MASSACHUSETTS PRIMARY CARE ACCESS, DELIVERY, AND PAYMENT TASK FORCE

COMPENDIUM REPORT TO THE MASSACHUSETTS LEGISLATURE

SEPTEMBER 2026

MASSACHUSETTS HEALTH POLICY COMMISSION

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EXECUTIVE SUMMARY

BACKGROUND AND CONTEXT

The issues facing primary care in the Commonwealth are well documented. Recent research has found persistent access challenges for patients and unprecedented challenges of burden and burnout for clinicians, underscoring the need for urgent action to improve the Commonwealth's primary care system.[1]

In 2025, 30.1% of Massachusetts residents reported experiencing difficulty obtaining necessary primary care services in the past 12 months.[2] Patients reported not being able to schedule an appointment as soon as needed, their insurance type not being accepted, or the practice or clinic not accepting new patients.[3] The percentage of Massachusetts residents reporting they had a preventive care visit in the past 12 months decreased from 81.3% in 2023 to 75.1% in 2025.[3] This was disproportionately borne by those residing in Massachusetts communities with lower median incomes, where residents were likely to have had no primary care visits and sometimes no utilization of health care, especially compared to residents of communities with higher incomes.[1]

Though Massachusetts has a generally high number of medical professionals overall, the total share of the physician workforce that has gone into primary care, compared to a specialty, is relatively low. This is also true for the share of new physicians entering primary care compared to other states.[1] High administrative burden and lower reimbursement rates for primary care compared to other medical fields are key factors that discourage new graduates from entering the field of primary care and drive current clinicians to reduce their hours or leave the field entirely. Compounding this issue, Massachusetts has an aging workforce, with 20% of office-based physicians age 65 and older and just 8% of office-based physicians under the age of 35, which means that as more experienced physicians exit the field, they are not being replaced by younger entrants, thus furthering the lack of access to care.[1]

Additionally, spending trends signal persistent underinvestment in primary care. While commercial spending on primary care services in Massachusetts increased from $1.8 billion in 2023 to $2.0 billion in 2024, spending on other services outpaced that of primary care, resulting in a decline in the proportion of commercial primary care spending from 7% in 2023 to 6.6% in 2024.[2]

These challenges have downstream effects on the Commonwealth's health care system and the health outcomes of its residents. Approximately 40% of emergency department (ED) visits in Massachusetts are attributed to potentially avoidable, non-urgent conditions that could be more effectively and affordably treated or prevented in a primary care setting.[4] A 2025 survey of Massachusetts residents found that 54.8% of individuals who visited the ED for a nonemergency condition sought care in that setting because they were unable to get an appointment at a doctor's office or clinic as soon as they needed.[3]

LEGISLATIVE CHARGE

In January 2025, Governor Maura Healey signed Chapter 343 of the Acts of 2024, *An Act Enhancing the Market Review Process.* This historic health care legislation seeks to lower health care costs, cap prescription drug costs, and increase oversight of the health care industry to protect patients and providers. The law established the Primary Care Access, Delivery and Payment Task Force (PCTF) to examine the challenges affecting the essential but fragile primary care system in Massachusetts and develop policy solutions to stabilize and improve primary care access, delivery, and payment. The 25-member task force was co-chaired by the Executive Director of the Massachusetts Health Policy Commission (HPC) and the Secretary of the Commonwealth's Executive Office of Health and Human Services (EOHHS). The membership included primary care clinicians, legislators, payer representatives, and stakeholders from across the health care system.

The PCTF was charged with issuing seven statutory deliverables to stabilize and strengthen the Commonwealth's primary care system.

1. **Define primary care services, codes, and providers**
2. **Develop a standardized set of data and reporting requirements for private and public payers, providers and provider organizations**
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**

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

2 Center for Health Information and Analysis. Massachusetts Primary Care Dashboard. June 2026.

3 Center for Health Information and Analysis. Findings from the 2025 Massachusetts Health Insurance Survey. December 2025.

4 Health Policy Commission analysis of Center for Health Information and Analysis Emergency Department Database, CY2016 – 2022.

4. Propose payment models to increase public and private reimbursement for primary care services
5. Assess the impact of health plan design on health equity and patient access to primary care services
6. Monitor and track the needs of and service delivery to residents of the Commonwealth
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

TASK FORCE MEETINGS AND OPERATIONS

The task force first convened in April 2025 and held 11 public meetings of the full body to deliberate and develop recommendations for each statutory deliverable. The co-chairs convened two smaller workgroups – one on Data and Research and one on Workforce – to conduct focused discussions and develop recommendations for specific deliverables closely aligned with workgroup members' areas of expertise.

The **Data and Research Workgroup** convened for three public meetings to deliberate recommendations for statutory deliverable #1 (define primary care services, codes, and providers), statutory deliverable #2 (develop a standardized set of data and reporting requirements for private and public payers, providers and provider organizations), and statutory deliverable #5 (assess the impact of health plan design on health equity and patient access to primary care services).

The **Workforce Workgroup** convened for six public meetings to deliberate recommendations for statutory deliverable #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).

Key priorities and potential solutions identified during workgroup discussions were shared at the subsequent PCTF meetings for further deliberation amongst all members. For each deliverable, a written draft recommendation that incorporated PCTF member deliberations was shared with PCTF members for written feedback prior to publication.

All meeting materials, including meeting presentations and recordings, can be found on the PCTF webpage on the HPC's website.

SUMMARY OF STATUTORY DELIVERABLES

The PCTF issued recommendations on each of the seven topics identified by the statue on a rolling schedule from April 2025 to June 2026, delivering concrete policy recommendations to policymakers to stabilize the state's health care backbone of primary care. PCTF members agreed that primary care reforms should be based on the four pillars of primary care: first-contact care, continuity of care, comprehensive care, and coordination of care.

The primary policy recommendations and statutory deliverables issued by the task force include:

1. Double State Primary Care Spending (15% Target)

The task force recommended establishing an aggregate **primary care spending target of at least 15%** of total health care expenditures. (Statutory Deliverable #3)

- **The Goal:** This would double the state's historical average of roughly 6.7% over a five-year window, utilizing a newly measured 2026 baseline.
- **Enforcement:** The Commonwealth should direct the HPC to set annual improvement targets and empower HPC, DOI, and other state agencies to hold payers and providers accountable to these requirements and ensure compliance with both the targets and affordability requirements. Any increase in primary care spending 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.
- **Accountability for Payments:** The task force recommended additional transparency and accountability guidelines to ensure that this influx of funding flows directly to primary care clinicians rather than being absorbed by parent health system administrations. (Statutory Deliverable #2)

2. Reform Payment Model and Health Plan Design

To transition away from fee-for-service and other current payment systems, the task force submitted recommendations to:

- **Advanced Primary Care Payment Model:** The Commonwealth should develop common guidelines and a framework for an advanced primary care payment model that would be available to all primary care practices in Massachusetts. This new payment model would encourage providers to transition toward prospective, capitated monthly payments that enable team-based care models (with integrated behavioral health care) and expand access for patients, tailored to patient needs. (Statutory Deliverable #4)
- **Patient-Centered Health Plan Design:** Health plans should work to minimize out-of-pocket cost sharing (high deductibles and copays) for baseline primary care visits and minimize patient and provider administrative burden. Efforts to reduce cost sharing must be coupled with measures to address the underlying drivers of health care costs and improve health care affordability. (Statutory Deliverable #5)

3. Stabilize Workforce and Improve Working Conditions

The task force's dedicated Workforce Workgroup formulated short-term and long-term blueprints to rebuild the primary care pipeline:

- **Fund Primary Care Education:** The Commonwealth should consider resuming funding for Graduate Medical Education (GME) pathways with a specific focus on training for primary care clinicians in community-based settings, including community health centers. (Statutory Deliverable #7)
- **Expand Family Medicine Education and Training:** The Commonwealth should work with large health systems, academic medical centers, and community-based settings to expand the number of family medicine residencies and should implement initiatives that support graduate-level nursing education in the wake of recent federal policy changes to student loans.
- **Reduce Administrative Burden:** The task force recommended reducing sources of administrative burden and burnout for primary care clinicians, including in areas such as credentialing processes, prior authorization requirements, referral practices, quality reporting, and claims submissions. (Statutory Deliverable #7)

4. Standardize Data Definitions and Requirements

To provide greater public transparency of primary care spending trends and how health systems record expenditures, the task force recommended codifying and strengthening the statutory framework:

- **Standardize Definitions:** The Commonwealth should codify the Center for Health Information and Analysis (CHIA) as the agency responsible for explicitly defining which clinical codes, services, and multi-disciplinary providers (including nurse practitioners and physician assistants) qualify under "primary care." (Statutory Deliverable #1)
- **Track Funds Flow to Primary Care Providers:** The Commonwealth should implement standardized data reporting requirements across all public and private payers to effectively track spending and collect information on the flow of primary care payments within provider organizations. (Statutory Deliverable #2)

5. Tracking and Monitoring Need and Service Delivery

To support the existing infrastructure in place to monitor primary care needs and utilization and support proposed new investments in primary care, the task force recommended:

- **Focused Assessment:** The HPC's Office of Health Resource Planning (OHRP) will conduct a focused assessment of primary care need, supply, and access. (Statutory Deliverable #6)
- **Effective Investment in Primary Care:** Improved understanding of provider capacity is necessary for providers, payers, and policymakers to direct their investments effectively, and to quantify the gap between supply and need. (Statutory Deliverable #6)

COMPENDIUM REPORT

This compendium report includes the full text of all seven statutory deliverables,[5] together which provide a bold and meaningful path forward for primary care reform in Massachusetts.

The final recommendations reflect the input of all task force members and were published on a rolling basis on the HPC's website and submitted to the Massachusetts Legislature. Each deliverable includes an introduction and summary background on the topic (including existing state actions or infrastructure where applicable), and an overview of member deliberations and policy recommendations for consideration.

CONCLUSION

Massachusetts has a strong legacy as a national leader on promoting access to affordable, equitable, health care for all residents. As states across the country continue to grapple with the challenges facing the primary care system, the Commonwealth once again has an opportunity to lead on primary care reform to support patients, employers, and the primary care workforce.

Greater investment and support for primary care can ultimately drive down total health expenditures by reducing avoidable emergency department visits and hospitalizations, improving health outcomes, and reducing health disparities.[6] Recognizing that Massachusetts is experiencing a health care affordability crisis,[7] primary care reform efforts must be paired with actions to address underlying drivers of growing health care costs.

Together, these Primary Care Task Force recommendations prescribe critical steps to fundamentally rebalance the Commonwealth's health care resources, equip primary care providers to improve the health and well-being of Massachusetts residents, and stabilize primary care as the front door to the state's world-class health care system.

5 The versions of the deliverables included in this compendium report reflect updated data made available since each recommendation was first published. The original versions are available on the PCTF webpage of the HPC's website.

6 Foubister V. Five States Leading Efforts to Increase Primary Care Spending. The Milbank Memorial Fund. March 12, 2025.

7 Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System, 2026.

Statutory Deliverable #1

DEFINING PRIMARY CARE SERVICES, CODES, AND PROVIDERS

PUBLISHED SEPTEMBER 2025

INTRODUCTION

High-quality primary care encompasses an array of vital services that can meaningfully shape patient outcomes and can lower overall health care expenditures while improving population health. The core functions that characterize effective, person-centered primary care are first-contact care, continuity of care, comprehensive care, and coordination of care.[8] These four pillars of primary care represent the foundation of a high-functioning health care system, yet primary care remains both overburdened and undervalued in Massachusetts and throughout the United States.

Data-driven policy changes, investments, and market reforms are needed to address these significant challenges and improve the Commonwealth's primary care system. Recent research by the Massachusetts Health Policy Commission (HPC) found that primary care spending in Massachusetts grew half as fast as spending on all other medical services from 2017-2022, 11.8% compared to 24.7%.[9] Transparent, comprehensive expenditure data on primary care services in Massachusetts are essential to inform these reforms and are also critical for setting and tracking investment improvement targets.

Understanding the importance of measuring primary care for evidence-based reforms, nearly 20 states have developed methods for measuring primary care spending. While there is no national consensus for measuring primary care spending and variation exists in data specifications across states (e.g. California, Connecticut, and Rhode Island), total primary care expenditures are generally measured by collecting data on primary care services delivered by primary care providers.[10] In Massachusetts, the Center for Health Information and Analysis (CHIA) measures primary care spending using a similar means.

CHIA's methodology for measuring primary care expenditures was developed in 2019 by leveraging standard billing codes, aligning with other states' approaches, and through a public listening session with stakeholders.[11] Since 2020, CHIA has collected summary-level data from health insurers to measure overall spending on primary care and behavioral health services covered by insurance. The recent *Massachusetts Primary Care Dashboard* published in June 2026 by CHIA in collaboration with the Massachusetts Health Quality Partners found that, in 2024, the share of primary care spending declined among commercial payers, and only grew from 4.1% to 4.2% for Medicaid Advantage. However, MassHealth had the highest growth in and percentage of spending on primary care (8.4% in 2024 compared to 7.5% in 2023).[12]

Once a method for measurement is established, many states have pursued investment targets for primary care system improvement. This was a topic of active consideration by the Massachusetts Primary Care Access, Delivery, and Payment Task Force (PCTF) and recommendations for a primary care spending target were published in Statutory Deliverable #3, pursuant to Chapter 343 of the Acts of 2024. The PCTF was charged with developing a series of recommendations to stabilize and strengthen the primary care system across Massachusetts, including the first statutory deliverable to define primary care services, codes, and providers in Massachusetts outlined below.

PRIMARY CARE TASK FORCE RECOMMENDATION

CHIA has already developed and implemented a highly credible and robust process for defining and measuring primary care spending in Massachusetts. The PCTF recommends that the Commonwealth of Massachusetts rely on CHIA's technical expertise and experience to continue this foundational measurement work, critical for informing policies to increase investment in primary care and other strategies to strengthen primary care access, delivery, and financial stability. To effectuate this goal, the PCTF further recommends the following:

» **Designated Agency:** The Legislature should codify CHIA as the agency responsible for defining, measuring, and reporting

8 Starfield B, Shi L, Macinko J. (2005) Contribution of primary care to health systems and health. *Milbank Quarterly*, 83(3), 457-502. https://doi:10.1111/j.1468-0009.2005.00409.x

9 The Health Policy Commission. (January 2025). A dire diagnosis: The declining health of primary care in Massachusetts and the urgent need for action. https://masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and

10 Foubister V. (2025) Five states leading efforts to increase primary care spending. *The Milbank Memorial Fund*. https://www.milbank.org/publications/states-lead-efforts-to-increase-primary-care-spending/

11 Massachusetts Center for Health Information and Analysis. Payer Data Reporting: Primary and Behavioral Health Care Expenditures. https://www.chiamass.gov/payer-data-reporting-primary-and-behavioral-health-care-expenditures

12 Massachusetts Center for Health Information and Analysis. (2026) *Massachusetts Primary Care Dashboard*. https://www.chiamass.gov/wp-content/uploads/2026/06/MA-PC-Dashboard-2026.pdf. Note that MassHealth financing differs substantially from Medicare and commercial payers.

on primary care spending in Massachusetts and authorize CHIA to require such reporting from payers and providers as is necessary for these purposes.

- **Transparent Methodology:** The Legislature should require that CHIA develop and publicly post its detailed methodology and data specifications for defining and measuring primary care spending based on summary-level reporting from commercial and public payers. The methodology should incorporate a designated list of primary care services by codes, a list of provider types, and non-claims payments to support primary care. In developing the methodology, CHIA should be informed by methodologies used in other states, and, to the extent appropriate, should align its methodology with those used in other states, particularly those used in neighboring states, to allow for cross-state comparisons. CHIA should include a comparison of its methodology to alternative approaches. CHIA should finalize data specifications and require data collection within six months of the legislation's effective date.
- **Annual Review Process:** The Legislature should require that CHIA establish an annual process for reviewing and revising as necessary its methodology for measuring primary care spending. The process should include consultation with a Primary Care Advisory Body, other states, and experts.
- **New Primary Care Technical Advisory Body:** The Legislature should establish an ongoing primary care technical advisory body to advise and provide technical input on CHIA's data specifications, methodology, measurement, and reporting. The Legislature should consider including the following members to the advisory body: primary care providers, behavioral health providers, health systems, community health centers, health plans, and government agency representatives, including HPC, MassHealth, the Department of Public Health, the Division of Insurance, and technical experts in health care spending measurement.
- **Annual Reporting:** The Legislature should require CHIA to report annually on spending on primary care in Massachusetts, including as a share of total statewide health care expenditures, by member, by insurance type, by a range of age groups, by payer, and managing clinician group[13]. HPC should include primary care spending trends in its annual cost trends report, including complementary analyses based on data from the All-Payer Claims Database (APCD), and make corresponding policy recommendations.[14]
- **Spending Target Measurement:** CHIA's annual reporting should be used for the purposes of setting a primary care spending target (further defined by the PCTF in Statutory Deliverable #3). CHIA should consider the inclusion of pharmaceutical spending data as appropriate in the calculation in order to ensure clear incentives and accountability for the state, market actors, and the public to be able to track meaningful progress on spending targets (as recommended by the PCTF).

SUMMARY OF CURRENT CHIA METHODOLOGY AND ANNUAL UPDATE PROCESS

- **Modular Methodology:** CHIA calculates spending on primary care by first classifying if the service is (1) a specified service type (based on CPT/HPCPCS code) and (2) delivered by a primary care provider type (based on taxonomy code). Service types and provider categories (physician, other professional, facility) are modular and can be included or excluded in the total primary care measurement based on purpose.
- **Service Classification:** The service types include problem-focused office visits, preventive office visits, chronic care management, immunizations/injections, home/nursing facility visits, screenings and assessments, and integrated behavioral health care. The full list of service codes is available in CHIA's *Primary Care and Behavioral Health Care Data Specification Manual* on CHIA's website.
- **Provider Types:** The designated provider types include a range of provider specialties including family medicine, internal medicine, general practice, pediatrics, OB/GYN, adolescent, and geriatric medicine. Professionals include physicians, registered nurses, nurse practitioners, and physician assistants. The full list of provider codes is available in CHIA's *Primary Care and Behavioral Health Care Data Specification Manual* on CHIA's website.
- **Insurance Type Covered:** CHIA's primary care analysis includes approximately 80% of Massachusetts residents with primary medical coverage through private commercial insurance (including self- and fully insured, and Connector plans), MassHealth, Medicare Advantage, and Senior Care Options (SCO), One Care, Programs for All-Inclusive Care for the Elderly (PACE).

13 "Managing clinician group" has historically been referred to as "managing physician group" in CHIA and HPC reports.

14 If, in any year, CHIA makes substantial changes to their methodology for defining and measuring primary care, CHIA should note caveats and implications for longitudinal analysis public report notes.

» CHIA's current annual calendar for data collection and reporting is detailed below:

TIMELINE	ACTIVITY
SUMMER	CHIA releases updated draft data specifications for comment period
FALL	• Payers report data to CHIA • CHIA performs QA and releases results to payers and providers
SPRING	Report released

ADDITIONAL POLICY CONSIDERATIONS

In developing this recommendation, the PCTF discussed a number of known limitations with the current methodology as well as further considerations which CHIA should explore and seek to address in the future, to the extent feasible, including:

» **Inclusion of Original Medicare data:** While Medicare Advantage members as well as dually eligible members are included in CHIA's primary care spend methodology, primary care services covered by original Medicare is excluded due to data availability. CHIA can explore Centers for Medicare and Medicaid Services (CMS) data sources.

» **Identification, measurement, and inclusion of services for patients that are delivered by primary care providers but are not billed through insurance codes:** Primary care providers often provide services for which they are unable to bill through insurance, such as answering messages submitted by patients through electronic patient portals after hours, providing behavioral supports or treatment plan consultation with schools or other care team members, or assisting with social and behavioral resource navigation. CHIA should explore ways to measure this unbilled primary care work.

» **Consider inclusion of other professionals that provide services in a primary care setting:** Non-physician professionals, such as social workers, care coordinators, clinical pharmacists or patient navigators may be members of care teams who provide services that enhance patient-centered primary care delivery. CHIA should explore capturing delivery of these services as part of primary care spending.

» **Inclusion of spending on behavioral health integration and associated time spent on care delivery:** In addition to including behavioral health screenings and services, such as medication management, CHIA should consider behavioral health services delivered through an integrated behavioral health model in primary care spending.

» **Measuring spending for primary care providers engaged in direct contracts with employers or who offer services that are not reimbursed through the health insurance plans (e.g. direct primary care, concierge):** The market for concierge medicine and direct primary care has been increasing.[15] As more clinician and consumers opt for these models, CHIA may explore methods for measuring this spending.

» **Inclusion of OB/GYN provider spending only for primary care services (e.g. wellness visits but not childbirth):** Because most maternity care payments use global codes, CHIA's current methodology includes both pre-natal visits and labor and delivery services in primary care spending. CHIA should consider refining the methodology to exclude childbirth.

15 Song, Z., & Zhu, J.M. (2025). Primary care — from common good to free-market commodity. The New England Journal of Medicine, 392(20): 1977-1979. https://www.nejm.org/doi/full/10.1056/NEJMp2501717

Statutory Deliverable #2

DATA AND REPORTING REQUIREMENTS FOR PRIMARY CARE PAYMENTS

PUBLISHED MAY 2026

INTRODUCTION

The Massachusetts Primary Care Access, Delivery, and Payment Task Force (PCTF) recommends 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 recommends 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 Statutory Deliverable #3, the PCTF emphasizes accountability for both payers and providers and recommends that the Legislature enact sufficient enforcement mechanisms to ensure payer and provider compliance with both the spending target and affordability requirements. (See *Statutory 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 *CHIA's Primary Care and Behavioral Health 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

In 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, PCTF Member Dr. Ryan Schwarz, Medicaid Director and Assistant Secretary for 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 Massachusetts Health Policy Commission (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 by and/or contract through the systems and the need to promote independent primary care practices. In discussing primary care payment, for practices employed by and/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 recommends:

> **Payment Intended for Primary Care Ultimately Benefits the Primary Care Practice.** The HPC, 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 are included in Statutory Deliverable #2.

PRIMARY CARE TASK FORCE RECOMMENDATION

The PCTF recommends additional transparency about the flow of primary care payments within health systems. As a large percentage of PCPs in Massachusetts (76%) are employed by or affiliated with large provider organizations,[1] transparency is necessary for the goals of accountability and primary care improvement, especially in the context of policies aimed at increasing the share of overall health care spending on primary care. (See Statutory 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 Statutory 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 Statutory 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 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 Organizations (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 on funds flow practices and accounting/allocation of expenses for administration and infrastructure for primary care practices.
  - In developing the MA-RPO Program 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 Statutory 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

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

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 Statutory Deliverable #3), enable the adoption of advanced primary care payment models (consistent with Statutory Deliverable #4), and reduce administrative burden (consistent with Statutory 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-Capitation Program's payment process, described below.

ADDITIONAL INFORMATION

Massachusetts Registration of Provider Organizations 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 Organizations (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 most recently updated in Chapter 343 of the Acts of 2024. The program is jointly administered by the 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 (approximately 85%) 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).

MassHealth develops primary care sub-capitation rates at the 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.

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

3 See: Accountable Care Partnership Plan Contract Section 2.23.A.1.h

4 See: Primary Care Accountable Care Organization Contract Section 2.14.A.1.h

Statutory Deliverable #3

ESTABLISH A PRIMARY CARE SPENDING TARGET

PUBLISHED DECEMBER 2025

INTRODUCTION

Despite evidence that access to high-quality primary care is associated with increased health outcomes and lower health care costs, only five to seven cents of every health dollar is spent on primary care in the United States.[1] In 2021, the U.S. spent 4.7% of its total health care spending on primary care, compared to an average of 14% in other high-income nations, many who rank higher in health outcomes than the US.[2] In Massachusetts, primary care spending as a percentage of all commercial health care spending was 6.6% in 2024, and is declining.[3]

To address this underinvestment, many states have passed legislation to increase the proportion of total health care spending directed to primary care. In 2024, California's Office of Health Care Affordability set a goal of increasing primary care spending to 15% of total medical expenditures by 2034.[4] In 2017, Oregon set a primary care expenditure target of at least 12% for all payers to be reached by 2023. Though this benchmark is not enforceable, the Oregon Health Authority can require carriers that do not reach the target to submit a plan to increase spending on payment for primary care as a percentage of total health expenditures by at least one percent each plan year.[5] In March 2025, the Rhode Island Office of the Health Insurance Commissioner set a primary care expenditure obligation of 10% of total medical spending by 2028.[6]

1 Koller, C., Bianco, D., Greene, K., Hraber, M., Wilkniss, S. (2025). Implementing high-quality primary care: A policy menu for states. *The National Academy for State Health Policy and Milbank Memorial Fund*. https://www.milbank.org/publications/implementing-high-quality-primary-care-a-policy-menu-for-states/

2 Gumas, E.D., Lewis, C., Horstman, C., Gunja, M.Z. (2024, March 28). Finger on the pulse: The state of primary care in the U.S. and nine other countries. *The Commonwealth Fund*. https://www.commonwealthfund.org/publications/issue-briefs/2024/mar/finger-on-pulse-primary-care-us-nine-countries

3 Massachusetts Center for Health Information and Analysis. (2026). *Massachusetts Primary Care Dashboard*. https://www.chiamass.gov/wp-content/uploads/2026/06/MA-PC-Dashboard-2026.pdf

4 Department of Health Care Access and Information. (2024, October 22). California sets benchmarks for primary care investment to promote high-quality, equitable health care. *California Department of Health Care Access and Information News*. https://hcai.ca.gov/california-sets-benchmarks-for-primary-care-investment-to-promote-high-quality-equitable-health-care/

5 Primary Care Payments Act, 2017 Ore. Laws ch. 489, § 3 https://olis.oregonlegislature.gov/liz/2017R1/Measures/Overview/SB934

6 Rhode Island Office of the Health Insurance Commissioner (2026). Primary Care Spending and Utilization in Rhode Island. https://rhodeislandcurrent.com/wp-content/uploads/2026/05/OHIC-Primary-Care-Report-2026_final-v2.pdf

PRIMARY CARE TASK FORCE DELIBERATION

At the Massachusetts Primary Care Access, Delivery, and Payment Task Force (PCTF) meeting on June 17, 2025, Christopher Koller, President of the Milbank Memorial Fund, gave a guest presentation, *Increasing Primary Care Spending Rates in Massachusetts: Lessons from Other States*, and provided insights on how best to set a target for increasing spending in primary care. This presentation provided the PCTF with a guiding framework, design questions, and a set of principles for establishing a primary care spending target here in Massachusetts.

At the PCTF meeting on July 22, 2025, task force members reflected on available state data regarding primary care spending from the Center for Health Information Analysis (CHIA) 2025 *Primary Care Dashboard* and reviewed legislative proposals calling for a spending target in Massachusetts. Drawing on their experience and expertise in the Massachusetts primary care landscape, they provided their feedback on the primary care spending target design questions shared by Mr. Koller. HPC staff then developed a draft proposal incorporating this feedback and presented it to members at the PCTF meeting on September 17, 2025 before further task force deliberation at the December 3, 2025 meeting.

Through this work, the PCTF has developed the following recommendations for establishing a primary care spending target for private and public health care payers, pursuant to Chapter 343 of the Acts of 2024.

PRIMARY CARE TASK FORCE RECOMMENDATION

The PCTF recommends the Commonwealth of Massachusetts take bold action by setting an aggregate primary care spending target with a timeline that reflects the urgency of the current crisis in primary care. This recommendation is a necessary goal that is aligned with best practices put forth by policy experts, recent primary care reform legislation passed in other states, and pending legislation in Massachusetts. If achieved, Massachusetts will be a national leader among states in rebalancing its health care system to one that prioritizes sustainable primary care, supports and strengthens the primary care workforce, and delivers more accessible, efficient, effective, and equitable care to patients.

- **Primary Care Spending Target.** The Legislature should establish an aggregate primary care spending target for the Commonwealth that is equivalent to either (1) doubling the share of health care spending on primary care as a percentage of total health care spending or (2) 15%, whichever is greater, within five years from the base-line year 2026, with improvement measured annually.
- **Health Care Affordability.** The Legislature should ensure that any increase in primary care spending 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 and should authorize the Massachusetts Health Policy Commission (HPC) and the Division of Insurance (DOI) to hold payers and providers accountable for any such increases.
- **Designated Agencies.** The Legislature should direct the Commonwealth's independent agencies focused on health care policy, planning, workforce, and data to oversee the primary care spending target for the Commonwealth.
  - The HPC is broadly charged in M.G.L. c. 6D to "monitor the reform of health care payment and delivery system in the commonwealth", to "set health care cost goals", and to set "goals to reduce health care disparities" and has considerable experience and expertise to implement such an initiative. Chapter 343 of the Acts of 2024 also created the new HPC Office of Health Resource Planning, charged with using robust data analysis and strategic planning to promote the alignment of health care resources and population needs, which further adds to HPC's strong expertise to implement this work. HPC should, following the base-line year measurement by CHIA (see below), establish annual, measurable improvement targets to meet the primary care spending target. These targets should apply to both payers and providers. Following the initial five-year period, the HPC should be provided the flexibility to set new five-year and annual improvement targets. Throughout, the HPC should develop additional policy recommendations to advance the successful attainment of the primary care spending target and other complementary goals.
  - CHIA has established a robust methodology for defining, measuring, and reporting on primary care spending in Massachusetts. This spending is reported by payers and calculates spending on primary care services and as a percentage of total medical spending by insurance type, by Per Member Per Month (PMPM), and by providers (through managing clinician groups). For commercial payers, this reporting includes both fully-insured and self-insured spending (full claims), to ensure monitoring across the commercial market. As further described in Statutory Deliverable #1, the Legislature should also require CHIA to report annually on spending on primary care by a range of age groups, to enable monitoring of primary care spending trends for pediatric populations and other age groups. The spending calculations for 2026 should be the base-line year to establish the primary care spending improvement target and inform the annual improvement targets.
  - Additionally, the agencies should rely on information collected from provider organizations through the Massachusetts Registration of Provider Organizations (MA-RPO) Program (see Statutory Deliverable #2) to monitor progress and ensure that the additional spending is increasing support for primary care practices within, or affiliated with, larger provider organizations.
- **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 are included in Statutory Deliverable #4.
- **Accountability.** The Legislature should authorize the HPC, DOI, and other state agencies to hold payers and providers accountable to these requirements and to establish sufficient enforcement mechanisms in statute to ensure compliance with both the targets and affordability requirements. Based on CHIA reporting, HPC should monitor primary care spending trends by payers and providers and require organizations to take steps to increase spending on primary care, including pediatrics, subject to penalties if annual improvement targets are not met. The Legislature should authorize the HPC to impose compulsory performance improvement plans that achieve measurable improvement in meeting the annual improvement targets and consider monetary penalties commensurate with spending deficiencies. HPC and DOI should receive data in their performance improvement plan review process and premium filings, respectively, and take the necessary steps to ensure that any increase in primary care spending does not lead to an increase in the growth of overall health care expenditure trends or to a net new increase in health care premiums and cost sharing.

ADDITIONAL POLICY CONSIDERATIONS

Complementary Goals: PCTF members have stressed the importance of transforming primary care delivery and reducing administrative expenses for primary care practices as essential complementary goals to a primary care spending improvement target.

Payment and practice reforms are addressed in recommendations included in Statutory Deliverable #4: Propose Payment Models to Increase Public and Private Reimbursement for Primary Care Services.

Detailed recommendations for reducing administrative burden and complexity are addressed in 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.

Statutory Deliverable #4

PAYMENT MODELS TO INCREASE REIMBURSEMENT FOR PRIMARY CARE

PUBLISHED MARCH 2026

INTRODUCTION

The primary care crisis in Massachusetts is fueled not only by underinvestment, but also by misaligned incentives and high administrative burden exacerbated by traditional fee-for-service (FFS) payment models that drive burnout for physicians and advanced practice providers and contribute to workforce shortages.[1] One approach to support care delivery redesign in primary care to improve both patient and provider experience is shifting towards multi-payer aligned Alternative Payment Models (APM). APMs are a value-based reimbursement approach designed to reward providers for delivering high-quality, coordinated, and cost-effective care rather than for the volume of services provided. Several health plans and states have enacted policies for advancing APMs for primary care, with many focusing on models that utilize a prospective, capitated payment approach that enables comprehensive, patient-centered care. While there is no one-size-fits-all primary care APM, research examining these efforts has identified the following three key features for impactful primary care APM policy:[2]

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

In Statutory Deliverable #3, the Massachusetts Primary Care Access, Delivery, and Payment Task Force (PCTF) recommends an approach for increasing investment in primary care by establishing a primary care spending target. As part of this recommendation, the PCTF notes that increases in spending should be prioritized by payers and providers to support the adoption of innovative payment models in alignment with the four pillars of person-centered primary care delivery: first-contact care, continuity of care, comprehensive care, and coordination of care. In Statutory Deliverable #4, the PCTF recommends the principles necessary to achieve this goal.

1 The Health Policy Commission. (January 2025). A dire diagnosis: The declining health of primary care in Massachusetts and the urgent need for action. https://masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and

2 Gold S, Leggott K, Hemeida S, Karra L, Ram A, Hughes LS. (April 2025) *State policies to advance primary care payment reform in the commercial sector.* The Eugene S. Farley, Jr. Health Policy Center. https://medschool.cuanschutz.edu/docs/librariesprovider231/default-document-library/CommercialPCReform-Report.pdf

PRIMARY CARE TASK FORCE DELIBERATION

At the PCTF meeting on October 29, 2025, the co-chairs shared examples of policies to advance primary care payment reform enacted for the commercial sector in Colorado, Delaware, and Rhode Island. PCTF member Dr. Ryan Schwarz, Medicaid Director and Assistant Secretary for MassHealth, provided a brief overview of the MassHealth Primary Care Sub-Capitation Program, and members reviewed APMs for primary care proposed in pending legislation in Massachusetts.

At the PCTF meeting on March 4, 2026, members reviewed proposed recommendations for this deliverable. During this meeting, members expressed support for the principles of multi-payer alignment in primary care payment reform, discussed the need to support practices as they transition to the new model, and considered the need to balance standardization and flexibility in model design. Members discussed the importance of extending primary care payment reform to the self-insured commercial market and the barriers states face to mandate participation due to the federal Employee Retirement Income Security Act (ERISA). Some members expressed support for a single public financing mechanism for primary care, carving these services out of commercial insurance, as a way to address this limitation.

At several meetings, members discussed the prevalence of hospital system-based primary care where Primary Care Providers (PCPs) are employed by and/or contracted through the systems and the need to promote independent primary care practices. For practices employed by and/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 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 providers to "provide the right care, at the right time, in the right location" that meets patients where it is 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.

Member deliberations guided the development of the PCTF recommendation for this deliverable.

PRIMARY CARE TASK FORCE RECOMMENDATION

To achieve the core goals stated above, the PCTF recommends that the Commonwealth of Massachusetts should enact the following policies that advance multi-payer primary care payment reform.

Advanced Primary Care Payment Model

The Legislature should authorize the development of common guidelines and a framework for an 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 (FQHCs), and hospital system-based-practices, and all patients. 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.
- Support enhanced care delivery capabilities and recognize quality and outcome performance with enhanced payments.
- Provide for appropriate risk adjustment that includes adjustment for patient social needs to reduce disparities.
- Establish aligned quality and outcome measures and reporting to promote administrative simplification for practices.

Payment Model Design Considerations

The design of the advanced primary care payment model and components should balance principles of standardization and flexibility, recognizing that not one model fits all providers or payers, and abide by the following considerations:

- **Alignment with MassHealth.** The advanced primary care payment model design, including but not limited to a capitated payment methodology and funds flow accountability, 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, consistent with standard quality measure set as determined by the Statewide Quality Advisory Committee (SQAC).
- **Promote Enhanced Care Capabilities and Quality Performance.** The advanced primary care model should provide additional payment for primary care practices that maintain or improve high quality and outcome performance and should support practices to enhance care delivery capabilities, including team-based care, with an approach that allows payers and primary care practices to innovate and adapt as needed for their unique circumstances and patient population.
- **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, FQHCs, 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.
- **Pediatric Care Differences.** The advanced primary care model should incorporate differences in providing primary care to adult and pediatric populations.
- **Incorporate Fair Pricing.** The advanced primary care model design should provide fair pricing for primary care across market segments in line with increased investment. Commercial payment levels should reflect appropriate public payer benchmarks (e.g., for all providers at least a percentage of Medicare; for FQHCs at least as much as MassHealth), while consistent with the health care affordability principles articulated below.

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 (GIC) for all new and renewing contracts. 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 primary care 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, 60.7% of the commercial health insurance market is self-insured[3] 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 often choose to mirror state requirements and have a high uptake of state mandated benefits.
  - 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 offering the advanced payment model directly to self-insured employers.
  - The Legislature should further explore additional policy and financing options for extending the model to self-insured employer plans, including study and consideration of a single payer public financing system for primary care.
- **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.[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 and providers 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 the 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 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 are included in Statutory Deliverable #2.
- **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 other components of health system contracts.
- **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. The Legislature should consider appropriate oversight mechanisms, as further described in Statutory Deliverable #3.

3 Center For Health Information and Analysis. (2025). Enrollment Trends through March 2025, Private Commercial Enrollment Overview: Market Sector, Product Type, and Funding Type. https://www.chiamass.gov/enrollment-in-health-insurance

4 Centers for Medicare & Medicaid Services. AHEAD (Achieving Healthcare Efficiency through Accountable Design) Model. https://www.cms.gov/priorities/innovation/innovation-models/ahead

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

PCTF members have also stressed the importance of reducing administrative expenses for primary care practices as an essential complementary goal to a primary care spending improvement target and primary care payment reform.

> *Further recommendations for reducing administrative burden and complexity are addressed in 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.*

Statutory Deliverable #5

ASSESS THE IMPACT OF HEALTH PLAN DESIGN ON HEALTH EQUITY AND PATIENT ACCESS TO PRIMARY CARE SERVICES

PUBLISHED MAY 2026

INTRODUCTION

Health care affordability ranks as a top concern among Massachusetts residents.[1] As health care costs continue to rise, growth in two key features of health insurance benefit design – health insurance premiums and cost sharing – is straining household budgets.[2] From the insured's perspective, premiums are fixed costs in a household's monthly budget, whether deducted from an employee's paycheck or paid directly to the insurer, while out-of-pocket health care spending (cost sharing) are variable costs that individuals and families often are not able to plan for. If these costs pose a financial challenge, the consumer may forgo care, incur medical debt, or cut back on other necessities. Together, premiums and cost sharing reflect underlying health care costs which continue to grow steeply; the balance between the two requires significant trade-offs. Efforts to constrain or reduce cost sharing should therefore be paired with policy reforms to address the underlying drivers of health care spending to ensure that premiums do not increase.

In Statutory Deliverable #4, the Massachusetts Primary Care Access, Delivery, and Payment Task Force (PCTF) recommends that the Legislature should authorize the development of common guidelines and a framework for an 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 (FQHCs), and hospital system-based-practices, and all patients in Massachusetts. As part of this recommendation, the PCTF advises that 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."

PRIMARY CARE TASK FORCE DELIBERATION

At the PCTF Data and Research Workgroup meeting on November 18, 2025, workgroup members reviewed key findings and policy recommendations from the Massachusetts Health Policy Commission (HPC) *2025 Annual Health Care Cost Trends Report and Policy Recommendations*. The presentation included a brief policy background on cost sharing, opportunities to improve out-of-pocket costs for Massachusetts residents, trends in growth in average cost sharing and deductible spending per resident, trends in cost sharing by type of service, the effect of ancillary services provided at office visits on unanticipated cost sharing, and an analysis of cost sharing for preventive services. Members also reviewed considerations for health insurers to design more consumer-friendly cost sharing benefits, examples from payers and public employers who have implemented innovative cost sharing strategies, and policy options to improve cost sharing predictability and affordability. (See HPC Findings below.)

At the PCTF meeting on April 8, 2026 the full task force membership was also briefed on key findings and policy recommendations from the HPC's research on trends in cost sharing. After the presentation, task force members engaged in discussion about the impact of high deductibles and out-of-pocket costs on patient access to primary care services. Many of the clinicians on the task force described experiences with patients who would ration care for themselves and their families or refrain from bringing up medical concerns out of fear the care they received would result in a bill they could not afford. Members noted that patients need transparent, predictable, and comprehensible cost sharing policies from their health plans to be able to make informed decisions about their health care. While members reflected on the inverse relationship between cost sharing and premiums, one member highlighted that some insurers have started offering innovative plan designs that redistribute cost sharing from deductibles to copays, with variable copay-only cost sharing without the negative effects of deductibles with competitive premiums. Another member highlighted the Massachusetts Health Connector's efforts to minimize cost sharing for primary care and behavioral health, including exempting primary care from deductibles and capping patient copays for primary care at $10 per visit. The health plan representative emphasized that high underlying medical spending trends lead employers and individuals to make difficult trade-offs between premium and cost sharing amounts and, as a result, often choose high deductible plans.

1 Blue Cross Blue Shield of Massachusetts. Massachusetts residents cite high costs as the most important issue in health care. Mar 20, 2024. See: https://newsroom.bluecrossma.com/2024-03-20-MASSACHUSETTS-RESIDENTS-CITE-HIGHCOSTS-AS-THE-MOST-IMPORTANT-ISSUE-IN-HEALTH-CARE

2 Insurers' approved rate increases in the individual and small group markets averaged 11.5% for 2026. See: https://www.mass.gov/info-details/2026-health-insurance-rates#final-merged-market-rates-effective-for-2026/. Massachusetts family premiums were highest in the U.S. in 2024 at $28,151 annually. See https://datatools.ahrq.gov/meps-ic/

At the PCTF meeting on May 5, 2025, members considered draft recommendations developed by the PCTF co-chairs and HPC staff, focusing on cost sharing as an element of health plan design impacting patient access to primary care services and increasing administrative burden. Members discussed direct and concierge primary care models and the potential benefits to patients and clinicians of excluding Primary Care Provider (PCP) visits (such as 1-2 visits per year) from cost sharing so all patient concerns could be addressed. Members agreed that efforts to restructure cost sharing to improve access to primary care and increase health equity must be paired with actions to address underlying drivers of growing health care costs.

PRIMARY CARE TASK FORCE RECOMMENDATION

The Commonwealth should continue its efforts to improve health care affordability, including addressing the burden of cost sharing and underlying growth in health care spending, and should promote health plan benefit designs that minimize barriers to primary care, are consumer-friendly, and are less burdensome for providers. Recent actions by the Division of Insurance (DOI) in the Merged Market to limit cost sharing growth for 2027 filings to 3.6% is one example of meaningful cost sharing regulation.[3]

- **Cost sharing design should encourage patient use of primary care.** To encourage and empower patients to discuss medical concerns with their primary care providers, deductibles and co-insurance for primary care services should be minimized. In addition, plans should minimize cost sharing, including through episode-based co-payments, for routine services commonly associated with a preventive care visit (e.g., evidence-based labs, imaging) and integrated behavioral health and in line with federal requirements (e.g., for health savings account (HSA)-compatible high deductible health plans (HDHPs)).[4] The Legislature should consider requiring carriers to prohibit or moderate cost sharing for services, as allowable under federal guidance, covered by the advanced primary care payment model.
- **Plan design should minimize patient and provider administrative burden.** In addition to considering the patient user experience, plan designs should aim to reduce administrative burdens on primary care providers, by reducing prior authorization for evidence-based primary care services (in line with DOI guidance), reducing and standardizing prior authorization requirements for other appropriate evidence-based services, and easing referral management. Further recommendations for reducing administrative burden and complexity are addressed in *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*.
- **Efforts to reduce cost sharing must be coupled with measures to reduce health care costs.** To ensure that consumer-friendly benefit design reforms do not increase premiums or the total cost of care they should be paired with reforms that address the underlying drivers of health care costs and improve health care affordability.

HPC FINDINGS: TRENDS IN COST SHARING AND OPPORTUNITIES TO IMPROVE BENEFIT DESIGN IN MASSACHUSETTS

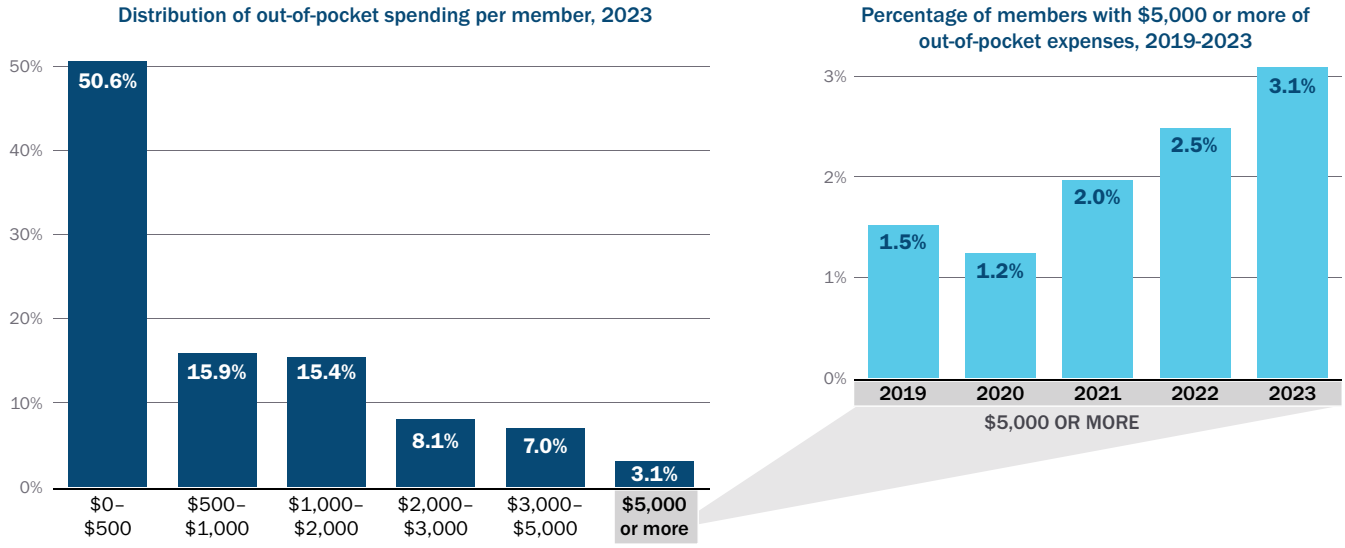
As discussed in the HPC's *2025 Annual Health Care Cost Trends Report and Policy Recommendations*, deductible-based cost sharing benefit designs can result in large bills that are difficult for consumers to anticipate in advance, including for common primary care services. As a result, this type of benefit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

Patient cost sharing in Massachusetts is high and growing. From 2019-2023, average commercial member cost sharing grew by 29%, from $849 annually per member to $1,094, faster than the growth in insurer-paid amounts. Additionally, the distribution of cost sharing varies dramatically. Half of commercial members paid under $500 in 2023, while 10% paid more than $3,000 – and the share paying $5,000 or more has doubled since 2019 (**Exhibit 1**). Payments towards deductibles represented 58% of all cost sharing in 2023, up from 54% in 2019, indicating that the composition of cost sharing is increasingly shifting to the type of out-of-pocket spending that is most unpredictable for patients.

3 Commonwealth of Massachusetts Division of Insurance Health Coverage Filing Guidance Notice 2026-B (February 2026). See: https://www.mass.gov/doc/filing-guidance-notice-2026-b-rate-and-form-filings-for-calendar-year-2027/download

4 To be HSA-eligible, HDHPs must meet federal requirements regarding minimum deductible levels, maximum out-of-pocket limits, and restrictions on first dollar coverage. 26 U.S.C. § 223.

Exhibit 1. 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



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.

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 emergency department (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. HPC analysis found that average cost sharing was $74 for office visits with a lab test for common concerns such as sore throat or cough, with about 10% of patients paying $200 or more. In addition to presenting financial challenges for many patients, unexpected bills for common and easily treatable conditions can create a chilling effect, leading patients to avoid primary care in the future. Such avoidance may result in more costly downstream health care use, such as ED visits or treatment for an exacerbated condition.

Additionally, deductibles may also result in one or more bills weeks or months after the care is provided, increasing the potential for patient confusion and administrative burden. According to the Center for Health Information and Analysis (CHIA) *Findings from the 2025 Massachusetts Health Insurance Survey*, 20% of Massachusetts residents surveyed in 2025 experienced some type of administrative burden related to their health care or health coverage, and nearly 10% reported problems resolving a bill with a health plan. Administrative burden related to medical bills raises further equity concerns, as patients with lower socio-economic status may be less likely to have the time, resources, or expertise needed to understand and address them. It may also increase administrative burden for providers, who must field questions and concerns from patients who have received unanticipated bills.

The *2025 Annual Health Care Cost Trends Report* described opportunities for alternative cost sharing models that would be more consumer-centric, incorporating principles of predictability, transparency, and ease of understanding. The report identified affordability is a key consideration for cost sharing for primary care services and provided examples from both public and private sectors of innovative approaches to cost sharing designs that incorporate consumer-friendly principles.

Statutory Deliverable #6

MONITOR AND TRACK THE NEEDS OF AND SERVICE DELIVERY TO RESIDENTS OF THE COMMONWEALTH

PUBLISHED JUNE 2026

INTRODUCTION

Over the last several years, as the Massachusetts health care system faced the COVID-19 pandemic, the bankruptcy and dissolution of Steward Health Care, and several closures of maternity and behavioral health services, health care leaders across the Commonwealth of Massachusetts repeatedly called for a greater ability to align health care resources with health needs. Providers, payers, community advocates, and policymakers agreed that an assessment of health care resources should be informed by robust data and analysis that considers past, current, and future health needs of the population.

In Statutory Deliverable #3, the Massachusetts Primary Care Access, Delivery, and Payment Task Force (PCTF) recommends that the Legislature establish an aggregate primary care spending target for the Commonwealth that is equivalent to either (1) doubling the share of health care spending on primary care as a percentage of total health care spending or (2) 15%, whichever is greater, within five years from the base-line year 2026, with improvement measured annually. As Massachusetts considers making significant new investments in primary care, the Commonwealth must have the ability to monitor and track the primary care needs of and service delivery to its residents so that providers, payers, and policymakers can direct their investments effectively.

Assessing the alignment of primary care supply with resident needs is a complex undertaking. By some measures, the Commonwealth's primary care system appears strong: Massachusetts ranks third nationally for the number of primary care physicians per capita (101 physicians per 100,000 residents)[1], and 90% of the population reported having a primary care provider in a 2025 survey.[2] Yet these statewide measures obscure significant variation in supply of and access to primary care among geographic and demographic groups.

For example, primary care supply levels vary widely by region, from 158.2 primary care providers (PCPs) per 100,000 residents in Suffolk County to 41.4 in Nantucket County.[1] The share of individuals that reported having a primary care provider drops from 90% statewide to 84% for Asian residents and those with family incomes below 139% Federal Poverty Level (FPL), and to 43% for uninsured individuals.[2] Nearly one-third of Massachusetts residents experience difficulty accessing primary care; residents in Western Massachusetts are more likely to experience difficulty (30% vs. 37%, respectively).[2] The Massachusetts Health Policy Commission (HPC) found that in 2023, nearly 30% of commercially-insured adults living in the lowest-income communities had no primary care visits, compared with 20% of those living in the highest-income communities.[3]

More granular assessments of primary care need, supply, capacity, and utilization can help ensure that new primary care investments are targeted to the geographies and communities with greatest unmet need. In this deliverable, the PCTF describes the Commonwealth's current ability to undertake such assessments and makes recommendations to strengthen the available tools and data assets.

PRIMARY CARE TASK FORCE DELIBERATION

At the PCTF meeting on May 5, 2026, members considered draft recommendations developed by the HPC's Office of Health Resource Planning (OHRP) outlining the existing infrastructure that the Commonwealth can leverage to monitor and track the needs of and service delivery to residents for primary care, as well as existing gaps in data collection and opportunities for improvement. Members identified additional existing infrastructure to add to this recommendation, including the Massachusetts Health Insurance Survey (MHIS) conducted by Center for Health Information and Analysis (CHIA), and the Board of Registration in Medicine (BORIM). Members suggested there are national organizations, such as the National Academies of Science, Engineers, and Medicine (NASEM) Standing Committee on Primary Care, that may have guidelines or best practices for setting standards and/or benchmarks for key metrics related to access such as patient wait times, patient transportation times, and provider to population ratios. Members highlighted MassHealth's work in setting standards and measuring key indicators related to access, and suggested creating alignment with these standards to avoid duplicative reporting. One member suggested that establishing separate primary care contracts, as recommended in Statutory Deliverable #2, could create another opportunity for monitoring and tracking access to primary care.

1 HPC analysis of Area Health Resource File 2022-2023 Dataset

2 Center for Health Information and Analysis (2025). The 2025 Massachusetts Health Insurance Survey. https://www.chiamass.gov/massachusetts-health-insurance-survey/

3 HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2022, 2022.

PRIMARY CARE TASK FORCE RECOMMENDATION

Massachusetts has the necessary authority and infrastructure in place to monitor primary care needs and utilization. The Department of Public Health (DPH) and HPC are explicitly charged with undertaking assessments of primary care supply, capacity, need and utilization under their Primary Care Needs Assessment and OHRP authorities, respectively, and both agencies, along with CHIA and MassHealth, have prioritized assessments of primary care access and utilization within their broader missions. (See description of existing infrastructure below.) These agencies should engage in ongoing collaboration and coordination to ensure alignment and non-duplication of efforts.

Massachusetts has robust data assets for measuring primary care supply and access, such as the All-Payer Claims Database (APCD), the MHIS, the Public Health Data Warehouse, and the Massachusetts Registration of Provider Organizations (MA-RPO) Program dataset, as well as several federal and private data assets. However, additional data on provider capacity (e.g., full-time equivalent (FTE) estimates, patient panel sizes, wait times) is necessary to quantify the gap between supply and need. Efforts to collect this information should not increase administrative burden on primary care providers nor duplicate existing reporting.

Recognizing the Commonwealth's existing assets and gaps, the PCTF makes the following recommendations:

- **OHRP Focused Assessment.** OHRP should build on the Commonwealth's existing efforts, using available data and seeking new data assets, to conduct a focused assessment on primary care need, supply, and access. In conducting this assessment, OHRP should implement access standards, including provider-to-population ratios, time and distance, continuity of care with a PCP, and wait time standards, that can be used to measure areas of need and progress over time. In implementing such standards, OHRP should collaborate with DPH's Primary Care Office and the new primary care technical advisory body recommended in Statutory Deliverable #1. The assessment should consider standards utilized by other states, recommended by national bodies, and those applicable to Medicare Advantage Plans, Qualified Health Plans, and Medicaid Managed Care Organizations. OHRP's assessment should include a specific focus on health equity, including segmenting analyses by age, race, ethnicity, language, disability sexual orientation, gender identity, and socioeconomic status where possible.
- **Capacity and Access Indicators.** State agencies and other interested stakeholders should identify evidence-based methods for collecting or estimating other key indicators of primary care capacity and access, such as primary care provider FTE counts, patient panel size (weighted for patient age/acuity), emergency department and urgent care utilization that could have been treated in a primary care setting, availability of after-hours care, patient travel times, including for those utilizing public transportation, and language accessibility. Policymakers should consider how to account for artificially low demand for care caused by patient access barriers when interpreting these indicators. Relevant measures should be collected for all primary care clinicians, including those providing direct patient care and concierge medicine, to the extent possible. Efforts to collect this information should not increase administrative burden on primary care providers nor duplicate existing reporting. State agencies should explore opportunities to leverage existing data assets, such as Community Health Needs Assessments, clinician re-licensure surveys, or insurance plans' provider directories.
- **Primary Care Wait Times Data.** OHRP should collect data and report on the average time between when a PCP appointment is requested and when it is scheduled. Data should be segmented by provider specialty, insurance type, and office location. Such data will enhance the Commonwealth's ability to assess access against OHRP's access standards (see above) regionally and statewide, over time.
- **Primary Care Employment and Ownership Reporting.** The Commonwealth should prioritize capturing and reporting information on primary care employment and ownership to more closely track trends in private equity acquisitions, concierge medicine, and direct primary care. The HPC should collect information on direct and concierge primary care practices, such as through the MA-RPO Program, to provide the Commonwealth with greater transparency on the supply, capacity, and financial performance of these practices. CHIA should report key datapoints as part of the *Massachusetts Primary Care Dashboard*.[4]

LEVERAGING EXISTING INFRASTRUCTURE IN THE COMMONWEALTH TO MONITOR AND TRACK SERVICE DELIVERY NEEDS

The Commonwealth has existing tools to monitor and track the primary care needs of and service delivery to its residents housed across several state agencies. CHIA, DPH, MassHealth, and the HPC all have a role in monitoring, assessing, and reporting on the state of primary care need, supply, capacity and utilization.

4 Center for Health Information Analysis. (2026). *Massachusetts Primary Care Dashboard*. https://www.chiamass.gov/massachusetts-primary-care-dashboard

Center for Health Information and Analysis, in partnership with the Massachusetts Health Quality Partners

CHIA and the Massachusetts Health Quality Partners (MHQP) developed the *Massachusetts Primary Care Dashboard*[4] to track the health of the Commonwealth's primary care system and inform targeted policy solutions and investment, as well as monitor the impact of such reforms. The dashboard aggregates key information from across state, federal, and private data sources across the following domains:

- Finance (metrics focused on spending for primary care services)
- Capacity (metrics focused on the primary care workforce and pipeline)
- Utilization (metrics focused on the use of primary care services)
- Care (metrics focused on quality of primary care)
- Access (metrics focused on access to primary care)
- Equity (metrics focused on assessing inequities in the primary care system)

To support its goal of tracking the health of primary care over time, existing measures are regularly updated with the latest available data. The latest edition of the *Massachusetts Primary Care Dashboard*[4] was released in June 2026 and included expanded measures on the primary care workforce and new geographic stratifications for certain measures where possible. A new domain on primary care utilization provides insight into where and how patients access care, including the proportion of children receiving well-child visits and the number of patients served by Federally Qualified Health Centers. The 2026 dashboard also includes more detailed information about primary care spending, including breaking out expenditures to primary care providers for problem-based visits, preventive care, and behavioral health services. CHIA and MHQP also added new affordability indicators to the dashboard that capture residents' reported difficulties accessing primary care specifically.

Beyond the Primary Care Dashboard, CHIA maintains several data assets that could be used to assess primary care access and utilization, most notably the MHIS and the APCD. The MHIS is fielded biennially and collects information on health care affordability, coverage, access, and utilization trends in the Commonwealth. Though the scope of the MHIS is broad, it includes primary care specific questions, such as whether the respondent has a primary care provider, whether they have seen a general doctor in the past 12 months, and whether they had difficulty accessing primary care in the past 12 months. The APCD is a set of comprehensive claims data that the Commonwealth can use to track the cost and utilization of primary care services by geography, insurance type, and other relevant factors.

CHIA has also developed a uniform methodology for defining primary care services that can be leveraged to assess need and utilization. In Statutory Deliverable #1, the PCTF recommends that Massachusetts rely on CHIA's technical expertise and experience to continue this foundational measurement work.

Massachusetts Department of Public Health

DPH operates many programs designed to support the Massachusetts health care workforce, provide public data and information, and assess the general needs of and access to primary care across the Commonwealth. Select examples of DPH's work are included below.

- **State Health Assessment.** DPH periodically undertakes a State Health Assessment (SHA) that evaluates the health status of the population and identifies unmet needs and barriers to care.[5] As part of the SHA, DPH tracks several measures related to primary care at the statewide and sub-state levels, such as:
  - Chronic and infectious disease rates;
  - Measures of mental and behavioral health;
  - Preventative screening rates;
  - Immunization and vaccination rates;
  - Total and per capita number of primary care providers, behavioral health providers, dental health providers, and other providers;
  - Presence of health professional shortage areas;
  - Percent of adults with a primary care visit in the last year;
  - Ambulatory care sensitive condition rates;
  - Percent of children with one or more preventative care visits; and
  - Percent of patients visiting a primary care clinician within 14 days after a medical or surgical discharge.

In the accompanying State Health Improvement Plan (SHIP), DPH defines goals, strategies, and resources for addressing priority areas. Collectively, the SHA and SHIP provide critical insights into geographic variation in access to and utilization of primary care services, and could be leveraged by OHRP and other interested parties to identify the geographic areas of the state most in need of increased primary care investment.

5 Massachusetts Department of Public Health. SHA/SHIP Process and Partnerships. Available at: https://www.mass.gov/info-details/shaship-process-and-partnerships

- **Primary Care Needs Assessment.** The Primary Care Office within DPH's Health Care Workforce Center is responsible for conducting a Primary Care Needs Assessment every five years. The next assessment is anticipated to be released in 2027 and will include both quantitative and qualitative components. As part of the assessment, DPH compares Massachusetts' performance to U.S. performance on key indicators in three domains: 1) social determinants of health, 2) health care access and workforce, and 3) health outcomes. The assessment will also incorporate qualitative perspectives from a broad array of primary care providers. The final Primary Care Needs Assessment will serve as the basis for DPH's five-year primary care strategic plan.
- **Health Professional Shortage Designations.** DPH works in partnership with the federal Health Resources and Services Administration (HRSA) to designate health professional shortage areas (HPSAs)[6] and medically underserved areas or populations (MUA/Ps).[7] Areas that qualify as primary care HPSAs are eligible for various federal programs designed to improve provider recruitment and retention. For example, physicians who provide services within a HPSA qualify for a 10% bonus payment from Medicare on their professional billing.[8] HPSA designation also confers scholarship and loan repayment benefits and J-1 visa benefits. In recent years, DPH has updated its strategy for identifying shortage areas to optimize HPSA coverage for the Commonwealth.[9] By proactively reviewing data across the Commonwealth, DPH has been able to qualify new areas for these important federal supports, particularly in Western Massachusetts.

6 A HPSA is designated as having a critical shortage of either primary care, dental or mental health providers. Each type of HPSA is further classified as being a specific geographic area, a specific population group, or in some cases, a specific facility. This designation must be renewed every three years. Massachusetts Department of Public Health. Shortage Designation Management System (SDMS). Available at: https://www.mass.gov/info-details/shortage-designation-management-system-sdms

7 A MUA/P designation identifies areas or populations with a shortage of primary care services. MUA/Ps are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty, and/or high elderly population. This type of designation does not expire. An MUA/P may apply to whole counties, a group of counties or civil divisions, or a group of urban census tracts. The MUP includes groups of persons who face documented economic, cultural or linguistic barriers to care. Massachusetts Department of Public Health. Shortage Designation Management System (SDMS). Available at: https://www.mass.gov/info-details/shortage-designation-management-system-sdms

8 Centers for Medicare & Medicaid Services (2026). *Physician Bonuses in Health Professional Shortage Areas.* CMS.gov. https://www.cms.gov/medicare/payment/fee-for-service-providers/physician-bonuses-health-professional-shortage-areas-hpsas.

9 Massachusetts Department of Public Health. (2026) *Public Health Council Meeting*, March 11, 2026. Mass.gov. https://www.mass.gov/event/public-health-council-meeting-march-11-2026-03-11-2026

In addition to these specific functions, DPH maintains the Public Health Data Warehouse, which contains a host of supply, access, utilization, outcome, and equity measures across a wide range of domains.

Massachusetts Health Policy Commission

Office of Health Resource Planning. The HPC's Office of Health Resource Planning (OHRP) was established in 2025 pursuant to Chapter 343 of the Acts of 2024, *An Act enhancing the market review process*. OHRP is leading the Commonwealth's first comprehensive state health planning initiative in over a decade, using robust data analysis and strategic planning to promote the alignment of health care resources with population needs. 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. The office also has the authority to conduct focused assessments, which can serve as a deeper investigation into a specific geography, service type, or community.

Were OHRP to conduct a focused assessment of primary care, it would seek to build off of DPH's latest Primary Care Needs Assessment, adding new data and analysis where available. OHRP would prioritize novel measures of supply and capacity, such as primary care wait times, or modeling anticipated changes in primary care supply or demand in the future.

OHRP also maintains the Massachusetts Registration of Provider Organizations (MA-RPO) Program dataset, which includes key information about primary care providers employed by or affiliated with the largest health care systems in the Commonwealth, including their primary and secondary sites of practice, medical group and provider organization affiliation, and more. The MA-RPO dataset is estimated to include about 85% of the primary care physicians in the Commonwealth. In 2025, advanced practice providers were added to the dataset for the first time.

In addition to work undertaken by OHRP, the HPC has released various publications related to primary care supply and need, most notably the January 2025 report, *A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action.*

Additional State Assets Focused on Network Adequacy

MassHealth. MassHealth uses several adequacy standards and indicators to ensure that its members have sufficient access to primary care providers. For instance, MassHealth employs time and distance standards, which measures the proportion of members who are within an allowable drive time, or allowable distance in

miles, to at least two unique, in-network PCPs.[10] MassHealth also employs wait time standards to measure the average wait time, in calendar days, for a routine (i.e., non-symptomatic) appointment and a sick appointment (i.e., non-urgent, symptomatic).[11]

Division of Insurance. The Division of Insurance (DOI) requires commercial carriers to demonstrate network adequacy for each plan that includes a provider network but does not mandate specific standards. Carriers must report on their network adequacy standards as well as their processes for monitoring network sufficiency, network accessibility analysis that includes geographic access tables, and information about primary care and behavioral health providers accepting new patients.[12]

Massachusetts Health Connector Authority. Qualified health plans offered through the Massachusetts Health Connector Authority marketplace must meet network adequacy standards that are at least as strict as those required by federal marketplaces.[13] These standards, which are the same as those required for Medicare Advantage and federal marketplace plans, have specific time and distance standards, and wait time standards including for primary care.

10 See: https://www.mass.gov/doc/accountable-care-partnership-plans-acpp-eqr-technical-report-2024-0/download

11 See: https://www.mass.gov/doc/managed-care-organizations-mco-eqr-technical-report-2024-0/download

12 See: 211 CMR 52.12 https://www.mass.gov/doc/211-cmr-5200-managed-care-consumer-protections-and-accreditation-of-carriers/download

13 See: 45 C.F.R. 155.1050 https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-155/subpart-K/section-155.1050

Statutory Deliverable #7

CREATE SHORT-TERM AND LONG-TERM WORKFORCE DEVELOPMENT PLANS AND IMPROVE WORKING CONDITIONS

PUBLISHED JULY 2026

INTRODUCTION

In January 2025, the Massachusetts Health Policy Commission (HPC) published a special report on primary care workforce, access, and spending trends, *A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action*, which called attention to the numerous challenges affecting the well-being and sustainability of the Commonwealth of Massachusetts' primary care workforce and the impact on providers and patients. The report cites research demonstrating that primary care physicians experience lower pay compared to specialist physicians and high levels of administrative burden requiring a substantial amount of work outside of regular hours.[1,2,3] This dynamic discourages medical students from choosing to go into primary care and drives currently practicing primary care physicians to reduce their hours or leave practice altogether, negatively impacting the provider pipeline, increasing patient panel size, and reducing patient access to timely primary care.[4] Indeed, while Massachusetts has the third-largest number of primary care physicians per resident in the country, its overall physician workforce is heavily tilted toward specialist physicians, more so than all but four other states.[5] While nurse practitioners (NPs) and physician assistants (PAs) are playing a growing role as primary care providers, they are subject to the same payment and administrative burden challenges as physicians, and the same disincentives to enter or remain in the field. As employers, community health centers (CHCs) in particular face an exacerbated version of these challenges, as they are less able to offer competitive wages than hospitals or hospital-affiliated practices. Retention difficulties and burnout due to staffing shortages are common workforce challenges reported at CHCs.

In addition to contributing to provider burnout, research demonstrates that high administrative burden may add to health care costs and worsen patient health outcomes. For example, one study estimates that prior authorization costs an individual primary care physician between $2,161 and $3,430 annually in terms of lost time.[6] Additionally, a 2025 American Medical Association (AMA) physician survey on prior authorization found that physicians and their staff spend an average of 13 hours on prior authorization requests a week, and 95% of respondents reported that for patients whose treatment requires prior authorization, the process delays access to necessary care.[7] The average physician also spends 785 hours per year reporting on quality measures, costing the health care system more than $15 billion per year.[8] This burden is disproportionately shouldered by the primary care field.[9]

As the Commonwealth considers increasing investment and reforming payment for primary care, it must also prioritize complementary efforts to address these workforce challenges. In Statutory Deliverable #3, the Massachusetts Primary Care Access, Delivery, and Payment Task Force (PCTF) recommends the establishment of a primary care spending target. As part of this recommendation, the PCTF stresses the importance of reducing administrative expenses for primary care practices and transforming primary care delivery as essential complementary goals to a primary care spending improvement target. In Statutory Deliverable #4, the PCTF makes a recommendation for advancing multi-payer, aligned primary care payment reform. In this recommendation, the PCTF identifies several core goals for reforming primary care payment including strengthening primary care capacity and stability, supporting team-based care models, reducing administrative burden, and enhancing primary care practice sustainability and the ability of practices to operate independently.

1 Sinsky C.A., Dugdale D.C. (2013) Medicare payment for cognitive vs procedural care: minding the gap. *JAMA Internal Medicine*. 2013;173(18):1733-1737. https://pubmed.ncbi.nlm.nih.gov/23939411/

2 Congressional Budget Office. (2022, January 22) The prices that commercial health insurers and Medicare pay for hospitals' and physician's services. https://www.cbo.gov/publication/57422

3 Sinsky, C., Colligan, L., Li, L., Prgomet, M., Reynolds, S., Goeders, L., Westbrook, J., Tutty, M., & Blike, G. (2016). Allocation of physician time in ambulatory practice: A time and motion study in 4 specialties. *Annals of internal medicine*, 165(11), 753–760. https://doi.org/10.7326/M16-0961

4 Hahn LM. (2024, October 7). Unsustainable: Why I left primary care. *Health Affairs*. 43(10):1349-1480. https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2024.00406.

5 HPC analysis of Association of American Medical Colleges. State Physician Workforce Data Report, 2021

6 Henry, T.A. (2025, April 17). Don't fall for these myths on prior authorization. *AMA Newswire*. https://www.ama-assn.org/practice-management/prior-authorization/don-t-fall-these-myths-prior-authorization

7 American Medical Association. (2026) 2025 AMA prior authorization physician survey. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

8 Casalino, L.P., Gans, D., Weber, M.C., Tuckovsky, A., Bishop, T.F., Miranda, Y., Frankel, B. A., Ziehler, K. B., Wong, M.M., Evenson, T.B. (2016) US physician practices spend more than $15.4 billion annually to report quality measures. *Health Affairs*. 35(3), 401-406. doi: 10.1377/hlthaff.2015.1258

9 Dubard, A., Israel, J., Mostashari, F. (2023). Less is more: quality measurement in primary care. *Health Affairs Forefront*. doi: 10.1377/forefront.20230614.546595

In this Statutory Deliverable #7, the PCTF makes additional specific recommendations to reduce sources of administrative burden, improve the working conditions for the primary care workforce, and strengthen the provider pipeline to grow and sustain access to primary care in the Commonwealth.

PRIMARY CARE TASK FORCE DELIBERATION

To develop this recommendation, the PCTF co-chairs convened the PCTF Workforce Workgroup, a subgroup of task force members charged with considering and developing specific recommendations for this workforce-focused deliverable. At the first meeting of the Workforce Workgroup on June 12, 2025, members shared their lived experiences providing primary care to Massachusetts residents and echoed many of the findings of the HPC's 2025 primary care report. In this initial discussion, workgroup members identified their key priorities for addressing primary care workforce challenges, specifically: 1) reducing sources of administrative burden and other working conditions driving clinician burnout; 2) supporting team-based care models and improving care coordination; and 3) strengthening the primary care pipeline. During this meeting, members discussed the concept known as "moral injury," or the distress caused to providers when resource or time constraints prevent them from providing the care they know their patients need, underscoring the impact of systemic workforce challenges on both patients and providers. Following that meeting, the PCTF co-chairs developed a comprehensive list of discussion topics addressing these priorities. This list informed agenda planning for future workgroup meetings and, ultimately, the development of this recommendation.

At the November 18, 2025 meeting, workgroup members focused on addressing **prior authorization and quality measures as they relate to administrative burden**. While members expressed support for prior authorization reform, they acknowledged that, when applied appropriately, it can be a helpful cost saving measure for health plans and a tool to reduce the provision of care that provides little or no patient value. Members urged caution against eliminating prior authorization entirely, as well as consideration of potential unintended consequences for specific policies to limit prior authorization. Members then reviewed changes the Massachusetts Quality Measure Alignment Taskforce (QMAT) implemented, in its transition to the Statewide Quality Advisory Committee (SQAC) in compliance with Section 44 of Chapter 343 of the Acts of 2024, which updated the process for developing a standard set of quality measures for use in the Commonwealth. Members acknowledged the important work of the QMAT in developing a measure set focused on a small number of meaningful, patient-centered quality measures for primary care, but suggested that improvements can still be made to decrease the administrative burden caused by quality measure reporting.

At the February 11, 2026 meeting, workgroup members discussed operational barriers to implementing **team-based care models, care coordination, and behavioral health integration in primary care**. Members described the problem of "scope creep," in which team members are gradually assigned responsibilities unrelated to their original roles, and the increasing amount of time staff members dedicate to patient behavioral health and social needs. Members also noted that while Primary Care Providers (PCPs) can prescribe behavioral health medication, they are limited in their ability to address escalated or more complex behavioral health needs. Members noted that payment reform and multi-payer alignment is necessary to support building and supporting care teams and enabling meaningful care transformation in primary care practices, citing the MassHealth Sub-Capitation Program[10] as a model that allows for practices to invest in staff, allocate time for administrative activities, and increase patient panel size and capacity. Members stressed that adequate funding for primary care services will enable practices to offer appropriate compensation to staff and increase the workforce pipeline for roles that are critical for team-based care, such as peer support specialists, care navigators, and social workers.

At the March 31, 2026 meeting, workgroup members discussed additional sources of primary care **provider burnout**. Members described growing administrative demands such as high call volumes, managing portal messages, renewing prescriptions, and providing referrals. Members agreed that high patient volume and the many administrative tasks to complete outside of providing direct patient care reduce the time available to patients and contribute substantially to provider burnout. Members identified the credentialing process as a significant barrier to patient access and provider retention, as the process is often long, duplicative across payers, resource-intensive for practices, and delays appropriate payment for services provided. The workgroup also discussed the need for improved usability of electronic health record systems (EHRs) and the opportunity for using artificial intelligence (AI) to ease EHR-related burden.

At the final meeting of the PCTF Workforce Workgroup on April 28, 2026, members reviewed and discussed strategies to address **workforce pipeline and retention challenges**. Members focused on the important role of family medicine residency programs at CHCs in providing community-based training and offering loan reimbursement to support workforce development. Concurrently, members noted that CHCs often face resource and

10 See: https://www.mass.gov/masshealth-primary-care-sub-capitation-program

funding constraints that impact their ability to offer competitive salaries compared to large health systems. Members expressed frustration that the two largest health systems in Massachusetts do not currently offer family residency programs. Additionally, members discussed the feasibility of renewing state funding for Medicaid Graduate Medical Education (GME) to support efforts towards increasing the provider pipeline.

Members shared concerns that new borrowing limits for federal student loans for NP and PA programs could impact the workforce pipeline, and urged support for nurse practitioner residency programs, as well as onboarding and mentorship programs for advanced practice providers (APPs) to improve retention of these roles. Members also noted that many organizations have by-laws inconsistent with full practice authority for NPs, and that PAs are required to have a supervising physician on file, creating additional barriers for APPs to exercise their full scope of practice.

The comprehensive discussions and recommendations from the Workforce Workgroup informed the development of the PCTF recommendation for this final deliverable.

PRIMARY CARE TASK FORCE RECOMMENDATION

To achieve the core goals stated above, the PCTF recommends the Massachusetts Legislature, state agencies, public and private payers, and health care delivery organizations take the following actions to bolster, increase, and improve working conditions for the primary care workforce.

Increase Spending for Primary Care and Reform Primary Care Payment

A core driver of many of these workforce challenges is that the current health care system generally undervalues and overburdens primary care. To address this foundational imbalance, the PCTF reiterates its baseline recommendation put forth in Statutory Deliverable #3 and Statutory Deliverable #4 for increased spending for primary care, the deployment of an aligned, multi-payer primary care payment model, and that the payment model should provide fair pricing for primary care across market segments in line with increased investment. Together, these policies will enable practices to build and sustain team-based care delivery approaches, reduce the administrative burden related to the complexity of payer payment requirements, and adequately support the current workforce and increase the workforce pipeline for the future.

Reduce Sources of Administrative Burden and Burnout for Primary Care Clinicians

Reducing sources of administrative burden and burnout for primary care clinicians is critical for improving working conditions, increasing provider capacity, and driving down administrative costs. The PCTF makes the following recommendations to ease identified sources of administrative burden:

- **Payer Credentialing Process.** PCTF members described the current process for credentialing providers to participate with commercial and public payers as long, complicated, and duplicative. The current process also limits capacity as providers who are waiting to complete the process are unable to see patients and receive payment. The Legislature should consider opportunities to create a more coordinated, streamlined provider onboarding process across state licensing agencies, commercial health plans, MassHealth, and provider organizations to make the process quicker and less resource intensive for providers.
- **Referral Practices.** PCTF members identified managing a high number of referral requests as a source of administrative burden. In an optimal system, referrals provide important and timely specialist recommendations for patient care without undue burden for primary care clinicians or patients. But frequently, the referral process creates frustration, additional administrative work, and potential delays in receiving necessary care. Many of these requests are from specialist physicians seeking referrals from primary care providers on behalf of patients, even when a referral may not be necessary. Health plans should implement uniform, clear, transparent, and regularly updated guidelines to providers on referral requirements and appropriate use of referrals in order to reduce unnecessary referral requests. Primary care clinicians and specialists should work to develop policies which provide clear guidance about who is responsible for initiating referrals, conducting pre-referral consultations, tracking referrals, and providing follow-up information. Promoting these collaborative relationships can not only streamline the referral process but also support more efficient care coordination and appropriate access to timely care.
- **Prior Authorization.** PCTF members discussed the ways in which prior authorization can increase administrative burden and delay patient care when not implemented appropriately. The PCTF supports reducing prior authorization for evidence-based primary care services, increasing transparency of prior authorization processes, and accelerating timeliness standards for prior authorization approval in line with recent Division of Insurance (DOI) regulatory changes, which went

into effect on June 5, 2026.[11] The ongoing work of implementation, monitoring, and enforcement of these regulatory changes is critical to ensure this achieves its intended goal.

- **Claims Submission Practices.** The PCTF supports the updates to DOI's regulation to improve claims submission practices, which will allow insurer-provider contracts to address the submission of inappropriate and duplicate claims.[12] DOI should continue its efforts to direct insurers to address high administrative denial rates and expand outreach to providers, with the use of targeted data analysis, to better streamline claim submission processes.
- **Pay for Performance Quality Measures.** PCTF members agreed that excessive quality measure reporting can add to administrative burden and that some requirements related to population health can potentially be misaligned with what individual patients truly need. The PCTF makes the following recommendations to make quality measure reporting requirements more meaningful and patient-centered and less burdensome:
  - Prioritize quality measures for clinical outcomes that focus on improvement rather than on absolute numbers (e.g., decrease in blood pressure).
  - Include patient experience measures in quality reporting.
  - Ensure adequate expert clinician and health plan representation on technical advisory groups (TAGs) advising the SQAC.
  - Payers should align and standardize quality measure and reporting requirements as defined by the mandatory *statewide quality measure set* (SQMS) endorsed by the SQAC. The SQAC should define a clear pathway to moving all quality measures to Electronic Clinical Quality Measures[13] (eCQM) no later than January 1, 2030.
- **Artificial Intelligence.** As use of AI expands in clinical settings, there are early indicators that it presents an opportunity for positive impact, such as reducing administrative burden, enhancing chronic disease management, communicating with patients, and improving care coordination. However, strategic action is necessary to provide guardrails to ensure that the use of AI delivers meaningful change in primary care that is positive and equitable, protects patient privacy, and guards against potential unintended consequences, such as enabling algorithmic bias or discriminatory practices. Specifically, the PCTF recommends that the Commonwealth establish a state advisory body to develop clear standards, best practices, evaluation, and oversight of the use of AI in health care in the Commonwealth, with a specific focus on the use of AI in primary care settings.

Support Team-Based Care Models and Improve Care Coordination

The National Academies of Science, Engineering, and Medicine (NASEM) define high-quality primary care as "the provision of whole-person, integrated, accessible, and equitable care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities."[14] The delivery of such accessible, high-quality, and equitable primary care requires a well-trained and well-supported workforce. The PCTF recommends the following actions to support primary care practices to effectively implement team-based care models and behavioral health integration, support non-licensed professionals in the primary care workforce, and measure use of the direct primary care model.

- **Support Team-Based Care and Other Innovative Models and Behavioral Health Integration in Primary Care.** Payers should shift away from fee-for-service (FFS) payment models to prospective, capitated Per Member Per Month (PMPM) payment models for primary care to provide the financial stability to adult, pediatric, and family primary care practices necessary to implement care delivery transformation, behavioral health integration, and leverage team-based care and other innovative models. (See Statutory Deliverable #4.)
- **Support the Integration of Non-Licensed Professionals into Primary Care.** The Commonwealth should support training and workforce development opportunities and promote appropriate financial compensation for the non-licensed professional workforce, including community health workers, patient navigators, peer specialists, and other non-licensed professionals. Primary care payment models should encourage practices to integrate these professionals into care teams to address social determinants of health, support clinicians, and improve care coordination and patient navigation.

11 See 211 CMR 52.07: https://www.mass.gov/doc/211-cmr-5200-managed-care-consumer-protections-and-accreditation-of-carriers/download

12 See: 211 CMR 52.11: https://www.mass.gov/doc/211-cmr-5200-managed-care-consumer-protections-and-accreditation-of-carriers/download

13 The eCQI Resource Center defines eCQM as a measure specified in a standard electronic format that uses data electronically extracted from electronic health records (EHR) and/or health information technology (IT) systems to measure the quality of health care provided.

14 National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Implementing High-Quality Primary Care, Robinson, S. K., Meisnere, M., Phillips, R. L., Jr., & McCauley, L. (Eds.). (2021). *Implementing high-quality primary care: Rebuilding the foundation of health care.* National Academies Press (US). https://doi.org/10.17226/25983

Strengthen the Primary Care Provider Pipeline and Workforce Retention

The PCTF recommends the following actions to increase the primary care provider pipeline. Reducing barriers to practice, including those for APPs, is of particular importance for underserved areas and populations.

- **Medicaid Graduate Medical Education Funding for Primary Care.** The Legislature should consider a new appropriation to resume Medicaid funding for GME with a specific focus on training for primary care clinicians in community-based settings, including community health centers.
- **Expand Family Medicine Residency Programs and Support for Nursing Preceptorships.** The Commonwealth should work with large health systems, academic medical centers, and community-based settings to expand the number of family medicine residencies. The Commonwealth should implement investments and initiatives that support graduate-level nursing education in the wake of recent federal policy changes to student loans.
- **Increase Workforce Diversity.** The Commonwealth should invest in state supported employer-academic partnerships and primary care career ladder programs that offset the cost of tuition for undergraduate students or entry level primary care staff from low-income and/or historically underserved communities to earn their associate's, bachelor's, master's, or doctoral degree and pursue licensure/certification, while maintaining employment. The Commonwealth should also consider providing greater support for and expanding existing workforce training pilot programs.
- **Improve Integration of APPs in Primary Care.** Ensure that all provider organizations enable the fullest use of NPs working in primary care, and that payers and provider organizations are aligned on requirements to facilitate full independent practice and reimbursement for Advanced Practice Registered Nurses (APRNs). Massachusetts should create pathways to ensure PAs can continue delivering services in their primary care setting within their full scope of practice, even if their supervising physician has decided to leave the primary care setting, such as by decoupling maintenance of PA licensure from a supervising physician.
- **Invest in Rural Health Training.** Investment in training focused on strengthening and increasing a sustainable workforce in the Commonwealth's rural communities is critical for improving health care access and patient outcomes in underserved areas. The state should continue to prioritize the use of federal funding from the Rural Health Transformation Fund to support the primary workforce practicing in rural communities.

Invest in and Evaluate Effectiveness of Primary Care Workforce Initiatives

The PCTF acknowledges that, while the Commonwealth is facing a health care affordability crisis, these recommended initiatives may require increased investment. In 2022, Massachusetts voters passed the Fair Share Amendment ("Fair Share"), which created a 4% surtax on annual income above $1 million. Since then, Fair Share has brought in billions of dollars in state revenue every year to be used for investments in public transportation and public education. The PCTF recommends the Legislature consider designating a portion of Fair Share dollars for public educational initiatives designed to expand the pipeline for the health care workforce, especially for roles whose shortages contribute to more expensive health care, including primary care, nurses, and the workforce for community-based and behavioral health care.

Finally, to assess the impact of these recommendations over time, the PCTF reiterates the importance of monitoring and tracking the primary care needs of and service delivery to its residents so that providers, payers, and policymakers can direct their investments effectively. (See Statutory Deliverable #6.)

ACKNOWLEDGEMENTS

PRIMARY CARE ACCESS, DELIVERY, AND PAYMENT TASK FORCE MEMBERSHIP

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David Seltz, Executive Director, Massachusetts Health Policy Commission	The executive director of the health policy commission or a designee, co-chair
Senator Cindy Friedman, Chair, Joint Committee on Health Care Financing	The Senate chair of the joint committee on health care financing or a designee
Representative John Lawn, Chair, Joint Committee on Health Care Financing	The House chair of the joint committee on health care financing or a designee
Michael Caljouw, Massachusetts Commissioner of Insurance	The commissioner of insurance or a designee
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The 25 members of the Primary Care Access, Delivery, and Payment Task Force (PCTF), listed above, contributed significantly to the development of these recommendations through robust discussion and feedback. Task force members dedicated a significant amount of time to this effort over more than 15 months of meetings and deliberation. The PCTF was co-chaired by Dr. Kiame Mahaniah, Secretary of the Executive Office of Health and Human Services, and David Seltz, Executive Director of the Massachusetts Health Policy Commission (HPC). Dr. Ryan Schwarz, Massachusetts Medicaid Director and Assistant Secretary for MassHealth, and David Seltz, co-led the two PCTF workgroups.

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