

Primary Care Access, Delivery, and Payment Task Force

April 8, 2026



MASSACHUSETTS
HEALTH POLICY COMMISSION



EOHHS

Agenda



Call to Order



UP NEXT: Approval of Minutes: March 4, 2026 (VOTE)

Statutory Deliverable #2: Develop a Standardized Set of Data and Reporting Requirements for Private and Public Payers, Providers and Provider Organizations

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

Statutory Deliverable #6: Monitor and Track the Needs of and Service Delivery to Residents of the Commonwealth

Upcoming Meetings

Adjourn

VOTE

Approval of Minutes from the March 4, 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 March 4, 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

Completed PCTF Statutory Deliverables



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
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	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

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Statutory Deliverable #2: Develop a Standardized Set of Data and Reporting Requirements for Private and Public Payers, Providers, and Provider Organizations

- Brief Introduction
- Background
- Summary of Task Force Deliberation of Statutory Deliverable #2
- Task Force Recommendations
 - Attestation and Audit
 - Reporting to the Massachusetts Registration of Provider Organizations (MA-RPO) Program
 - Separate Primary Care Contracts

- **The Center for Health Information and Analysis (CHIA) collects data from payers** on primary care spending and reports on **aggregate spending as well as by payer and managing clinician group.**
 - **Includes fee-for-service payments** for identified primary care services and provider types **as well as non-claims payments.**
- **Non-claims payments** paid pursuant to commercial or public payer contracts can include capitated or prospective payments, value-based payments, infrastructure payments, and surplus payments in a global budget or other risk-based arrangements.
- Payments may be paid to the **contracting entity, accountable care organization (ACO), or physician group** and then distributed to participating groups and/or providers.
- Once payers make payments to provider organizations, **they do not observe how claims and non-claims payments are distributed or allocated within an organization.**

- Provider organizations **have different organizational structures that contract with payers and distribute claims and non-claims payments to employed or participating Primary Care Providers (PCPs)**, including large provider organizations, independent practice associations, multi-specialty practices, and physician hospital organizations.
- **“Funds flow”** is the mechanism for distribution of claims and non-claims revenue or settlements, **is determined internally based on the unique profile and goals of each organization.**
 - Terms are set based on internal governance structures as agreed to in individual or practice group participation agreements. Can be considered proprietary and competitively sensitive.
- Many provider organizations have a management services organization (MSO) or administrative unit that provides contracting and/or a data and reporting infrastructure that **is supported by fees from member practices or PCPs and/or a portion of non-claims payments.**
- Payments from multiple payers **may be pooled with other revenue and distributed** to providers according to internal performance metrics.

Summary of Task Force Deliberations of Statutory Deliverable #2



- In deliberations, PCTF members **confirmed significant gaps in information about payments** to primary care providers **and support for tracking payments to primary care providers** and underscored the need to understand how different organizations, particularly hospital-based health systems, finance and internally support primary care providers.
- Members discussed the **importance of transparency of funds flow to primary care for non-claims payments as well as claims-based payments.**
- At the PCTF Data and Research meeting on July 10, 2025, Dr. Ryan Schwarz shared an overview of the **MassHealth Primary Care Sub-Capitation Program**, which requires distribution of payments to directly support the delivery of primary care services and includes attestation and audit mechanisms.
- Members considered how to **align recommendations for Statutory Deliverable #2 with recommendations for PCTF Statutory Deliverable #4** (proposing payment models to increase reimbursement for primary care services)

Primary Care Task Force Recommendation: Statutory Deliverable #2



The PCTF recommends additional transparency about the flow of primary care payments within health systems through the following mechanisms:

- **Attestation and Audit.** The Legislature should require that primary care practices and provider organizations that participate in the advanced primary care model described in [PCTF Deliverable #4](#) must execute an attestation that payments are paid to or directed to primary care practices in alignment with the MassHealth Sub-Capitation Program, and be subject to payer audits.
- **Reporting to the Registration of Provider Organizations Program.** The Legislature should authorize CHIA and the HPC to collect information on the flow of primary care payments within provider organizations as a required component of the current MA-RPO Program.
 - The MA-RPO Program should prioritize the collection of data and information necessary to understand the financial support provided to primary care providers within hospital-based provider organizations.
 - In developing the MA-RPO reporting requirements, CHIA and HPC should
 - work with Massachusetts provider organizations, payers, and other interested parties to examine the complexity and variation of primary care funds flow and accounting mechanisms.
 - limit administrative burden for provider organizations and primary care clinicians.

- **Separate Primary Care Contracts.** To further facilitate the transparency and accountability of primary care payments within large health systems, payers and providers should work toward establishing distinct primary care payment contracts that are separate from overall health system contracts.
 - Through separate primary care contracts, payers and hospital-based provider organizations should develop contract terms that set clear expectations for the amount and use of payments for primary care within the health system. These contracts should also:
 - Increase the overall share of spending on primary care (consistent with [Deliverable #3](#))
 - Enable to adoption of advanced primary care payment models (consistent with [Deliverable #4](#))
 - Reduce administrative burden (consistent with upcoming Deliverable #7)

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

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While **H.1370 prohibits cost sharing** for primary care services, **S.867 and H.2537** give the proposed 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.

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.^{1,2}
 - [Chapters 342 of the Acts of 2024](#)³ **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.
3. An Act Relative to Pharmaceutical Access, Costs and Transparency, Chapter 342, Acts (2024), The 194th General Court of the Commonwealth of Massachusetts

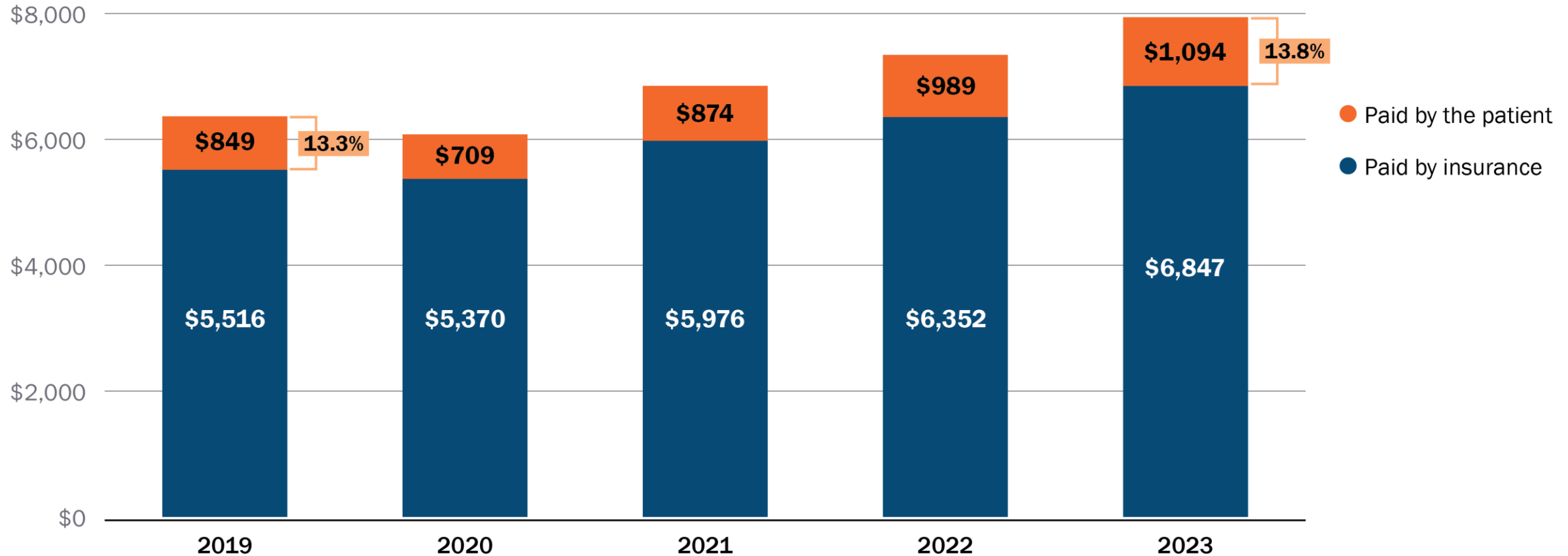
HPC Findings: Trends in Cost Sharing and Opportunities to Improve Benefit Design in Massachusetts

- As discussed in the HPC's [2025 Health Care Cost Trends Report](#), **deductible-based cost sharing benefit designs can result in large bills that are difficult for consumers to anticipate in advance**, including for common primary care services.
- **This type of benefit design can pose equity challenges**, placing Massachusetts residents with limited savings at particular risk of financial harm.

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%).



Commercial spending per member per year by insurer and patient paid amounts, 2019-2023



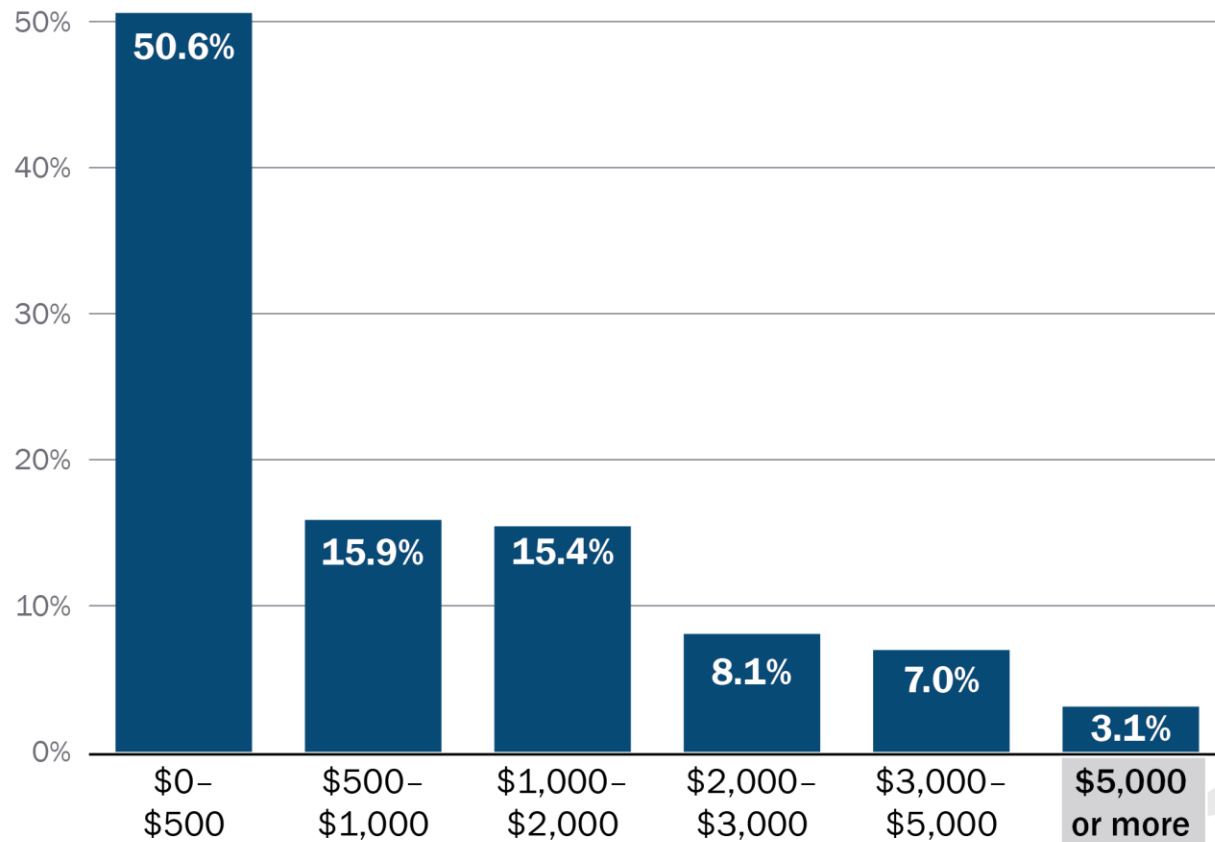
Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization. Pharmacy spending is net of rebates.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019-2023.

The distribution of cost sharing varies dramatically.

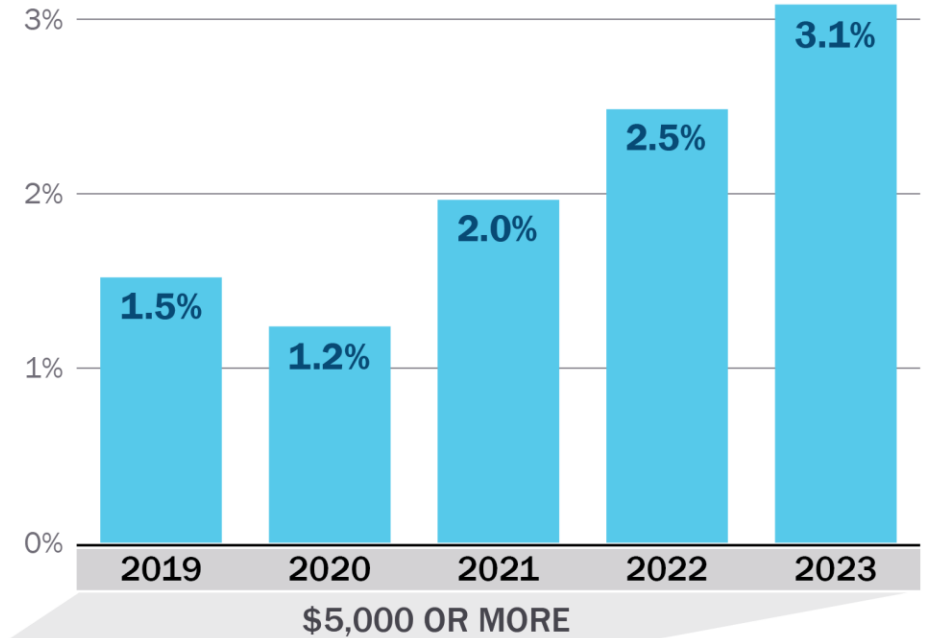


Distribution of cost sharing per member per year in 2023; percent of members with \$5,000 or more in cost sharing per year, 2019-2023

Distribution of out-of-pocket spending per member, 2023



Percentage of members with \$5,000 or more of out-of-pocket expenses, 2019-2023



Notes: Data represents cost sharing among commercial members with full year medical and pharmacy coverage ages 0-64 with any utilization.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2019-2023.

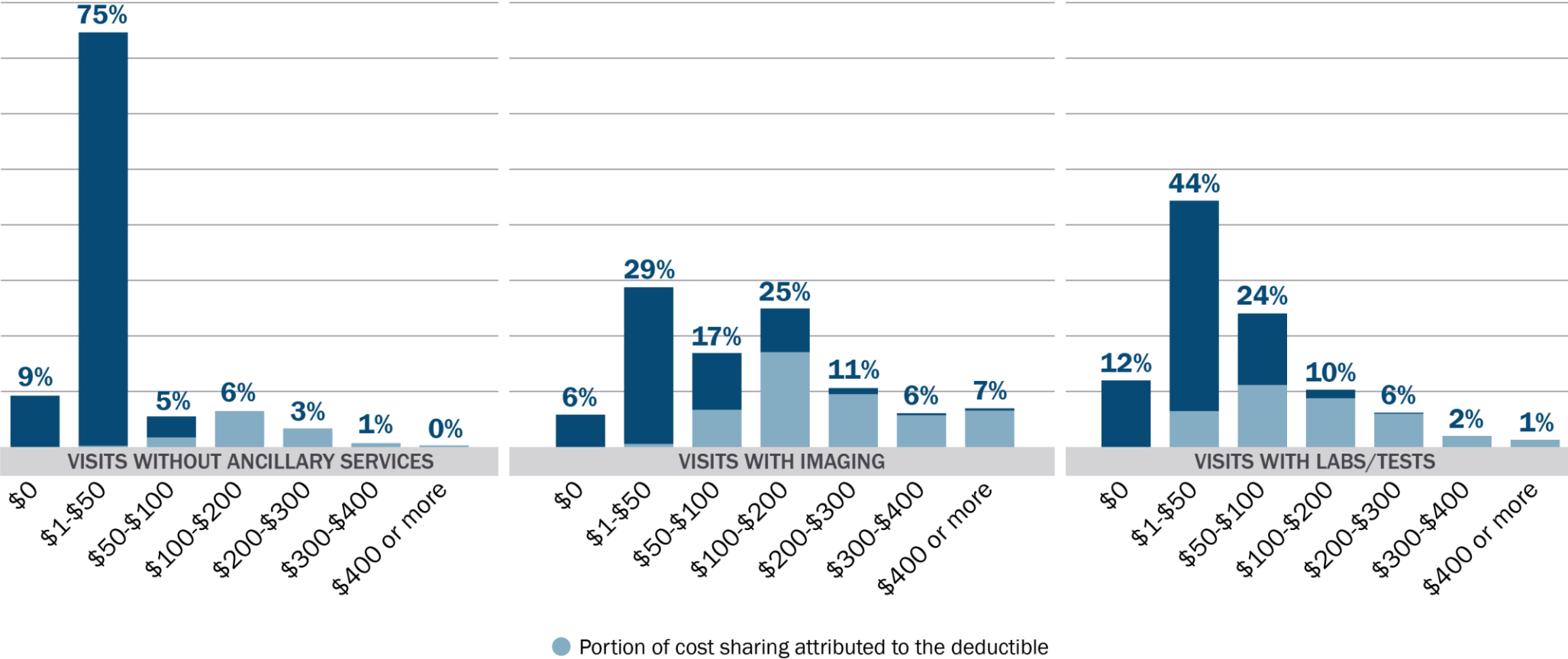
HPC Findings: Trends in Cost Sharing and Opportunities to Improve Benefit Design in Massachusetts

- Average annual commercial **out-of-pocket spending was similar for patients across all community income levels** in 2023, meaning that **it represented a greater financial burden for members with lower incomes.**
- **A large, unexpected medical bill can pose financial risk for households with lower incomes:** if savings are unavailable, paying an anticipated bill can require the use of debt or making tradeoffs in household necessities.
- The **negative impacts** associated with deductibles **are not limited to infrequent and high intensity services** like ED visits and inpatient care. Even when patients seek primary care, deductibles can lead to unpredictable and potentially large bills.
 - A common benefit design **is applying a copay for the primary care office visit itself, while applying the deductible for ancillary services** provided during the visit, such as lab tests or simple imaging.

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.



Distribution of cost sharing for evaluation and management (E&M) problem visits for ten selected diagnoses, 2023



Notes: Data represents episodes at ambulatory settings for ten principal diagnoses (F41, J02, F90, F33, M25, I10, M54, R05, H66, E66). Episodes were defined as same person and date of service as an E&M problem visit procedure code (99201-99215). Episodes were dropped if they occurred on the same day for the same person as an emergency department visit, major surgery, chemotherapy, or other preventive visit. Out of E&M problem visits examined for the selected diagnoses visits without ancillary services represented 51%, visits with imaging represented 5%, and visits with labs/tests represented 20% of the total.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023.

HPC Findings: Trends in Cost Sharing and Opportunities to Improve Benefit Design in Massachusetts

- Deductibles may also result in one or more bills weeks or months after the care is provided, **increasing the potential for patient confusion and financial burden.**
- According to CHIA,¹ in 2025:
 - **20%** of Massachusetts residents **experienced some type of financial burden** related to their health care or health care coverage.
 - Nearly **10%** **reported problems resolving a bill** with a health plan.

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.**

- **Health insurers**, along with employers and brokers, should **consider patient access and affordability in cost sharing design**.
- **Cost sharing should be predictable** in advance of receiving a service, **transparent**, and **easy to understand**, enabling patients to make informed choices and to make a financial plan, such as seeking financial assistance in advance where available.
 - **Deductibles and co-insurance should be minimized and redistributed in the form of episode-based copayments.**
- Cost sharing for **primary care and chronic disease management services should be minimized.**
- Plan design should **minimize the patient administrative burden associated with paying bills.**
- Higher versus lower cost sharing can be used to impact patient decision-making in **specific cost-effective care choices** such as higher value treatment alternatives or sites of care.
- Consumer-friendly reforms to cost sharing benefit design **should not increase the total cost of care**, and should be paired with reforms to address health care costs and improve health care affordability.

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UP NEXT: Statutory Deliverable #6: Monitor and Track the Needs of and Service Delivery to Residents of the Commonwealth

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Statutory Deliverable #6: Monitor and track the needs of and service delivery to residents of the Commonwealth

- Pursuant to [Chapter 343 of the Acts of 2024](#), the PCTF is charged with reporting findings and recommendations to the Massachusetts legislature to **monitor and track the needs of and service delivery to residents of the Commonwealth.**
- The co-chairs are developing a proposed draft of this deliverable for submission, which will include:
 - Brief Introduction
 - A Summary of Task Force Deliberations for Deliverable #6
 - Analysis of Existing Infrastructure in the Commonwealth to Monitor and Track Service Delivery Needs
 - Task Force Recommendations



Existing Infrastructure in the Commonwealth to Monitor and Track Service Delivery Needs



CHIA in partnership with MHQP

- **CHIA**, in partnership with **Massachusetts Health Quality Partners (MHQP)** developed the **Massachusetts Primary Care Dashboard**.
- The dashboard is updated regularly and includes metrics across the following domains: **Finance, Capacity, Care, Access, Equity**.
- The next edition of the dashboard will be released in **June 2026**.

Department of Public Health

- **The Massachusetts Department of Public Health (DPH)** operates programs to support the health care workforce, provide public data and information, and assess the needs of and access to primary care, including: the **State Health Assessment (SHA)** and **State Health Improvement Plan (SHIP)**, the **Primary Care Needs Assessment (PCNA)**, and the **Health Professional Shortage Designations**.

HPC

- Pursuant to [Chapter 343 of the Acts of 2024](#), the HPC's **Office of Health Resource Planning (OHRP)** is responsible for developing a **State Health Resource Plan**, which will provide a broad overview of supply, capacity, utilization, and need across several service and provider types, including primary care.

- Massachusetts has **the necessary authority and infrastructure in place to monitor primary care needs and utilization.**
 - DPH and HPC are explicitly charged with undertaking assessments of primary care supply, capacity, need, and utilization.
 - Both agencies, along with CHIA and MassHealth, have prioritized assessments of primary care access and utilization in the context of their work.

The Commonwealth lacks uniform access standards (e.g., drive times, wait times) to serve as normative guidelines for such assessments, and against which the agencies can assess access patterns regionally and over time.

- **Massachusetts has robust data assets for measuring primary care utilization and some elements of access**, such as:
 - The All-Payer Claims Database
 - The Massachusetts Health Insurance Survey
 - Several federal data assets

- **CHIA's uniform methodology for defining primary care services that can be leveraged to assess need and utilization.**

The Commonwealth lacks established methods for measuring **need based on population demographics and clinical profile** and for assessing the extent to which **unmet need is due to insufficient provider supply or capacity.**

➤ **Massachusetts also has datasets that help measure the supply of primary care providers**, including:

- MA-RPO dataset
- MHQP Massachusetts Provider Database
- Other federal datasets

Primary care supply datasets allow the Commonwealth to estimate PCP counts by geography but **often lack critical detail on provider capacity** (e.g., FTE estimates, patient panel sizes, wait times).

These datasets also may not capture providers working in **concierge or direct primary care models**, which may undercount actual supply levels.

UNIFORM ACCESS STANDARDS



- The Legislature should direct the Office of Health Resource Planning, in consultation with the primary care advisory body, to develop **uniform time, distance, wait time, and provider-to-population ratio standards for primary care access.**
- Such standards would **set clear benchmarks for access** against which the Commonwealth could measure its efforts to measure its progress to improve primary care over time.
- The standards consider relevant federal and other state **standards.**

WAIT TIMES DATA



- HPC should explore methods to **collect data on appointment wait times.** by **provider specialty, insurance type, and office location.**
- Such data will enhance the Commonwealth's **ability to measure access against the uniform access standards** regionally and statewide, over time.

CAPACITY AND ACCESS INDICATORS



- State agencies and other interested stakeholders should **develop methods for collecting or estimating other key indicators of primary care capacity and access**, such as:
 - Primary care provider full-time equivalent (FTE) counts
 - Patient panel size
 - Patient barriers to access
 - Efforts to collect this information should not increase administrative burden on primary care providers

REPORTING FROM DIRECT/CONCIERGE PRACTICES



- The Legislature should **require direct and concierge primary care practices to register with the MA-RPO program**, allowing the Commonwealth to have greater transparency over:
 - Corporate structures
 - Locations where care is delivered
 - Rosters of physicians and APPs
 - Financial information of organizations.

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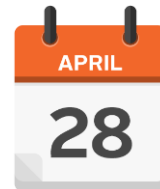
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UP NEXT: Upcoming Meetings

Adjourn

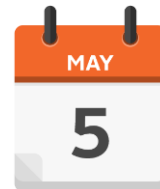
Upcoming Meetings



Workforce Workgroup Meeting

Tuesday, April 28, 2026

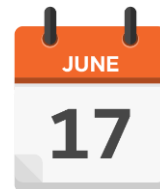
10:00 – 11:30 AM (Virtual via Zoom)



Primary Care Task Force Meeting

Tuesday, May 5, 2026

2:00 – 4:00 PM (Virtual via Zoom)



Primary Care Task Force Meeting

Wednesday, June 17, 2026

10:00 AM – 12:00 PM (in-person at the HPC)

Massachusetts Registration of Provider Organization Program



- The MA-RPO program was authorized in [Chapter 224 of the Acts of 2012](#) for **understanding the diverse composition of provider organizations** and was most recently updated in [Chapter 343 of the Acts of 2024](#).
- The program is jointly **administered by HPC and CHIA** and collects information from approximately **60 provider organizations** annually.
- It is guided by the following principles:
 - administrative simplification
 - avoiding duplicative data requests through coordination with other state agencies
 - balancing the importance of collecting data elements with potential burden to provider organizations
 - phasing in the types of information that provider organizations must report over time.
- It captures information on **majority of primary care providers** (~76%) in the Commonwealth.

- MassHealth pays its Accountable Care Organizations (ACOs) **a monthly capitation for each member enrolled.**
- A portion of this is allocated to the **Primary Care Sub-Capitation Program.**
 - MassHealth develops primary care sub-capitation rates at the tax identification number (TIN) level.
 - A TIN could correspond to a single practitioner, single practice's office site, several sites, or in some cases, a large multispecialty group of providers.
 - ACOs are contractually obligated to make sub-capitation payments to each participating TIN for all members attributed to that TIN each month.
 - If there are multiple unique practices that share one TIN, the ACO or TIN may determine how the base rate is allocated to each practice, as long as each practice's clinical tier is reflected in their payment.
 - TINs will receive the Per Member Per Month (PMPM) payment each month; however, ACOs must adjust payments regularly to accurately reflect changes to MassHealth enrollment or to the practice's patient panel.
- **MassHealth monitors and enforces** ACO payment requirements on a regular basis.