform in the Commonwealth:
 - **S.867**, *An Act relative to primary care for you* (Chair 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 bills would require the new permanent body to outline a prospective, per-member per-month (PMPM) payment model, with **PMPM payments adjusted based on**:
 - Providers' adoption of qualifying **advanced primary care services and investments**, as defined by the body;
 - The **quality of care** delivered; and
 - The **clinical and social risk of patients** attributed to participating providers.
- It would be **voluntary for providers** to participate in the prospective payment model. **S.867 and H.2537** require the GIC and state-regulated carriers to offer the primary care capitation model to primary care providers.
- **H.1370** specifies that at least 95% of payments made under the model would be required to go directly to primary care providers and would eliminate cost-sharing for primary care services provided by a participating provider.

Advanced Primary Care Services and Investments



- Employing **community health workers**
- Investing in **social determinants of health**
- Collaborating with primary care-based **clinical pharmacists**
- **Integrating behavioral health care** with primary care
- Offering **substance use treatment**
- Using clinical optimization programs to **minimize administrative burden**
- Investing in **care management**
- Establishing systems to facilitate **end-of-life care planning**
- Developing systems to evaluate patient **population health**
- Offering **walk-in or same-day appointments** or extended hours
- H.1370 additionally includes the provision of **medical education** and **integration of oral health** with primary care as possible advanced services.

The new primary care body would be directed by the three bills to also adjust PMPM payment rates based on the quality of care delivered to primary care patients.



S.867 and H.2537

- The body would be required to identify **up to eight** evidence-based, patient-centered, and actionable quality measures related to:
 - Care continuity, comprehensiveness, and coordination;
 - Patient access to primary care; and
 - Patient experience.
- Four of the eight quality measures would be measures of **patient experience**, and one would be a **person-centered** primary care measure.

These bills would require the Group Insurance Commission and all state-regulated health plans to provide contracted PCPs the option to participate in a primary care capitation model

H.1370

- The body would be required to identify **up to twelve** evidence-based, patient-centered, and actionable quality measures related to:
 - Care continuity, comprehensiveness, and coordination;
 - Patient access to primary care; and
 - Patient experience.
- Providers would be required to **adopt six** of the twelve measures, including at least two related to **patient experience** and at least one related to **health equity**.

To fund the primary care prospective payment model, H.1370 would establish a **Primary Care Stabilization Fund** administered by the HPC

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Principles for Primary Care Per-Member Payment

1

Support Provider Buy-In

Payers should guarantee transparent and reliable rate setting that moves away from fee-for-service payment toward per-member payment and provides sufficient compensation for providers and clinical care teams.

2

Advance Equity

The PMPM methodology should allow for adjustments based on critical factors such as age, disability status and social vulnerability to encourage care for underserved populations and only minimal reliance on patient diagnoses that can be influenced by coding intensity. It should also minimize the impact of historical pricing disparities across organizations and prior provision of low-value care.

3

Reduce Administrative Burden

The PMPM design should reduce administrative burdens by minimizing additional reporting and process requirements.

Discussion: Principles for Advancing Primary Care Payment Reform That Will Enable Care Transformation

- What principles for advancing primary care payment reform should be prioritized in the task force recommendations?
- What strategies should the task force recommend to promote multi-payer alignment and provider participation in payment reform?
- What support will be necessary to enable smaller practices and organizations to participate in new payment models? How should care delivery requirements and quality metrics be incorporated without increasing burden?
- What is your overall vision for a payment model that supports meaningful, patient-centered care delivery transformation?

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UP NEXT: Upcoming Meetings

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Upcoming Meeting Dates



Workforce Workgroup
Tuesday, November 18, 2025
10:30 AM – 12:00 PM (virtual)



Data and Research Workgroup
Tuesday, November 18, 2025
2:30 PM – 4:00 PM (virtual)



Primary Care Task Force Meeting
Wednesday, December 3, 2025
10:00 AM – 12:00 PM (Location TBA)