Statutory Deliverable #2: Data and Reporting Requirements for Primary Care Payments

Introduction

The Massachusetts Primary Care Access, Delivery, and Payment Task Force (PCTF) recommended in its first deliverable an approach for defining and measuring primary care spending in Massachusetts, pursuant to Chapter 343 of the Acts of 2024. Recognizing the credible and robust process currently implemented by the Center for Health Information and Analysis (CHIA), the PCTF recommended that Massachusetts rely on CHIA's technical expertise and experience to continue this foundational measurement work, with additional recommendations and considerations. This is a critical first step for establishing a baseline of primary care spending, including as a share of total statewide health care expenditures, by insurance type, by age group, by payer, and by managing clinician groups. In its recommendation to establish a target to increase primary care spending in Deliverable #3, the PCTF emphasized accountability for both payers and providers and recommended that the Legislature enact sufficient enforcement mechanisms to ensure payer and provider compliance with both the spending target and affordability requirements. (see Deliverable #3: Establish a Primary Care Spending Target). To complement such accountability mechanisms, additional reporting mechanisms are necessary to ensure that increased investments in primary care flow directly to primary care providers or are used to directly support primary care practices.

Background

Under the current process, CHIA collects data from payers on primary care spending and reports on aggregate spending as well as by payer and managing clinician group. (See the CHIA Data Specification Manual for discussion of/list of data specifications, etc.). Primary care spending reporting 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 (e.g., bonuses for quality or efficiency), infrastructure payments, and surplus payments in a global budget or other risk-based arrangements. Depending on the provider organization's structure, these 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 types of 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," 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 and can be considered proprietary and competitively sensitive. Terms are set based on internal governance structures as agreed to in individual or practice group participation agreements. Many provider organizations have a management services organization (MSO) or administrative unit that provides contracting, data, and reporting infrastructure that is supported by fees from member practices or PCPs and/or a portion of non-claims payments. Payments from multiple payers may be pooled with other revenue and distributed according to internal performance metrics.

Primary Care Task Force Deliberation: Statutory Deliverable #2

In its discussion at the PCTF Data and Research meeting on July 10, 2025, members cited significant gaps in information about payments to primary care providers. Members also discussed the importance for transparency of funds flow to primary care for non-claims payments as well as claims-based payments. At this meeting, Dr. Ryan Schwarz, PCTF member and Chief of the Office of Accountable Care and Behavioral Health at MassHealth, described MassHealth's 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. While MassHealth has faced challenges in tracking detailed funds flow information, it has been working with CHIA to understand and refine reporting methodologies in order to distinguish non-claims spending that is used for primary care instead of other purposes.

See Description of Sub-Capitation Funds Flow below.

At the PCTF meeting on July 22, 2025, members reiterated their support for tracking payments to primary care providers and the need to understand how different organizations, particularly hospital-based health systems, finance and internally support primary care providers.

At the PCTF meeting on December 3, 2025, members considered draft recommendations developed by the PCTF Co-Chairs and HPC staff. Members acknowledged that the complexity of finance structures across organizations presents significant challenges for standard reporting and emphasized the goal of avoiding additional administrative burdens on practices. Members considered how to align recommendations for Statutory Deliverable #2 with the recommendations for PCTF Statutory Deliverable #4: proposing payment models to increase public and private reimbursement for primary care services.

At several meetings, members discussed the prevalence of hospital system-based primary care where PCPs are employed and contract through the systems and the need to promote independent primary care practices. In discussing primary care payment, for practices employed or contracted through such systems, members urged policies to ensure that increased payments are ultimately directed to the primary care practices. Some members suggested separating primary care practices from hospital systems or requiring separate insurance contracts for primary care providers.

In Statutory Deliverable #4, the PCTF recommended:

> **Payment Intended for Primary Care Ultimately Benefits the Primary Care Practice**. The Massachusetts Health Policy Commission (HPC), the Center for Health Information and Analysis (CHIA), and the Division of Insurance (DOI) should be charged with monitoring implementation of the payment model to ensure primary care payments through the model are directed to primary care practices or for supports that directly benefit primary care practices. Additional recommendations from the PCTF on reporting or other requirements for payers, providers, and provider organizations necessary to ensure transparency and accountability of primary care payments to primary care practices will be included in PCTF Statutory Deliverable #2.

Primary Care Task Force Recommendation: Statutory Deliverable #2

The PCTF recommends additional transparency about the flow of primary care payments within health systems. As a large percentage (76%) of PCPs in Massachusetts are employed by or affiliated with large provider organizations,[1] transparency is necessary for the goals of accountability and primary care

[1] HPC analysis of 2023 Registration of Provider Organizations Provider Database and 2023 IQVIA commercial database

improvement, especially in the context of policies aimed at increasing the share of overall health care spending on primary care. (See Deliverable #3). The PCTF recommends 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 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 to verify that at least 90-95% of payments are supporting primary care practices. As described in Deliverable #4, providers organizations that participate in the advanced primary care payment model should also be accountable through appropriate attestation and audit mechanisms for meeting enhanced practice capabilities and improved patient outcomes that are the goals of the model.

- **Reporting to the Massachusetts Registration of Provider Organizations Program.** The Legislature should authorize CHIA and the Massachusetts Health Policy Commission (HPC) to collect information from registrants on the flow of primary care payments within provider organizations, including claims and non-claims revenue or settlements, as a required component of the current Massachusetts Registration of Provider Organization (MA-RPO) Program (see below for more information on this 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. This should include information funds flow practices and accounting/allocation of expenses for the administration and infrastructure expenses for primary care practices.
    - 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. The agencies should consult with MassHealth and incorporate best practices developed in the MassHealth Primary Care Sub-Capitation Program. The Primary Care Technical Advisory Body (see Deliverable #1) should also advise on the development of such reporting specifications.
    - In developing provider organization reporting requirements, CHIA and HPC should limit administrative burden for provider organizations and primary care clinicians.

- **Separate Primary Care Contracts/Tax Identification Numbers**. 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 the adoption of advanced primary care payment models (consistent with Deliverable #4), and reduce administrative burden (consistent with upcoming Deliverable #7). Separate primary care contracts should not result in an increase in the growth of overall health care expenditure trends or to a net new increase in health insurance premiums and cost-sharing.

  In addition, provider organizations should explore establishing separate tax identification numbers (TINs) for their primary care business units to facilitate the transparent distribution of primary care payments and accounting for system-level administrative, management and infrastructure services.

Providers should work with payers to align payments to separate TINs in alignment with MassHealth's Sub-Cap Program's payment process, described below.

Additional Information

Massachusetts Registration of Provider Organization Program

The Commonwealth currently has a robust process for collecting standardized information on the complex corporate, contracting, and operational structures of provider organizations: *The Massachusetts Registration of Provider Organization (MA-RPO) Program*. The MA-RPO program is a first-in-the nation program for understanding the diverse composition of provider organizations, as authorized in Chapter 224 of the Acts of 2012 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.

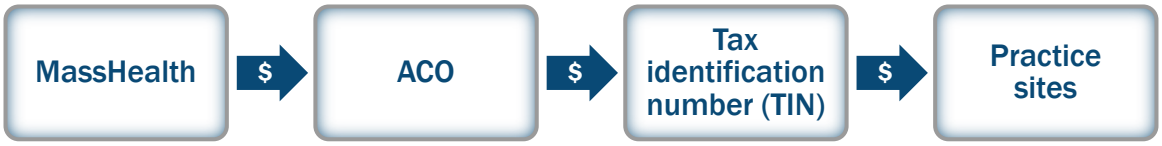
The MA-RPO Program is guided by the following principles: administrative simplification, avoiding duplicative data requests through ongoing coordination with other state agencies, balancing the importance of collecting data elements with the potential burden to provider organizations, and phasing in the types of information that provider organizations must report over time. Importantly, only provider organizations that meet certain size thresholds are required to register.[2] The program currently structures many of its reporting requirements around contracting practices within the system. For example, provider organizations identify which entities in their system establish contracts with payers and which of their owned and affiliated entities participate in each contract. The MA-RPO Program also collects basic questions about provider organizations' funds flow practices and financial performance, upon which more detailed questions could be organized. Additionally, because registering provider organizations report on their relationships with both owned and affiliated organizations, the program captures information on the vast majority of primary care providers (~76%) in the Commonwealth.

MassHealth Accountable Care Organization Sub-Capitation Funds Flow

MassHealth pays the Accountable Care Organizations (ACOs) a monthly capitation for each member enrolled. A portion of this is allocated to the Primary Care Sub-Capitation Program (the "sub-capitation" refers to a capitation that falls within the broader capitation payment to the ACO).

[2] The following provider organizations are required to register with the MA-RPO Program: 1. A Provider Organization, including its corporate affiliates, that (a) collectively receives $25,000,000 or more in annual NPSR from payers, or represents one or more Providers or Provider Organizations that collectively receives $25,000,000 or more in annual NPSR from payers; and (b) has a Patient Panel greater than 15,000 patients or represents one or more Providers or Provider Organizations that have a Patient Panel greater than 15,000 patients. 2. A Provider Organization that has received a risk certificate from the Division of Insurance as part of the Risk-Bearing Provider Organization

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[3],[4]. 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.



[3] Accountable Care Partnership Plan Contract Section 2.23.A.1.h
[4] Primary Care Accountable Care Organization Contract Section 2.14.A.1.h