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's 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

[1] Sinsky CA, Dugdale DC. 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/ 1 MedPAC Report to the Congress: Medicare and the Health Care Delivery System | June 2018
[2] Congressional Budget Office. The prices that commercial health insurers and Medicare pay for hospitals' and physician's services. Jan, 2022.
[3] Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. Annals of Internal Medicine. 2016;165:753-760. doi:10.7326/M16-0961
[4] e.g., Hahn LM. Unsustainable: Why I Left Primary Care. Health Affairs. 2024; 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) 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

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) recommended the establishment of a primary care spending target. As part of this recommendation, the PCTF stressed 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 made a recommendation for advancing multi-payer, aligned primary care payment reform. In this recommendation, the PCTF identified 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.

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: Statutory Deliverable #7

To develop this recommendation, the PCTF co-chairs convened the PCTF Workforce Workgroup, a subgroup of task force members charged 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 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 and 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 as it transitions to the Statewide Quality Advisory Committee (SQAC) in compliance with Section 44 of Chapter 343 of the Acts of

[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

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 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 primary care practices in building and supporting care teams and enabling meaningful care transformation, citing the MassHealth Sub-Capitation program[10] as a model that allows for practices to invest in staff and allocate time for administrative activities, while increasing 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, is 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 meeting, 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 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

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

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: Statutory Deliverable #7

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 to 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. The ongoing work of implementation, monitoring, and enforcement of these regulatory changes is critical to ensure it 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. 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[11] (eCQM) no later than January 1, 2023.
- **Artificial Intelligence.** As use of Artificial Intelligence (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 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

[11] 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.

through sustained relationships with patients, families, and communities."[12] 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 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.

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 advanced practice providers, 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 graduate medical education (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 off-set 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

[12] 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

requirements to facilitate full independent practice and reimbursement for 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, 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).