

Primary Care Access, Delivery, and Payment Task Force

January 14, 2026



Agenda



Call to Order



UP NEXT: Approval of Minutes: December 3, 2025 (VOTE)

Statutory Deliverable #4: Propose Payment Models to Increase Public and Private Reimbursement for Primary Care Services

Statutory Deliverable #5: Assess the Impact of Health Plan Design on Health Equity and Patient Access to Primary Care Services

Open Discussion: Priorities for PCTF in 2026

Adjourn

VOTE

Approval of Minutes from the December 3, 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 December 3, 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

Caitlin Sullivan, Deputy Executive Director, Health Informatics & Reporting, 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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Focus Today: Statutory Deliverables #4 and #5



DELIVERABLE		STATUTORY DEADLINE
✓ 1	Define primary care services, codes, and providers (complete)	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 (complete)	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

Recommendations for a Primary Care Spending Target (Deliverable #3) and Primary Care Payment Reform (Deliverable #4) are linked.



**Text from Statutory
Deliverable #3:
Establish a Primary
Care Spending Target**

Payment and Care Delivery Reform:

Increases in primary care spending should be prioritized by payers and providers to support the adoption of innovative payment models that support the delivery of the four pillars of person-centered primary care: first-contact care, continuity of care, comprehensive care, and coordination of care. **Recommendations from the PCTF on payment and care delivery models will be included in the upcoming PCTF Statutory Deliverable #4.**

Core Goals of Primary Care Payment Reform (For Discussion)



Primary care payment reform aims to realign reimbursement models so that the health care system better delivers care based on the four pillars of primary care: **first-contact care, continuity of care, comprehensive care, and coordination of care.**

Core goals include:

1. Improve patient access and experience

- Enable provider flexibility to “provide the right care, at the right time, in the right location” that meets patients where its best for them, when they need it

2. Strengthen primary care capacity and stability

- Provide reliable resources so practices can hire staff, extend hours, invest in technology, enable innovation, and build care teams

3. Support team-based care models

- Encourage integration of behavioral health and other supportive services

4. Improve quality, outcomes, and advance health equity

- Align payment with progress on meaningful measures

5. Reduce administrative burden

- Simplify and align billing, reporting, and other payer requirements

6. Enhance workforce sustainability

- Reduce burnout and improve the work experience of primary care providers

Principles for Primary Care Payment Reform (For Discussion)

1

Primary care payment reform should shift from fee-for-service to prospective, capitated payments that enable care delivery changes, promote innovation, and provide greater financial stability for primary care practices

2

Payments should be targeted to primary care practices directly or for supports that directly benefit primary care practices

3

Primary care payment reform principles should be aligned across payers and patient populations to the extent feasible, not only within the commercial sector but also across sectors

4

Ensure meaningful multi-payer alignment on payment reform reporting requirements and parameters to decrease administrative burden

5

Primary care payment reform should recognize enhanced care delivery capabilities and quality performance with payment adjustments

Principles for Primary Care Payment Reform (For Discussion)

6

Equity considerations (e.g., risk adjustment for social factors) should be incorporated in primary care payment development

7

Commercial primary care payments could include baseline levels indexed to public payer benchmarks (i.e., for all providers as a % of Medicare; for FQHCs at least as much as MassHealth)

8

Implementation should include robust monitoring of the effectiveness of new primary care payments and the impact on patient outcomes and other core goals

9

Align with primary care spending target and deliverable #3 including not increasing overall spending/premiums or out of pocket spending

Summary of Primary Care Payment Principles (For Discussion)



- 1 Primary care payment reform should shift from fee-for-service to **prospective, capitated payments** that enable care delivery changes, promote innovation, and provide greater financial stability for primary care practices
- 2 Payments should be **targeted to primary care practices directly** or for supports that directly benefit primary care practices
- 3 Primary care payment reform principles should be **aligned across payers and patient populations** to the extent feasible, not only within the commercial sector but also across sectors
- 4 Ensure meaningful multi-payer **alignment on payment reform reporting requirements** and parameters to **decrease administrative burden**
- 5 Primary care payment reform should **recognize enhanced care delivery capabilities and quality performance** with payment adjustments
- 6 **Equity considerations** (e.g., risk adjustment for social factors) should be incorporated in primary care payment development
- 7 Commercial primary care payments could include **baseline levels indexed to public payer benchmarks** (i.e., for all providers as a % of Medicare; for FQHCs at least as much as MassHealth)
- 8 Implementation should include **robust monitoring** of the effectiveness of new primary care payments and the impact on patient outcomes and other core goals
- 9 **Align with primary care spending target** and deliverable #3 including **not increasing overall spending/premiums or out of pocket spending**

Discussion: Recommendations for PCTF Deliverable #4

- Is a shift towards prospective, capitated payments the best recommendation for enabling and incentivizing care delivery change and supporting primary care practice financial stability with reliable revenue?
- What recommendations should we include to reduce administrative burden of payment reform implementation?
- What components of primary care payment reform can be aligned across payers, not only within the commercial sector, but also across sectors, that will ensure meaningful impact and reduce complexity across the system?
- What tools and mechanisms are needed to monitor, evaluate, and enforce primary care payment reforms?

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Statutory Deliverable #4: Propose Payment Models to Increase Public and Private Reimbursement for Primary Care Services



UP NEXT: Statutory Deliverable #5: Assess the Impact of Health Plan Design on Health Equity and Patient Access to Primary Care Services

Open Discussion: Priorities for PCTF in 2026

Adjourn

Policy Background: Opportunities for Improving Cost Sharing



- Massachusetts policymakers have sought to address the **high and growing burden of out-of-pocket health care spending** (“cost sharing”) through recent legislative and regulatory action:
 - The Healey-Driscoll Administration recently issued regulatory guidance through the Division of Insurance (DOI) that **requires payers to limit the growth of deductibles and copays** at the rate of medical inflation (~4.8%), starting in January 2026.¹
 - Chapters 342 of the Acts of 2024 **capped out-of-pocket costs for certain drugs** identified to treat asthma, diabetes, and prevalent heart conditions.
 - Health Connector Pilot for 2024 and 2025 expanded income eligibility to 500% of FPL. Plan design has **no deductible and no cost sharing for routine care** such as lab tests, E&M visits, common imaging services, and prescriptions for chronic diseases like diabetes and hypertension.
- Efforts to constrain or reduce health care cost sharing should be **paired with policy reforms to address the underlying drivers of health care spending to ensure premiums do not increase** and to improve health care affordability overall.
- In addition to efforts to reduce total cost sharing dollars, **improving cost sharing benefit design to increase predictability and minimize financial risk** of cost sharing is an important complement to these policy efforts.

1. Governor Healey and Lt. Governor Kim Driscoll. Healey-Driscoll Administration limits deductibles and co-pays to control health costs for patients. Press release. May 15, 2025. Available at: <https://www.mass.gov/news/healey-driscoll-administration-limits-deductibles-and-co-pays-to-control-health-costs-for-patients>

2. See DOI filing guidance 2025-J. March 12, 2025.

The HPC's Analysis of Cost Sharing in Massachusetts: Key Findings



- Average **annual cost sharing per person grew** from \$849 in 2019 to \$1,049 in 2023 (a 29% increase), faster than insurer-paid spending (24%).
- **Deductible spending grew** 38% from 2019 to 2023 while spending on copayments grew 12%, resulting in a cost sharing composition that is increasingly tilted towards deductibles.
- The **types of services that contribute most** to a patient's annual cost sharing outlay **reflect the frequency of service use and the amount of cost sharing paid per use.**
- Among ambulatory services, **the share of cost sharing represented by deductible spending varies widely**, reflecting differences by service in benefit design and price.
- Cost sharing for typical office visits **can also vary by hundreds of dollars**, largely due to deductibles on ancillary services **that patients may not be able to anticipate.**



While **H.1370 prohibits cost sharing** for primary care services, **S.867/H.2537** give the primary care advisory board discretion **to limit cost-sharing**.

H.1370

- **Prohibits cost sharing** (including deductibles) for **any covered primary care services** provided through the primary care prospective payment model it proposes.

S.867

- Directs the permanent primary care board within the HPC to include **patient cost sharing limits for primary care** in the all-payer primary care capitation model it proposes.*

H.2537

- Directs the permanent primary care board within the HPC to include **patient cost sharing limits for primary care** in the all-payer primary care capitation model it proposes.

***S.867** bill also **eliminates cost sharing and prior authorization** requirements for medically necessary emergency services.

November 18, 2025

PCTF Data and Research Workgroup Discussion on Cost Sharing: Key Takeaways

- There is **value in predictability and transparency** in potential cost-sharing for patients.
- **Fragmentation and complexity in the system can lead to errors** resulting in cost-sharing for preventative services where it should not be applied.
- High-deductible plans and concerns of potential out-of-pocket costs **can lead to patients delaying or forgoing necessary services.**
- At the same time, **a shift away from high-deductible plans could result in increasing premiums**, making for difficult choices for employers amidst the current affordability crisis.
- Policies addressing cost-sharing **must be paired with additional reforms to reduce costs.**

Discussion of Statutory Deliverable #5: Assess the impact of health plan design on health equity and patient access to primary care services

- If we were to redesign cost sharing to facilitate access to primary care, what would we change?
- What should cost sharing benefit design ideally look like for primary care to facilitate patient access and reduce provider administrative burden?
- What other features of insurance benefit design should we consider to support patient access (e.g. network design, benefit design), and what should they look like?

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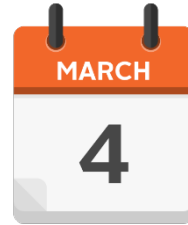
Open Discussion: PCTF Priorities for 2026

Achieving a primary care spending target in five years should not be the sole measure of success for the state's reform efforts to build a primary care foundation based on the four pillars of first-contact care, continuity of care, comprehensive care, and coordination of care.



- What are additional goals or indicators for measuring success, specifically in the domains of **patient experience, population health, workforce and clinician well-being**, and **health system performance**? For example:
 - Which elements of patient experience in primary care would we expect to change with primary care reform? (e.g. reduced wait times)
 - What are potential indicators of improved population health and reduced health disparities within primary care?
 - What are potential indicators of clinician well-being and workplace satisfaction? (e.g. reduced “pajama time”)
 - What are the most important metrics to measure to monitor progress within health system performance and structure due to successful primary care reform? (e.g. reduced avoidable ED visits; more independent clinician practices)

Next Steps



Primary Care Task Force Meeting
Wednesday, March 4, 2026
(Location TBA)

We will reach out to schedule the next PCTF **Workforce Workgroup** and **Data and Research Workgroup** meetings.