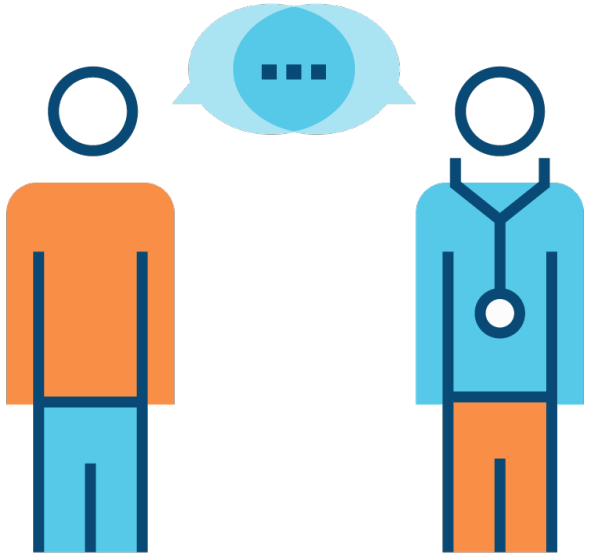

Primary Care Access, Delivery, and Payment Task Force

March 4, 2026

MASSACHUSETTS HEALTH POLICY COMMISSION

EOHHS

Agenda

Call to Order

UP NEXT: Approval of Minutes: January 14, 2026 (VOTE)

Overview: Health Care Affordability Working Group (HCAWG)

February 2026 Milbank Report: *Investing in Primary Care: The Missing Strategy in America's Fight Against Chronic Disease*

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

Adjourn

VOTE

Approval of Minutes from the January 14, 2026, 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 January 14, 2026, 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

Agenda

Call to Order

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Adjourn

Healey-Driscoll Administration's Health Care Affordability Working Group

On January 14, 2026, Governor Maura Healey announced a new working group charged with advancing proposals to reduce health care costs across the system, ultimately reducing costs for people and businesses across the state.

> *Health care is too difficult and too expensive for far too many people. We are taking the most comprehensive action in the country to make it faster, cheaper and easier to get the care you need. This is a moment of urgency, and today we are bringing together leaders from across health care, business and labor to find every possible step we can take to lower costs and improve health care in Massachusetts."*
>
> — Governor Maura Healey

Agenda

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Adjourn

Investing in Primary Care: The Missing Strategy in America's Fight Against Chronic Disease

February 2026 Milbank Memorial Fund Report

- This report examines the role of primary care in prevention, early detection, and management of chronic disease, including the most common causes of illness and death in the United States:
  - Cardiovascular Disease
  - Diabetes
  - Cancer
- Researchers analyzed the Medical Expenditure Panel Survey data from 2016-2022 and Medicare fee-for-service claims data from 2018-2019.

https://www.milbank.org/publications/investing-in-primary-care-the-missing-strategy-in-americas-fight-against-chronic-disease/

Key Findings

- Adults and children with a **usual source of primary care are more likely** to receive the necessary preventive services to **avoid the development of chronic disease**.
- A usual source of **primary care reduces the burden of chronic disease** on patients and the health care system.
- Keeping **the same source of primary care is essential to prevent the progression of chronic disease** in the sickest Americans and to lower health care costs.

A usual source of primary care reduces the burden of chronic disease on people and the health care system (2016-2022).

HOSPITALIZATIONS

Hospitalizations were **20% less likely for adults** and nearly **50% less likely for children with chronic disease** who had a usual source of primary care.

EMERGENCY DEPARTMENT VISITS

Emergency department visits were 11% less likely for adults and nearly **50% less likely for children with chronic disease** who had a usual source of primary care.

HEALTH CARE EXPENDITURES

Total health care expenditures were nearly **54% lower for adults** and nearly **40% lower for children with a chronic condition** who had a usual source of primary care.

Jabbarpour, Y., Jetty, A., Byun, H., Siddiqi, A., Park, J., Koller, C. (2026) *Investing in Primary Care: The Missing Strategy in America's Fight Against Chronic Disease*. Milbank Memorial Fund.

Milbank Memorial Fund Report: Recommendations for Federal, State, and Private Sector Policy Changes

- **Medicare** should pay more for primary care and pay for it differently.
- **Medicare** should eliminate beneficiary barriers to having a usual source of primary care by defining primary care services as preventive.
- **Federal and state policy** should reform Medicaid funding to increase investment in primary care through enhanced reimbursement, flexible payment models, and support for practice transformation.
- **Federal and state policy** should prioritize expanding primary care capacity in underserved areas, with a goal of ensuring every patient has a usual source of primary care.
- **Federal and state** graduate medical education (GME) policies should transform how we pay for graduate medical education.
- **States** should commit to measuring and increasing primary care spending and ensuring those dollars benefit primary care practices.
- **Large employers** should purchase health plans with benefit designs that promote access to a usual source of primary care.

Jabbarpour, Y., Jetty, A., Byun, H., Siddiqi, A., Park, J., Koller, C. (2026) *Investing in Primary Care: The Missing Strategy in America's Fight Against Chronic Disease*. Milbank Memorial Fund.

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

Adjourn

Statutory Deliverable #4

		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

masshpc.gov/offices-and-task-forces/pctf#StatutoryDeliverables

Statutory Deliverable #4: Propose Payment Models

Pursuant to Chapter 343 of the Acts of 2024, the PCTF is charged with reporting findings and recommendations to the Massachusetts legislature to **propose payment models to increase public and private reimbursement for primary care services** by March 15, 2026

The PCTF Co-Chairs are developing a proposed draft of this deliverable for submission, including:

- Brief Introduction
- Summary of Task Force Deliberation of Statutory Deliverable #4
- Task Force Recommendations
    1. Advanced Primary Care Model
    2. Payment Model Design Considerations
    3. Multi-Payer Implementation
    4. Monitoring and Accountability

https://masshpc.gov/sites/default/files/PCTFDeliverable3_Establish-a-Primary-Care-Spending-Target.pdf

Introduction

- The primary care crisis in Massachusetts is fueled not only by **underinvestment**, but also by the **misaligned incentives and high administrative burden** exacerbated by traditional fee-for-service (FFS) payment models that drive physician burnout and contribute to workforce shortages.[1]

- One approach to support care delivery transformation in primary care and to improve both patient and provider experience is through **multi-payer primary care payment reform** that shift from FFS to "alternative" or "advanced" payment models that utilize a prospective, capitated payment approach.

- Several health plans and states have enacted policies for advancing this type of primary care payment reform. While there is no one-size-fits-all primary care payment model, research examining these efforts has identified the following three key features for impactful primary care payment reform policy[2]:

    1. Provide a meaningful amount of payment delivered through non-FFS mechanisms, including **prospective payment**
    2. Increase investment in primary care
    3. Improve multi-payer alignment in both efforts

- The Massachusetts Primary Care Access, Delivery, and Payment Task Force (PCTF) recommended in Statutory Deliverable #3 an approach for increasing investment in primary care by establishing a primary care spending target for the Commonwealth.

- As part of this recommendation, the PCTF noted that increases in spending should be prioritized by payer 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**

https://masshpc.gov/sites/default/files/PCTFDeliverable3_Establish-a-Primary-Care-Spending-Target.pdf

1. The Health Policy Commission. (2025, January). A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action.
2. 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.

Summary of Task Force Deliberation of Statutory Deliverable #4

- In deliberations, members agreed that reforming primary care payment so that the health care system better delivers care should be based on the four pillars of primary care: first-contact care, continuity of care, comprehensive care, and coordination of care including the following core goals:

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

Draft PCTF Recommendation: Statutory Deliverable #4

The PCTF recommends the Commonwealth enact the following policies that advance multi-payer primary care payment reform to achieve the core goals stated above.

- **Advanced Primary Care Payment Model:** The Legislature should authorize the development of common goals, features, and specifications for an aligned multi-payer advanced primary care payment model that would be available to all primary care practices in Massachusetts, including independent practices, pediatric practices, federally-qualified health centers, and hospital system-based-practices. The payment model should include key components, such as:
  - Provide a prospective, capitated per member per month (PMPM) payment to primary care practices for a specified set of services;
  - Recognize enhanced care delivery capabilities and quality performance with enhanced payments;
  - Provide for appropriate risk adjustment, including for patient social needs;
  - Establish aligned quality measures and reporting to promote administrative simplification for practices.

Draft PCTF Recommendation: Statutory Deliverable #4

- **Payment Model Design Considerations.** The design of the advanced primary care payment model and components should balance goals of standardization and flexibility, recognizing that not one model fits all providers or payers, and incorporate the following principles :
  - **Alignment with MassHealth**: The advanced primary care payment model design should align with the MassHealth Primary Care Sub-Capitation Program, while allowing for appropriate adjustments reflecting different patient populations and program needs.
  - **Reduce Administrative Burden**: The advanced primary care payment model design should ensure meaningful multi-payer alignment on payer payment reform reporting requirements and parameters to decrease administrative burden. Quality measure reporting should be focused and aligned in the model payment design, in consultation with the Statewide Quality Advisory Committee.
  - **Allow Innovation and Flexibility in Enhanced Care Capabilities**: The advanced primary care model should set appropriate standards for demonstrating enhanced care delivery capabilities for the purposes of additional payment, while allowing for payers and primary care practices to innovate and adapt approaches as needed for their unique circumstances and patient population.

Draft PCTF Recommendation: Statutory Deliverable #4

- **Payment Model Design Considerations (continued)**:
  - **Input from Primary Care Clinicians, Payers, and Technical Experts**: The advanced primary care model should be designed and implemented with input from a range of primary care providers practicing in different settings and treating different patient populations, including, but not limited to, independent practices, pediatric practices, federally-qualified health centers, and hospital system-based-practices, as well as commercial health plans operating in Massachusetts, MassHealth, and the ongoing primary care technical advisory body referenced in Statutory Deliverable #1.
  - **Incorporate Fair Pricing:** The advanced primary care model design should reflect commercial payments that, at a minimum, meet levels indexed to public payer benchmarks to ensure fair pricing across market segments (e.g., for all providers as at least a percentage of Medicare; for FQHCs at least as much as MassHealth).

Draft PCTF Recommendation: Statutory Deliverable #4

- **Multi-Payer Implementation:** The Legislature should require that the advanced primary care payment model be implemented across all payers subject to state jurisdiction. The model should be required to be offered by carriers regulated by the Division of Insurance (DOI) and the state health plans for state employees, retirees, and their dependents provided by the Group Insurance Commission. The Executive Office of Health and Human Services (EOHHS) should seek alignment with the MassHealth Primary Care Sub-Capitation Program.
  - **Self-Insured Plans.** To maximize the efficacy of the advanced payment model in aligning incentives, providing needed resources to enable care redesign, and reducing administrative burden for primary care practices, the model would ideally be implemented across the entire commercial health insurance market. However, in Massachusetts, **~60% of the commercial health insurance market is self-insured**[1] and, because federal law (ERISA) broadly preempts state regulation that relates to employer-sponsored benefits, such plans are not subject to state requirements. Encouragingly, despite this exemption, **self-insured plans in Massachusetts have a very high uptake of state mandated benefits and often choose to mirror state requirements**.[2]

    To facilitate greater uptake of the model within the self-insured market, the Legislature should require that third party administrators offer the payment model to self-insured plans and provide an opportunity for such plans to opt in to the payment model. The state should additionally publicize and promote the value and benefit of adopting the advanced payment model directly to large, self-insured employers. Finally, **the state should explore and consider additional policy and financing options** for extending the model to self-insured employer plans.

1. Center For Health Information and Analysis. (2025, September 22). Enrollment Trends) through March 2025, Private Commercial Enrollment Overview: Market Sector, Product Type, and Funding Type.
2. Massachusetts Division of Insurance. (2020). Summary of 2020 Membership in Employment-Sponsored Self-Funded Health Benefit Plans.

Draft PCTF Recommendation: Statutory Deliverable #4

- **Multi-Payer Implementation (Continued):**

- **Medicare.** To further extend the potential impact of primary care payment reform in Massachusetts, the state should consider and pursue opportunities to participate in Medicare demonstration projects that **align Medicare payment with the principles of the advanced primary care model** and the MassHealth Primary Care Sub-Capitation program, such as the inclusion of prospective, flexible, risk-adjusted payments and enhanced investment in primary care to support team-based care models.

https://www.cms.gov/priorities/innovation/innovation-models/ahead

Draft PCTF Recommendation: Statutory Deliverable #4

- **Monitoring and Accountability:** The Legislature should require that implementation include robust monitoring of the effectiveness of the new primary care payment model, including the impact on patient outcomes and the provider workforce. The Massachusetts Health Policy Commission (HPC), the Center for Health Information and Analysis (CHIA), and DOI should be charged with monitoring implementation of the payment model to ensure:
  - **Model Adherence.** Plans are implementing the standard payment model and adhering to payment, quality measurement, reporting, and risk adjustment specifications.
  - **Model Uptake.** Plans and providers are making progress toward wide adoption of the advanced primary care model. The state should track and annually report on the uptake of the advanced primary care model, including within the self-insured commercial market, and HPC should be directed to make policy recommendations to remove barriers and promote adoption across all payers and providers.
  - **Payment Intended for Primary Care Ultimately Benefits the Primary Care Practice.** Primary care payments through the model are directed to primary practices or for supports that directly benefit primary care practices.
  - **Health Care Affordability.** Increased primary care spending does not increase overall health care expenditure growth or contribute to a net new increase in health insurance premiums and cost-sharing.

Statutory Deliverable #4: Additional Policy Considerations

- **Complementary Goals.** There is an opportunity to pair primary care payment reform with changes to commercial health plan benefit design, such as patient cost-sharing, that will complement the core goals stated above, particularly to "improve patient access and experience" and "reduce administrative burden."
- *Further recommendations for health plan benefit design will be addressed in* ***PCTF Statutory Deliverable #5: Assess the impact of health plan design on health equity and patient access to primary care services****.*
- Additionally, **PCTF members have stressed the importance of reducing administrative expenses for primary care practices** as essential complementary goals to a primary care spending improvement target and primary care payment reform.
- *Further recommendations for reducing administrative burden and complexity will be addressed in* ***PCTF Statutory Deliverable #7: Create short-term and long-term workforce development plans to increase the supply and distribution of and improve the working conditions of primary care clinicians and other primary care workers.***

Agenda

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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

Adjourn

Statutory Deliverable #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

masshpc.gov/offices-and-task-forces/pctf#StatutoryDeliverables

Policy Background: Opportunities for Improving Cost Sharing

Massachusetts policymakers have sought to address the **high and growing burden of out-of-pocket heath 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.

Provisions Related to Cost Sharing in Proposed Legislation

While **H.1370 prohibits cost sharing** for primary care services**, S.867 and 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__ also **eliminates cost sharing and prior authorization** requirements for medically necessary community-based emergency behavioral health services.

November 18, 2025, PCTF Data and Research Workgroup Discussion on Cost Sharing: Key Takeaways

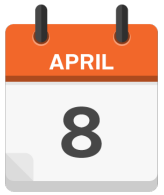
- There is **value in predictability and transparency** in potential cost-sharing for patients.
- **Fragmentation and complexity in the system can lead to errors** resulting in cost-sharing for preventative services where it should not be applied.
- High-deductible plans and concerns of potential out-of-pocket 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?

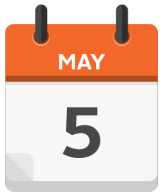
Upcoming Meetings

Workforce Workgroup Meeting
Tuesday, March 31, 2026
2:00 – 3:30 PM (Virtual via Zoom)



Primary Care Task Force Meeting
Wednesday, April 8, 2026
11:00 AM – 1:00 PM (Virtual via Zoom)

Workforce Workgroup Meeting
Tuesday, April 28, 2026
10:00 – 11:30 AM (Virtual via Zoom)



Primary Care Task Force Meeting
Tuesday, May 5, 2026
2:00 – 4:00 PM (In-person)