MASSACHUSETTS
HEALTH POLICY COMMISSION

EOHHS

Statutory Deliverable #6:

# Monitor and Track the Needs of and Service Delivery to Residents of the Commonwealth

## 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 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) recommended 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 baseline 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 be 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 percent 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% 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 only 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.

[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 Deliberation: Statutory Deliverable #6

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 Institute of Medicine's 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 the state Medicaid program (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.

## Primary Care Task Force Recommendation: Statutory Deliverable #6

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 a description of these activities 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) dataset, as well as several federal and private data assets. However, additional data on provider capacity (e.g., 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 and 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 full-time equivalent (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 Primary Care Dashboard.

## 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.

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

CHIA and the Massachusetts Health Quality Partners (MHQP) developed the 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 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 a health professional shortage area;
    - 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

---

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

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

- 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.

- **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.

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

---

[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

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) 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