THE OFFICE OF ATTORNEY GENERAL
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2026 Examination of Health Care Cost Trends




OFFICE OF THE ATTORNEY GENERAL
COMMONWEALTH OF MASSACHUSETTS

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I. EXECUTIVE SUMMARY

This is the Office of the Attorney General's ("AGO") report of its 2026 examination of health care cost trends, conducted pursuant to Section 11N of Chapter 12 of the Massachusetts General Laws. This report analyzes data on 2024 payments for primary care services from a sample of commercial payers[1] to health care providers. The report resulted in four principal findings.

First, we found that commercial supplemental payments are a significant source of primary care funding. "Supplemental payments" include population health and practice infrastructure payments, incentive and performance payments, shared savings payments and other payments not based on claims. Market-wide, total commercial supplemental payments across all services ($489M) are significant relative to total "fee-for-service" payments for core primary care services ($1.6B). Whereas prior state reports have not classified significant supplemental payments as primary care spending due to data limitations, our data shows that for some provider organizations and contracts, a large share of supplemental payments are distributed directly to primary care providers.

Second, we found high rates of self-insured coverage for commercial primary care visits. We examined commercial primary care visits by funding source and product type for each of the provider organizations in our study. We found that approximately two thirds of primary care visits for one major commercial payer were paid by self-insured plans, which are regulated by the federal Employee Retirement Income Security Act and exempt from most state insurance regulations.

Third, significant variation exists in commercial fee-for-service rates for core primary care services. Commercial price variation across health care providers has been documented in the Massachusetts market for decades, and primary care rates are no exception. We reviewed 2024 primary care rates from a sample of large commercial insurers and found a range from 127% to 244% of Medicare rates for the same primary care services for providers in our study. These rates also varied by the payer mix of the provider organization.

Fourth, adding estimated supplemental payments distributed to primary care providers to claims-based primary care payments increases overall primary care payments and payment variation. When we combined the core primary care fee-for-service payments with estimates from providers about the share of supplemental payments distributed directly to primary care providers, relative payment rates across provider organizations changed, and providers with higher shares of Medicaid patients fell further behind the rest of the market.

This report concludes with recommendations to support equitable and effective primary care reform.

[1] In this report, the term "payers" refers to commercial health insurers.

II. INTRODUCTION

Primary care in Massachusetts is under immense pressure. It is hard to find a primary care provider taking new patients, and many patients have trouble getting appointments for preventive care. For many Massachusetts residents, a primary care provider's referral is a prerequisite to getting insurance coverage or appointments for specialty care. In the 2025 state health insurance survey, nearly a third of all residents reported difficulties accessing primary care, including the inability to get an appointment when needed and practices not accepting new patients.[2] These access burdens fall disproportionately on low-income communities, communities of color, and rural communities.[3]

The primary care market is complex and faces significant workforce and payment challenges. Massachusetts primary care providers are aging and retiring, with lower numbers of new providers entering the field.[4] Administrative burdens, including electronic health record-related tasks, the proliferation of quality measures, patient correspondence, and prior authorization, make the work of providing primary care increasingly challenging.[5] Low payment rates for primary care relative to specialty care[6] disincentivize new physicians from entering the field. New concierge models are emerging that offer primary care providers higher pay and smaller patient panels, but they are available only to patients able to pay significant fees.[7]

Primary care in Massachusetts has rightly been a significant policy focus over recent years. In January 2025, Massachusetts enacted new health care market oversight legislation that established the Primary Care Access, Delivery and Payment Task Force to develop policy solutions to stabilize and improve primary care access, delivery, and payment.[8] The task force released detailed policy recommendations throughout 2025 and 2026,[9] including a recommendation that Massachusetts establish an aggregate primary care spending target of at least 15% of total health care spending without increasing overall health care spending beyond the existing cost growth benchmark. Governor Healey signed an executive order in August 2026 directing MassHealth to increase spending on primary care to 12% of MassHealth's total medical expenditures by 2028.[10]

The task force recommendations and pending legislation provide an important framework for increasing support for primary care. Two health care market observations may help implement new primary care investment in a manner that achieves the policy goal of improving access to primary care without increasing overall spending.

First, additional transparency into supplemental payments in Massachusetts will help the state target where additional primary care spending is likely to be most needed and impactful. Studies on state primary care spending have historically relied on data collected from payers.

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[2] Center for Health Information and Analysis, *Findings from the 2025 Massachusetts Health Insurance Survey* at 6 (Dec. 2025), https://www.chiamass.gov/wp-content/uploads/docs/r/survey/MHIS-2025/2025-MHIS-Report.pdf.

[3] *Id.* at 31.

[4] *See* Center for Health Information and Analysis, *Primary Care Dashboard 2026* at 5 (June 2026), https://www.chiamass.gov/wp-content/uploads/2026/06/MA-PC-Dashboard-2026.pdf (reporting a decrease from 19.2% to 18% in Massachusetts medical school graduates entering primary care and an increase in the number of primary care providers aged 65 and older).

[5] Mass. Health Policy Commission, *A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action* at 2 (Jan. 2025), https://masshpc.gov/sites/default/files/HPC%20Chartpack_A%20Dire%20Diagnosis%20-%20The%20Declining%20Health%20of%20Primary%20Care%20in%20MA_1.pdf.

[6] Mass. Health Policy Commission, *DataPoints Series Issue 30: The Primary Care Spending Gap: Paying Less for What Matters Most* (July 2025), https://masshpc.gov/sites/default/files/Datapoints_Primary%20Care_30.pdf.

[7] *See, e.g.* Jane M. Zhu et. al, *Growth in Number of Practices and Clinicians Participating in Concierge and Direct Primary Care, 2018-23*, 44 Health Affairs 1473, 1476 (2025) (reporting an 83.1% increase in concierge and direct primary care clinicians); *Concierge Medicine*, Mass General Brigham, https://www.massgeneralbrigham.org/en/services/concierge-medicine (last visited Oct. 13, 2026) (noting an annual $10,000 membership fee for concierge services at MGB).

[8] *See Chapter 343 of the Acts of 2024.*

[9] Mass. Health Policy Commission, *Massachusetts Primary Care Access, Delivery, and Payment Task Force Compendium Report to the Massachusetts Legislature* (Sept. 2026), https://masshpc.gov/sites/default/files/PCTF-Deliverable-Compendium.pdf.

[10] Mass. Exec. Order No. 657 (Aug. 3, 2026), https://www.mass.gov/executive-orders/no-657-investing-in-primary-care-in-massachusetts.

Payer data is comprehensive with respect to "fee-for-service" (FFS) payments or payments made by a health insurance company in exchange for a specific primary care service provided to a member. But this data offers poor visibility into "supplemental" payments[11] – those paid not for a particular service for a particular patient – that are significant for some Massachusetts primary care providers. Examples of supplemental payments include lump sum or per-member-per-month incentive or performance payments, shared savings and shared risk settlements, per-member care management fees, infrastructure and population health payments. Payer reports on supplemental payments made to provider contracting entities cannot provide insight into how provider organizations and health systems allocate these payments internally. This report offers new details on primary care payments by combining payer claims data on core primary care services[12] and provider data on supplemental payments in 2024.

Second, commercial provider price variation in the Massachusetts health care market creates a challenge and an opportunity for mandates on providers and payers to invest more in certain service categories. As state data has demonstrated for years, some providers have been able to negotiate significantly higher payments than others from insurers for the same services, due to market leverage.[13] This includes fee-for-service payments as well as supplemental payments, which are both negotiated as part of the contract between payer and provider.[14] The providers with the lowest commercial payment rates often serve the highest share of public payer patients and provide the highest rates of uncompensated care,[15] compounding their financial challenges. As federal health care safety net funding faces significant cuts, there is increasing necessity to not exacerbate existing unwarranted commercial payment variation.

III. COMMERCIAL PAYMENTS FOR PRIMARY CARE SERVICES VARY WIDELY ACROSS PROVIDER ORGANIZATIONS AND INCLUDE SIGNIFICANT SUPPLEMENTAL PAYMENTS

a. Supplemental Payments Are Significant Relative to Fee-For-Service Primary Care Payments

Massachusetts commercial payers paid $489 million in supplemental payments in 2024. These payments include population health and practice infrastructure payments, incentive and performance payments, shared savings payments and other payments made to providers that are not compensation for a specific claim. Figure 1 puts those supplemental payments into context compared to core primary care fee-for-service payments – payments to providers for office visits, preventive visits, and other primary care visits[16] – to all Massachusetts providers.

[11] As used in this report, "supplemental payments" includes all funds earned above and beyond the negotiated fee-for-service allowable payments, net of withholds. This includes a) quality and efficiency settlement amounts paid to the accountable provider organization; b) infrastructure payments to support population health arrangements; and c) earned or guaranteed withhold returns. Supplemental funds are distributed in accordance with the provider organizations' own criteria.

[12] "Core primary care services" means the following CPT codes: 99202–99205, 99212–99215, 99381–99397. This set of codes was chosen to capture most routine primary care visits, and to exclude behavioral health, maternity, and other services sometimes grouped with primary care. Primary care clinicians were defined to include specific primary care taxonomy numbers and practitioner types who provide primary care office visits. The Appendix lists the taxonomy codes used to designate primary care providers for purposes of this report.

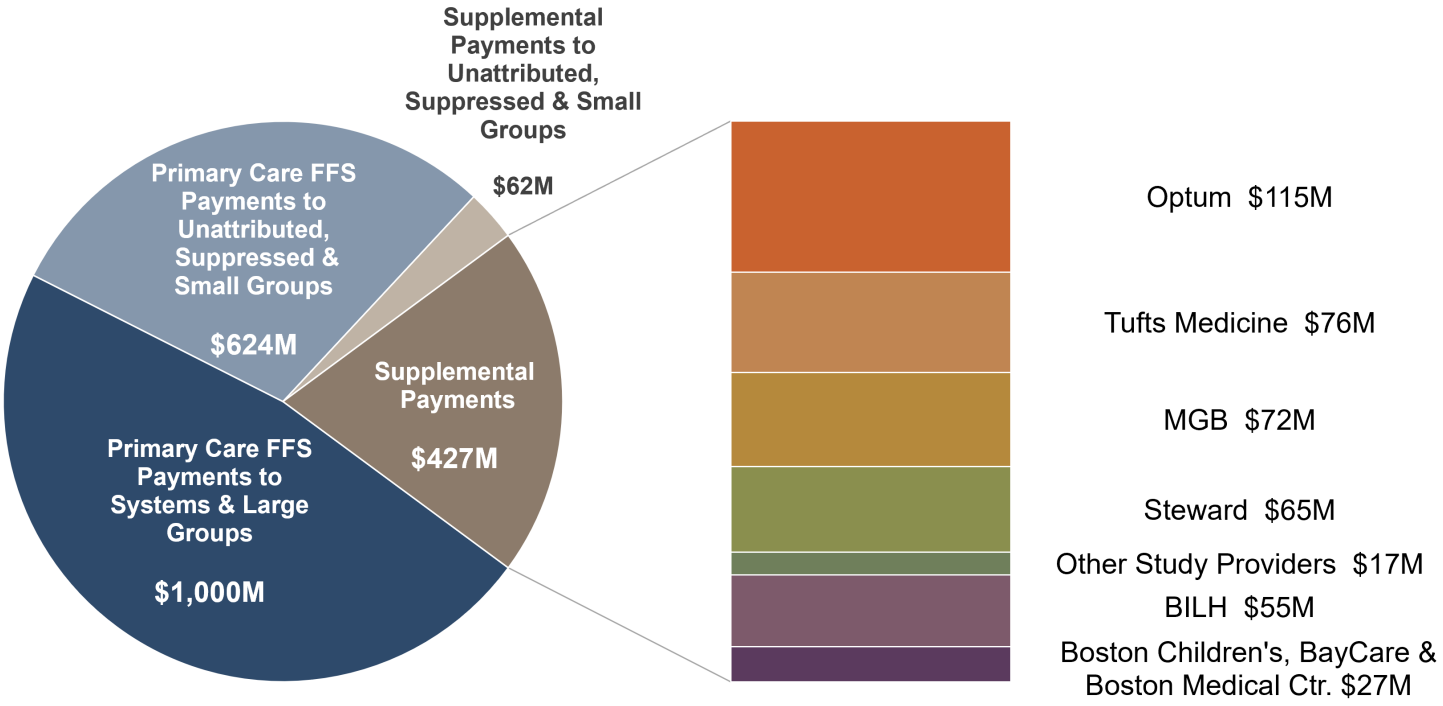
[13] Massachusetts Attorney General's Office, *Investigation of Health Care Cost Trends and Cost Drivers* (Jan. 29, 2010), https://www.mass.gov/doc/2010-investigation-of-health-care-cost-trends-and-cost-drivers-preliminary-report/download.

[14] Massachusetts Attorney General's Office, *Examination of Health Care Cost Trends and Drivers* (2022), https://www.mass.gov/doc/examination-of-health-care-cost-trends-and-cost-drivers-report-2022/download.

[15] Massachusetts Attorney General's Office, *Examination of Health Care Cost Trends and Drivers* (2024), https://www.mass.gov/doc/examination-of-health-care-cost-trends-2024/download.

[16] The Center for Health Information and Analysis (CHIA) reports on primary care spending using three categories (PC Office Visits, PC Preventative Visits, and PC Other Primary Care Visits) that align with the "core primary care" CPT codes used in this examination. *See* Ctr. for Health Info. & Analysis, *Primary Care and Behavioral Health (PCBH) Spending* (June 2026), https://www.chiamass.gov/wp-content/uploads/Primary-Care-Spending-Report-2026.pdf; *see also* Appendix for a table of specific taxonomy codes and provider types. There is some variation between the two sources, but there is no material impact on the findings of this report.

Figure 1: *CHIA Total Commercial Supplemental Payments Relative to Core Commercial Primary Care Fee-For-Service Payments, and Who Receives Them (2024)*

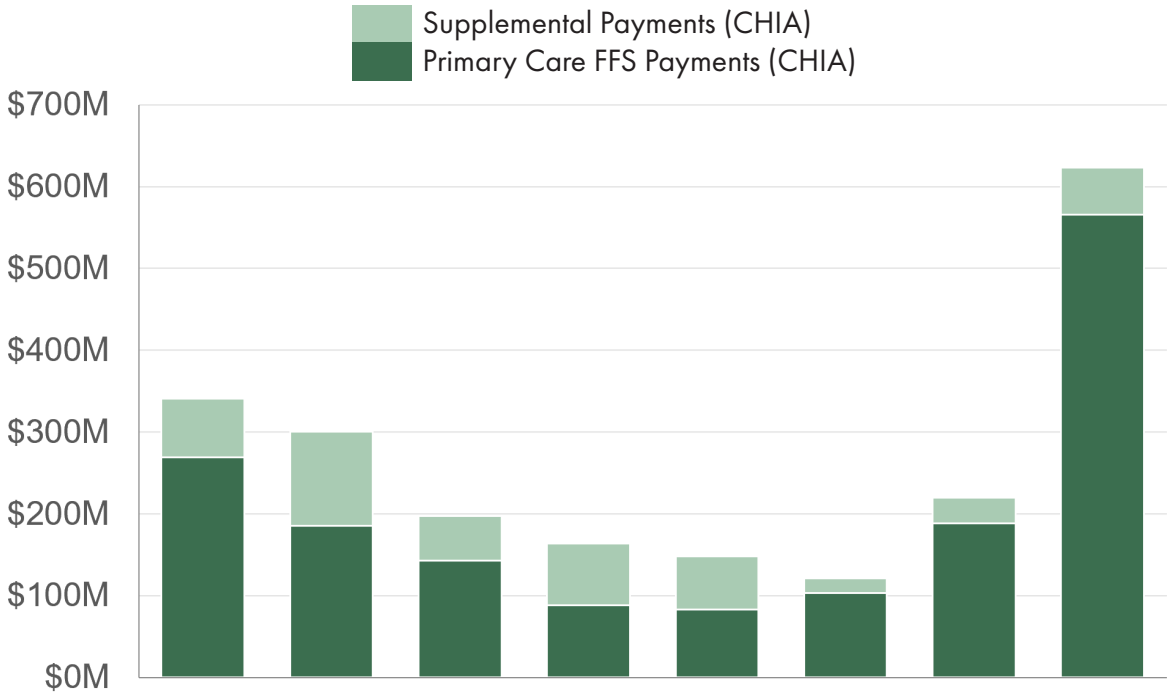


Source: CHIA Primary Care Spending Dataset 2026 (Expenditures Data). Notes: 1. Primary Care FFS Payments are CHIA's three primary care visit categories (office, preventive and other primary care visits). Supplemental Payments are CHIA's non-claims payments for all services. Both cover all commercial payers in 2024. 2. Systems & Large Groups: Mass General Brigham (MGB), Optum (Atrius Health and Reliant Medical Group), Beth Israel Lahey Health (BILH), Tufts Medicine, and the other Study Providers (UMass Memorial Health, South Shore Health, Southcoast Health, Cape Cod Healthcare, Signature Healthcare, Community Care Cooperative (C3)), plus Steward, Boston Children's, BayCare Health Partners and Boston Medical Center. 3. "Unattributed, Suppressed & Small Groups" includes members not attributed to any clinician group (including all of Health Plans, Inc. and Aetna), members of clinician groups below CHIA's 36,000-member-month reporting threshold, which CHIA suppresses, and 23 named small practice groups.

Across the commercial market, supplemental payments are significant relative to primary care fee-for-service payments, and most supplemental payments go to a handful of large provider organizations. As the state works to increase primary care capacity, understanding how these supplemental payments interact with primary care – how much is currently paid to primary care practices, how much goes to infrastructure that supports primary care and population health management, how much goes to support innovation in primary care practice, and how much goes to other uses – will help inform this work.

For the large provider organizations receiving significant supplemental payments, these payments can be almost equal to all primary care fee-for-service payments. As shown in Figure 2, Tufts Medicine received 2024 commercial supplemental payments that were 87% of the total fee-for-service payments received for core primary care claims.

Figure 2: *CHIA Total Commercial Supplemental Payments as a Percent of Core Commercial Primary Care Fee-for-Service Payments by Provider (2024)*



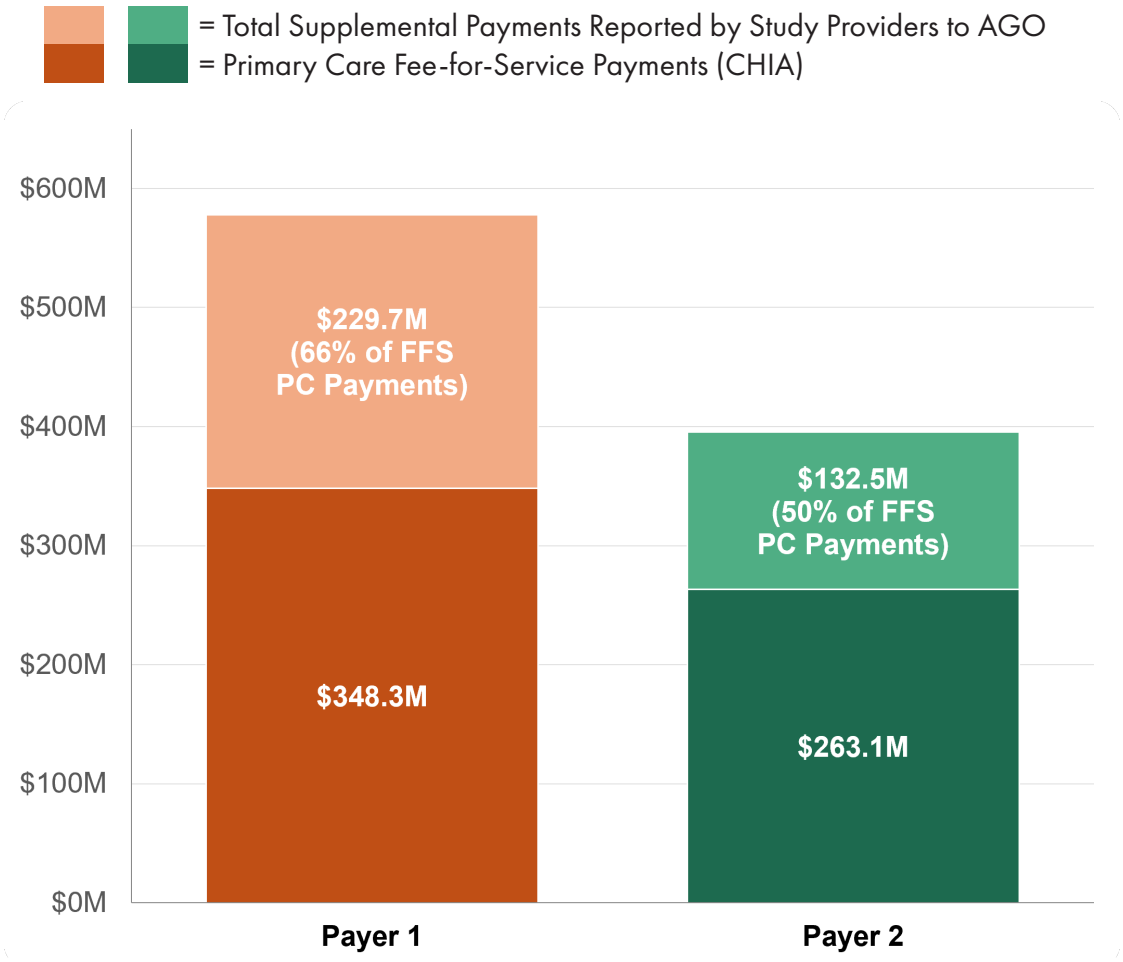
	MGB	Optum	BILH	Tufts Medicine	Steward	Other Study Providers	All Other Groups	Unattributed & Suppressed Groups
Total Supplemental Payments ($M)	$71.8	$115.1	$54.7	$76.2	$65.2	$17.2	$31.8	$57.3
Primary Care FFS Payments ($M)	$269.1	$185.0	$142.6	$87.8	$82.6	$103.5	$187.9	$565.6
Total Supplemental Payments as a % of PC FFS Payments	27%	62%	38%	87%	79%	17%	17%	10%

Source: CHIA Primary Care Spending Dataset 2026 (Expenditures Data). Notes: 1. Primary Care FFS Payments, Supplemental Payments and the Study Providers are as defined in Figure 1, notes 1 and 2; "Other Study Providers" are the six Study Providers not shown separately. 2. "All Other Groups" are the named clinician groups outside the Study Providers, including Boston Children's, BayCare Health Partners and Boston Medical Center. 3. "Unattributed & Suppressed Groups" is Figure 1's "Unattributed, Suppressed & Small Groups" without the 23 named small practice groups, which are included in "All other groups."

In this examination, we reviewed data on supplemental payments from a sample of major commercial insurers to ten Registered Provider Organizations: Beth Israel Lahey Health (BILH), Community Care Cooperative (C3), Cape Cod Healthcare, Mass General Brigham (MGB), Optum, Signature Healthcare, South Shore Health, Southcoast Health, Tufts Medicine, and UMass Memorial Health (UMass Memorial) (collectively "Study Providers"). These providers were selected to include a mix of payer mixes, regions, and practice types. The study payers comprise over 50% of the Massachusetts commercial market membership and over 75% of the commercial supplemental payments.

Most 2024 commercial supplemental payments came from two payers. Payer 1 made $230 million in supplemental payments and $348 million in primary care fee-for-service payments to the providers in our study. Payer 2 made $132 million in supplemental payments and $263 million in primary care fee-for-service payments to these providers.

Figure 3: *Magnitude of Supplemental Payments Reported by Study Providers to AGO Relative to CHIA Core Primary Care Fee-for Service Payments Reported by Two Payers (2024)*



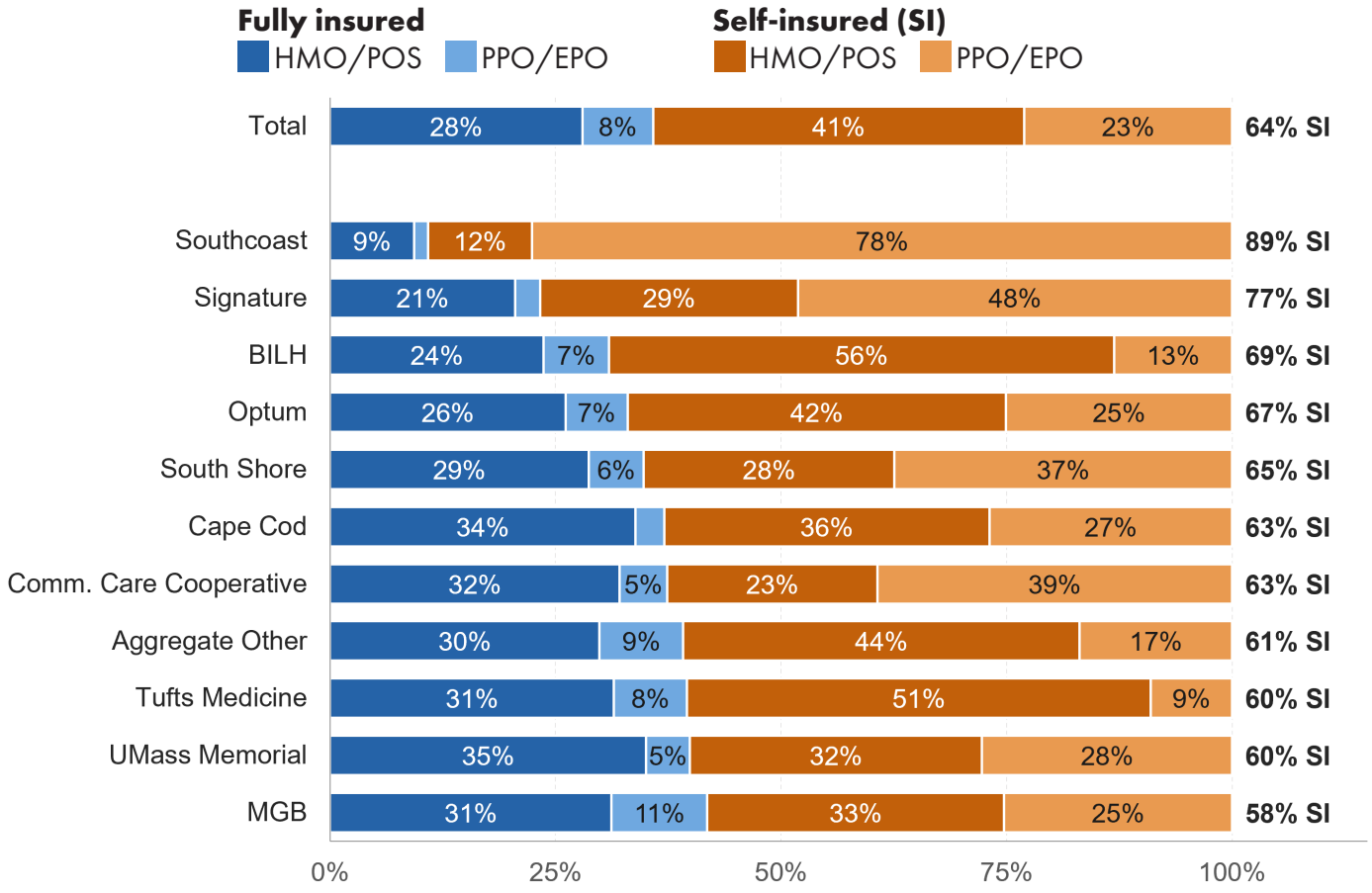
Source: CHIA Primary Care Spending Dataset 2026; payer and provider responses to AGO Civil Investigative Demands.
Note: Primary Care FFS Payments are as defined in Figure 1, for the two payers shown; where CHIA does not attribute a payer's spending to provider groups, the payer's own claims data are used.

b. A High Share of Commercial Primary Care Visits Are Paid by Self-Insured Plans

We examined commercial primary care visits by funding source and product type for each of the provider organizations in our study for one large commercial insurer. "Funding source" refers to whether a plan is fully insured or self-insured by its sponsor. In a fully insured plan, an insurance company bears the financial risk and makes claims payments for covered services in exchange for monthly premium payments. Such plans are regulated by the state's Division of Insurance and must follow state insurance regulations. In a self-insured plan, the sponsor – usually a large employer – bears the financial risk and engages an insurance company to administer claim payments for members in exchange for an administrative fee. Self-insured plans are regulated by the federal Employee Retirement Income Security Act (ERISA) and are exempt from most state insurance regulations.

"Product type" refers to the design of the insurance product. Health Maintenance Organization (HMOs) and Point of Service (POS) plans require patients to select a primary care provider to coordinate care within a network of providers. Preferred Provider Organization (PPO) and Exclusive Provider Organization (EPO) plans generally do not require a primary care provider selection or referral to see specialists.

Figure 4: *Primary Care Visits by Funding Source and Product Type, by Provider for a Large Commercial Insurer (2024)*



Source: Payer response to AGO Civil Investigative Demand. Notes: 1. Percentages stated in the chart's labels do not always add up to 100% or to the total self-insured percentages due to rounding. 2. "Aggregate Other" includes all primary care claims under this payer's contracts other than those with the Study Providers, including systems outside the study and independent practices.

For this insurer, 64% of primary care visits were for members of self-insured plans. Of the self-insured population, a significant share was in PPO/EPO plans, where referrals are not required and population health management is more challenging. Most fully insured primary care visits were for members in HMO/POS plans.

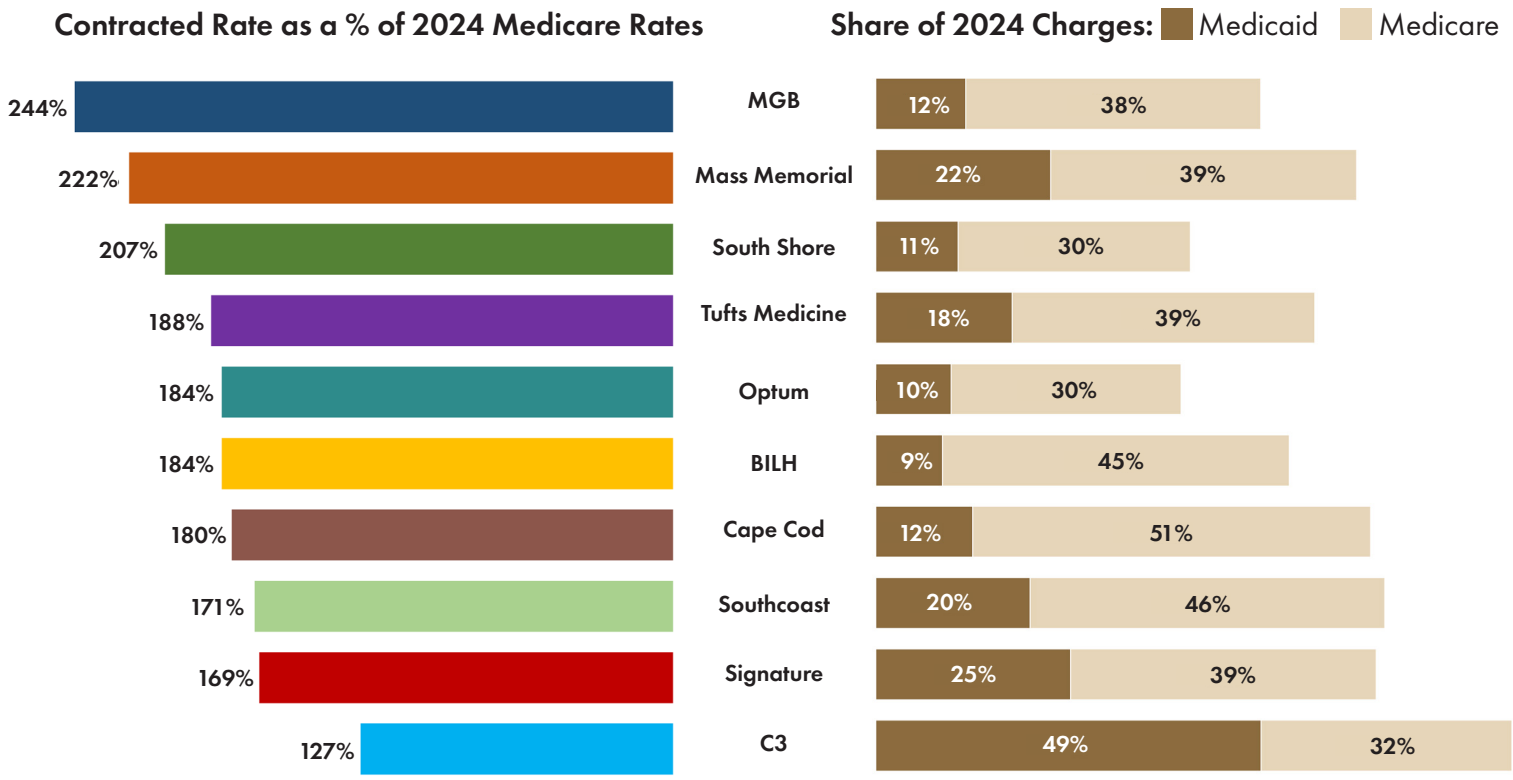
For the providers in the study, the share of self-insured visits ranged from 58% to 89% for this commercial payer. This variation is likely explained at least in part by specific large employers who use this insurer to administer self-insured plans in the areas served by one of these providers. Regardless of the local market forces driving this variation, the fact that providers serve such varying shares of fully and self-insured patients suggests a challenge in universal implementation of state mandates related to primary care product design and payment models, where state regulation of self-insured plans is limited by ERISA.

c. Commercial Fee-for-Service Rates for Primary Care Services Vary Significantly

Commercial fee-for-service payments vary significantly for core primary care services. Commercial price variation across health care providers has been documented in the Massachusetts market for decades, and primary care services are no exception. We calculated a weighted average commercial fee-for-service rate for primary care services for the payers in our study to assess current variation in this market.

In Figure 5, we present the range in contracted primary care rates expressed as a percent of Medicare rates, next to the provider organization's share of Medicaid and Medicare patients.

Figure 5: *Contracted Primary Care Rates Averaged Across Study Payers and Medicaid/Medicare Payer Mix by Provider Organization (2024)*

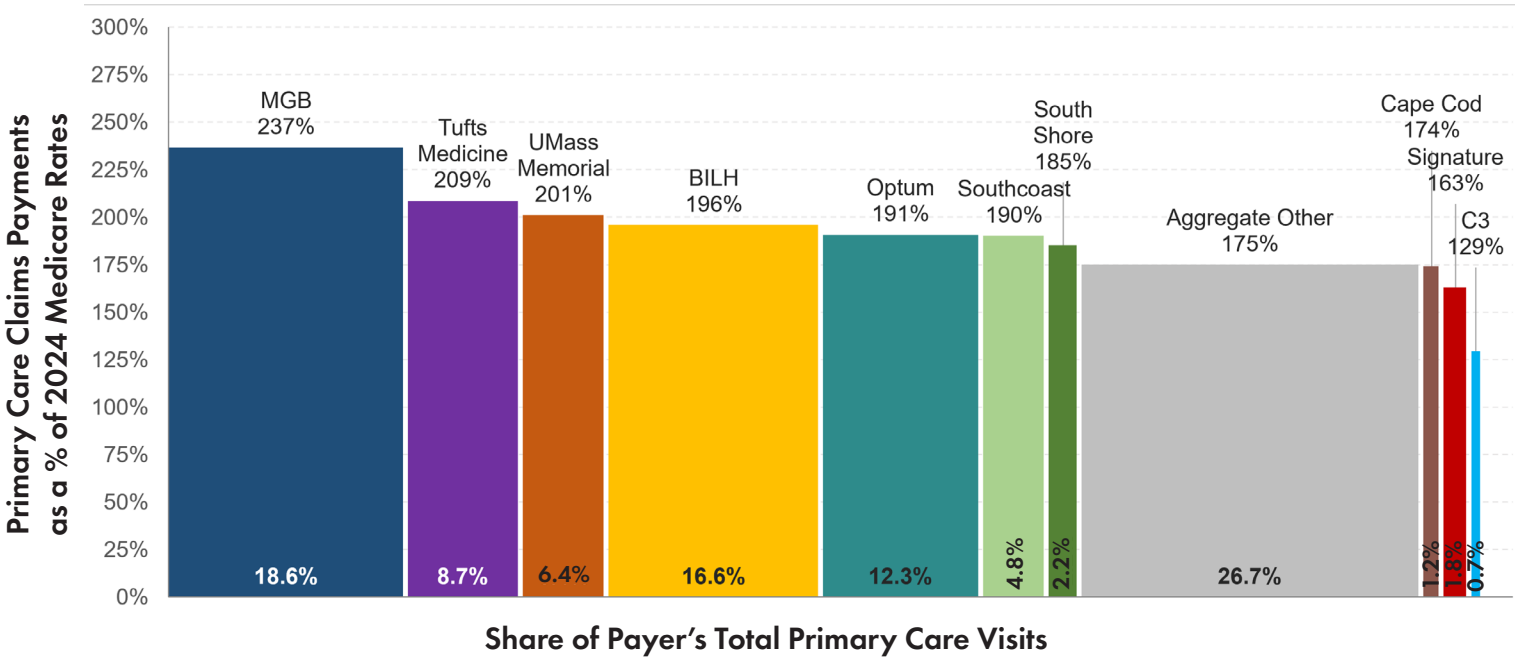


Source: Payer responses to AGO Civil Investigative Demand; 2024 Registration of Provider Organization Master File. Notes: 1. "Contracted Rate" is each Study Provider's principal contracted primary care rate with the study payers across the same basket of services, averaged across payers and product types using 2024 statewide commercial enrollment. "Medicare" in this report is the 2024 CMS Physician Fee Schedule, Massachusetts Locality 01 (Metropolitan Boston). 2. For providers that are not paid on an interim fee-for-service basis, the contracted rate is calculated using the statistical fee levels paid by the market. 3. "2024 Payer mix" is the Medicaid and Medicare share of each Study Provider's total 2024 charges. C3 is represented by Upham's Corner Health Committee, a Boston ACO member, as a proxy.

Overall, negotiated rates for primary care services ranged in our study from 127% to 244% of Medicare rates. Providers like Signature Healthcare and C3 receive significantly lower commercial rates for the same primary care services while serving a higher percentage of Medicaid patients. These contracted fee-for-service rates do not include negotiated supplemental payments, which are discussed below in Section III(e).

Actual claims payments reflect primary care payment disparities similar to the negotiated rates. Actual claims payments may differ from negotiated rates due to payer-specific payment policies, such as discounts on claims submitted for multiple services in one visit. In Figure 6, each bar area approximates the share of primary care claims payments by provider for one large commercial payer. The bar height is the primary care claims payment rate expressed as a percent of Medicare rates.

Figure 6: *One Commercial Payer's Actual Core Primary Care Claims Payments as a Percent of Medicare Rates, Sized by Share of Visits (2024)*



Source: Payer response to AGO Civil Investigative Demand. Notes: 1. Claims payments cover all product types (HMO/POS and PPO/EPO, fully and self-insured) and are compared with the payer's standard fee schedule for the same services, so differences in the mix of services do not affect the comparison. Supplemental payments are not included. 2. "Aggregate Other" is defined in Figure 4, note 2. 3. Bar width is each provider's share of this payer's 2024 primary care visits.

d. Distribution of Supplemental Payments Within Provider Organizations to Primary Care Varies Significantly

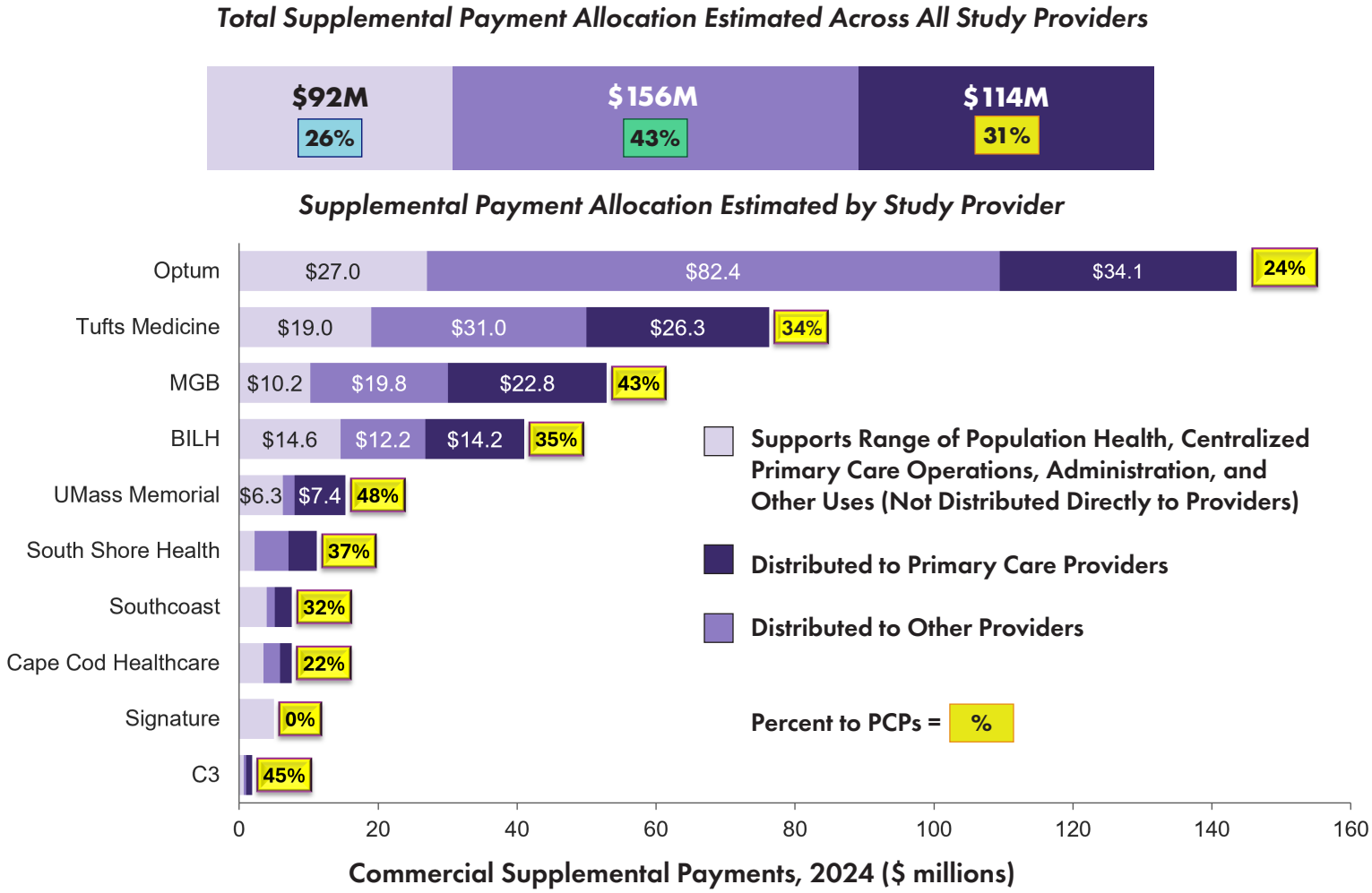
We used data from provider organizations to examine the distribution of supplemental payments to primary care providers. We asked provider organizations to report the total supplemental payments received from each study payer and the total amount of these payments distributed to provider practices. Uses of the funds not distributed to providers include population health initiatives, centralized primary care operations, administration, and other uses. Within the supplemental payments distributed directly to providers, we asked the provider organizations to estimate the approximate share of those payments that were distributed directly to primary care providers.

These responses do not fully answer the question of how supplemental payments support primary care, what kinds of supplemental payments are most likely to be distributed directly to providers, or how primary care providers are using these funds. Some provider organizations reported that their budget was payer agnostic and payments to primary care providers could not readily be traced back to a specific contract. Another challenge is that many provider organizations in this study employ most of their primary care providers, often within multi-specialty groups. These providers are typically salaried, with bonuses tied to group or system performance rather than to the supplemental payments generated by any one payer. Supplemental payments often become general operating revenue that supports both primary care and specialty practices, so dollars reported as not distributed directly to providers may still support primary care, and the share paid directly to primary care providers cannot be cleanly separated.

Provider organizations in our study estimated distributing varying but significant percentages of total supplemental payments received from payers directly on to primary care providers. Of all the provider organizations, only one reported distributing no supplemental payments to primary care providers. The other nine organizations reported distributing between 22% and 48% of the supplemental payments they received to primary care providers. Whereas payer reports have classified only minimal supplemental payments as primary care spending due to data limitations, these provider estimates suggest that for some provider organizations and contracts, almost half of supplemental payments are distributed to primary care providers.

Figure 7 shows the supplemental payments these provider organizations reported to the AGO – including their estimates about how these funds were distributed.

Figure 7: *Estimated Internal Distribution of Supplemental Payments From Study Payers as Reported by Study Providers (2024)*



Source: Provider responses to AGO Civil Investigative Demands. Notes: 1. Supplemental payments are the total each Study Provider reported receiving from the study payers in 2024. 2. The share distributed to primary care providers is the midpoint of each Study Provider's own reported range of payments distributed to primary care providers. 3. Optum produced an estimate of its overall allocation of supplemental payments and applied it to the supplemental payments received from study payers due to data limitations.

The supplemental payments distributed to providers outside of primary care include payments like funds paid to hospitals that earn quality payments on hospital-specific measures and extra payments on top of fee-for-service claims to specialists to increase their total payments.

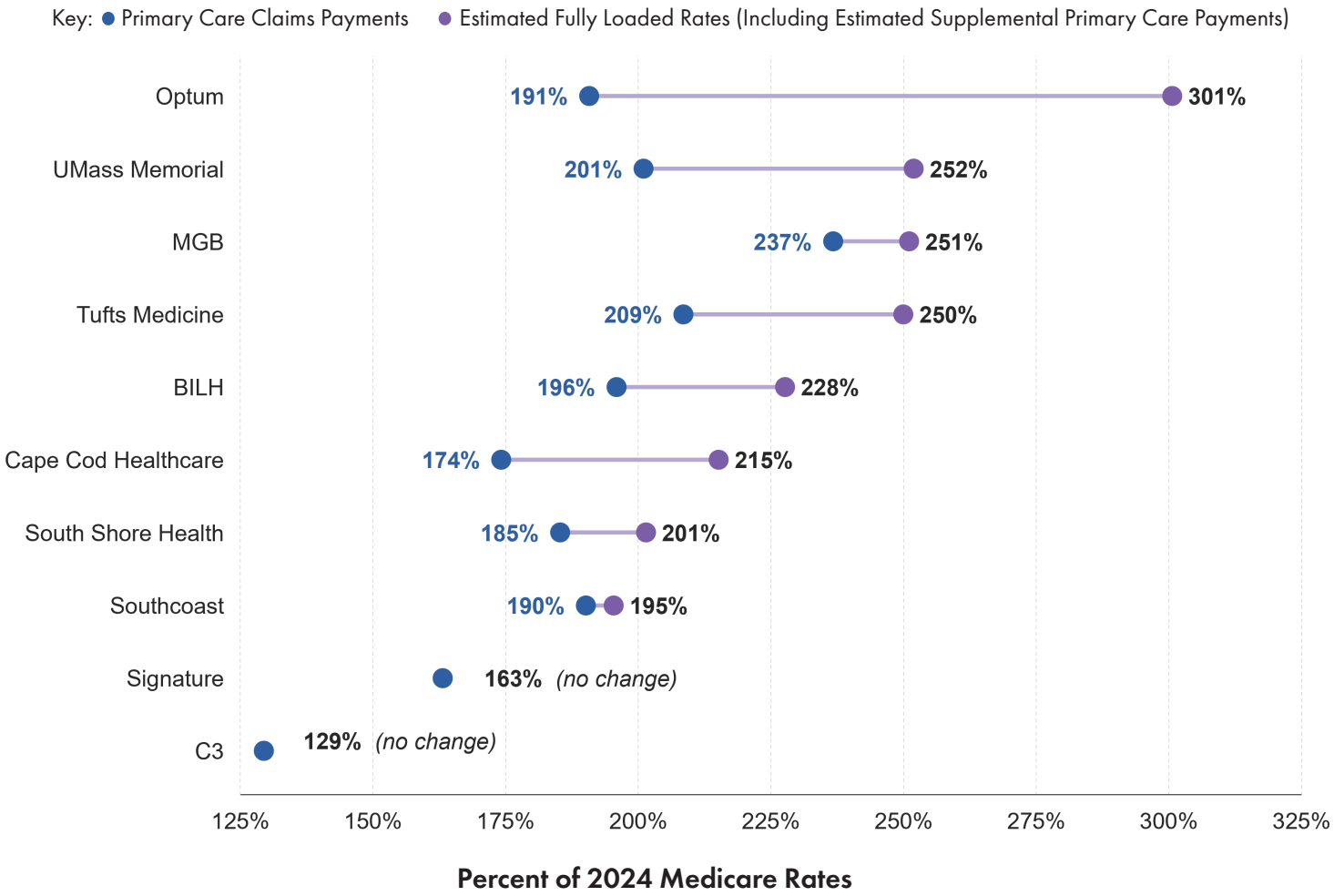
This data on the variation in supplemental payment distribution across provider organizations suggests there is variation in current funding available to support advanced primary care practice strategies like integrating behavioral health services with primary care, investing in the social determinants of health, reducing documentation burden, investing in care management, offering walk-in and same-day care appointments and extended hours of availability, and providing medication-assisted treatment.

e. Including Supplemental Payments to Primary Care Significantly Increases Payments to Most Providers and Increases Overall Primary Care Provider Price Variation

When we combined the actual core primary care claims payments with estimates from providers about the share of supplemental payments going to primary care providers, relative payment rates across large provider organizations changed, and providers with higher shares of Medicaid patients fell further behind the market. It is important to note that these estimates from providers do not include supplemental payments used at the system level to support primary care operations or population health, so these rate adjustments provide a conservative estimate of the total payments used to support primary care.



Figure 8: *Estimated Fully Loaded Core Primary Care Payments for One Commercial Payer (Including Claims Payments and Provider Estimates of Supplemental Payments Distributed to Primary Care Providers) as a Percent of Medicare Rates (2024)*



Source: Payer and provider responses to AGO Civil Investigative Demands. Notes: 1. Claims payments (blue) are as in Figure 6. Fully loaded rates (purple) add each Study Provider's estimated supplemental payments distributed to primary care providers (Figure 7, note 2) to its claims payments. 2. Aggregate Other is not shown because those providers were not asked to report supplemental payments.

While this data is based on provider organization self-reported estimates, it provides an estimate of the importance of supplemental payments in primary care financing. Future analyses informed by market-wide data collection from payers and providers on supplemental payments will help further understand how these payments are allocated.

IV. RECOMMENDATIONS

We offer the following recommendations as Massachusetts moves into the next phase of primary care reform.

1. Target investments to increase access to advanced primary care statewide.

A. Higher primary care rates are likely needed for some regions and provider organizations and may not be needed for others. Additional primary care investment should be targeted to most effectively address current access barriers. Factors that should be considered in the implementation of a state primary care investment strategy include public payer mix, support for independent practices, and current payment disparities when all payments, including supplemental payments, are included. As the state develops advanced primary care payment models, base capitation rates before health status adjustment should be consistent statewide and should not vary by organizations systems or payer.

B. New primary care spending should be used to address the practice challenges facing primary care providers. The primary care workforce is strained by administrative burdens and reports frustration in lacking the tools and resources to address their patients' social determinants of health and behavioral health needs. Community-based investment in innovative primary care models that leverage technology and team-based care hold significant promise but will require capital investment that is unlikely to happen organically in a market where specialty care offers providers a higher return on investment. Investment should ensure that all primary care practices are able to develop the capabilities to improve access and quality of care while supporting the strained workforce.

2. Ensure that commercial market changes do not negatively impact public payer patients or the providers that serve them.

A. Efforts to ease primary care capacity constraints should consider the incentives that large reimbursement gaps across payer types create for practices to allocate capacity toward higher-paying patients, especially given current uncertainty in the Medicare and Medicaid programs. The Massachusetts market already has some publicly traded and private equity-backed primary care-focused groups that restrict enrollment to commercially insured and limited Medicare patients. Monitoring primary care access should include reporting on access gains or losses (including appointment availability and wait times) by payer type and geography.

B. A shift of health care resources from specialty to primary care could have unintended consequences if safety net providers have to accept cuts to already-low commercial rates for specialists to balance additional primary care spending. To protect against this, relative price and payer mix should be incorporated into the cost neutrality enforcement of new spending targets, and access to specialty care should also be monitored by payer type and geography.

3. Enhance data collection and reporting to support primary care objectives.

A. Additional transparency into risk contracts and supplemental payments will help inform and monitor primary care investments. Risk contracts are complex, and payers and providers struggled to produce consistent records to the AGO on total supplemental payments and the share of supplemental payments distributed to primary care providers. Additional data reporting on supplemental payments through the Registration of Provider Organizations would enable all-in rate comparisons and evaluation of the impact of alternative payment models.

4. Include self-insured plans in state primary care policy.

A. Massachusetts must account for the fact that self-insured plans increasingly dominate the commercial health care market, including the market for primary care services. Self-insured plans are regulated by ERISA, and federal preemption limits the state's ability to mandate market-wide adoption of new commercial primary care payment models through legislation. The state must find other ways to engage large employers and incentivize self-insured participation in statewide primary care goals. There are options available for state policy to reach the self-insured market, including incentives for self-insured plans, see *Rutledge v. PCMA* (2020),[17] and separate reporting on progress towards primary care goals for the fully insured and self-insured markets.

B. An alternative approach to reach all segments of the insurance market would be to address mandates related to advanced primary care capabilities to providers rather than health insurance companies or plan sponsors.

5. Prioritize affordability and access.

A. Implementation of increased primary care spending must ensure that overall health care spending stays within the state cost growth benchmark without worsening commercial rate disparities. Massachusetts consumers, employers, and taxpayers are already struggling with annual premium increases far above what they can afford. Increasing primary care investment without adding to overall costs will require commitment from all health care market participants to redistribute spending in line with this state priority and will require an effective enforcement mechanism to ensure compliance and to protect against reductions in specialty services that could impair access to care.

[17] *Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 80–81 (2020) ("State rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage are not pre-empted by ERISA.").

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APPENDIX: PRACTITIONER TYPES INCLUDED AS PRIMARY CARE PROVIDERS

Taxonomy#	Practitioner Type
207Q00000X	Family Medicine Physician
207QA0000X	Adolescent Medicine (Family Medicine) Physician
207QA0505X	Adult Medicine Physician
207QG0300X	Geriatric Medicine (Family Medicine) Physician
207R00000X	Internal Medicine Physician
207RA0000X	Adolescent Medicine (Internal Medicine) Physician
207RG0300X	Geriatric Medicine (Internal Medicine) Physician
208000000X	Pediatrics Physician
2080A0000X	Pediatric Adolescent Medicine Physician
208D00000X	General Practice Physician
363AM0700X	Medical Physician Assistant
363L00000X	Nurse Practitioner
363LA2200X	Adult Health Nurse Practitioner
363LC1500X	Community Health Nurse Practitioner
363LF0000X	Family Nurse Practitioner
363LG0600X	Gerontology Nurse Practitioner
363LP0200X	Pediatric Nurse Practitioner
363LP2300X	Primary Care Nurse Practitioner
363LW0102X	Women's Health Nurse Practitioner
364S00000X	Clinical Nurse Specialist
364SA2200X	Adult Health Clinical Nurse Specialist
364SC1501X	Community Health/Public Health Clinical Nurse Specialist
364SP0200X	Pediatric Clinical Nurse Specialist
364SW0102X	Women's Health Clinical Nurse Specialist
363A00000X	Physician Assistant


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