

Introduction

The primary care crisis in Massachusetts is fueled not only by underinvestment, but also by the misaligned incentives and high administrative burden exacerbated by traditional fee-for-service (FFS) payment models that drive physician burnout and contribute to workforce shortages.¹ One approach to support care delivery 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 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) recommended an approach for increasing investment in primary care by establishing a primary care spending target. As part of this recommendation, the PCTF noted that increases in 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. In Statutory Deliverable #4, the PCTF recommends the principles necessary to achieve this goal.

Primary Care Task Force Deliberation: Statutory Deliverable #4

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. Dr. Ryan Schwarz, Chief of MassHealth's Office of Accountable Care and Behavioral Health, 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

¹ The Health Policy Commission. (2025, January). 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. State Policies to Advance Primary Care Payment Reform in the Commercial Sector. The Eugene S. Farley, Jr. Health Policy Center. April 2025.

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 PCPs are employed and contract through the systems and the need to promote independent primary care practices. For practices employed or contracted through such systems, members urged policies to ensure that increased payments are ultimately directed to the primary care practices. Some members suggested separating primary care practices from hospital systems or requiring separate insurance contracts for primary care providers.

In 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: Statutory Deliverable #4

To achieve the core goals stated above, the PCTF recommends that the Commonwealth 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 in Massachusetts. 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.
- *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, federally-qualified health centers, and hospital system-based-practices, as well as commercial health plans operating in Massachusetts, MassHealth, and the ongoing primary care technical advisory body referenced in [Statutory Deliverable #1](#).
- *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 as 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 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-insured³ 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 a study 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.

³ Center For Health Information and Analysis. (2025, September 22). Enrollment Trends) through March 2025, Private Commercial Enrollment Overview: Market Sector, Product Type, and Funding Type.

<https://www.chiamass.gov/enrollment-in-health-insurance>

⁴ <https://www.cms.gov/priorities/innovation/innovation-models/ahead>

- *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 will be included in PCTF 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](#).

Additional Policy Considerations: Statutory Deliverable #4

Complementary Goals: There is an opportunity to pair primary care payment reform with changes to commercial health plan benefit design, such as patient cost-sharing, that will complement the core goals stated above, particularly to “improve patient access and experience” and “reduce administrative burden.”

Further recommendations for health plan benefit design will be addressed in [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 will be 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).