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On behalf of the over 20,000 physician, resident, and student members of the Massachusetts Medical Society (MMS), we thank you for your work to reconcile S.3141 and H.5630 and advance meaningful primary care reform. Both bills recognize that a strong and sustainable primary care system is essential to improving health outcomes, expanding access, promoting equity, and controlling long-term health care costs. As you craft a final bill, we respectfully urge you to preserve the strongest elements of each proposal while ensuring that implementation supports, rather than further strains, the physician practices responsible for delivering care.

Expenditure Targets & Accountability

Application of Expenditure Targets: The MMS supports establishing a statewide aggregate primary care expenditure target and explicitly excluding pharmaceutical costs, including medically-administered drugs, from the calculation. A statewide target appropriately recognizes that rebuilding primary care is a shared responsibility across payers, health systems, and providers. We caution against applying the same expenditure target to every individual health care entity. A uniform expenditure target applied to individual entities would not account for substantial variation in provider organizational size, operational capacity, and patient population needs across the Commonwealth. Spending targets at an individual entity level, therefore, must account for size, resource capacity, and patient mix to determine an appropriate financial benchmark. Further, uniform targets applied to individual entities could create particular challenges for independent physician practices, which often lack the financial resources and administrative infrastructure of large, hospital-affiliated networks. Therefore, their exclusion from a mandated spending target is needed for their continued operability.

Implementation Timeline: We recognize the critical urgency of increasing investment. At the same time, implementation must reflect the practical realities of existing contract cycles and the practical necessity for payers and providers of negotiating and operationalizing significant payment changes.

Spending Target Accountability: Additionally, we recommend adopting a meaningful, carefully tailored accountability framework to advance spending targets. We support the framework in H.5630 under which the Health Policy Commission (HPC) may review the primary care investment of entities identified as exceeding the health care cost-growth benchmark, provided that the bill's exemption for smaller physician contracting units is preserved and independent physician practices are protected from disproportionate requirements.

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Additionally, we recommend authorizing the Center for Health Information and Analysis (CHIA) to conduct targeted analyses of payers and registered provider organizations (RPOs) when the Commonwealth does not meet the aggregate primary care spending target. Updated reporting requirements for primary care spending by RPOs should provide sufficient information to CHIA to review and understand whether and to what extent certain entities may be failing to contribute to the aggregate primary care spending target and such analysis should inform appropriate accountability.

Where additional action is warranted, the primary care commitment process should be strengthened to require a performance improvement plan. Accountability should focus on entities with excessive cost growth and the capacity to increase primary care investment.

Definition of Primary Care Services

The final bill should establish a clear, inclusive, and consistent definition of primary care services that applies across its expenditure, payment, reporting, and administrative provisions. While it is helpful to have key elements of primary care outlined in statute, the definition should also allow appropriate regulatory flexibility to promote adaptability as primary care practice and care delivery evolve.

Advanced Primary Care Payment Model & Practice Viability

The MMS supports expanding access to advanced primary care payment models, but provider participation must remain voluntary. As many experienced through entry into the MassHealth ACO sub-capitation model, participation in new payment models requires significant build and infrastructure work to meet the level of specificity of the baseline requirements, which is resource-intensive for practices. Specifically, mandating participation without any initial financial support may be impractical or unrealistic for some provider organizations. A voluntary framework would allow practices to evaluate whether the model is appropriate for their patient populations, operational capabilities, and financial circumstances, while still encouraging broad adoption where the model demonstrates value. We appreciate that both bills recognize the unique circumstances of independent primary care practices by exempting them from mandatory participation in the advanced care model and additional reporting requirements. We recommend retaining this approach in a final bill.

We also ask that you consider combining the House voluntary participation framework with a uniform model available across carriers and the Group Insurance Commission (GIC). Under such an approach, the Division of Insurance (DOI) could approve alternative models that meet comparable minimum standards and patient and provider protections with the aim of ensuring streamlined and uniform administrative rules and processes across carriers. Some provider organizations already participate in longstanding alternative payment arrangements with carriers. Existing arrangements that satisfy the minimum standards developed by the Division should be permitted to continue. This structure could promote consistency while preserving flexibility for practices with successful existing arrangements.

New primary care investment must reach the practices delivering care and primarily focus on the delivery of primary care services. We therefore support the provision in S.3141 requiring at least 90% of prospective primary care payments to be directly allocated to and retained at the primary care practice level and focused on care delivery. We also recognize the value of allowing up to 10% to remain at the system level when those funds can support infrastructure or other primary care investments that directly benefit participating primary care practices.

We also urge inclusion of a clear minimum payment protection. We prefer the Senate approach, which requires that a practice generate at least as much revenue under the advanced model as it generated under its historical fee-for-service payment arrangement, with appropriate accounting for differences between pediatric and adult care and for clinical and social complexity. The protection should be measured at the practice level so that increased system-level primary care spending does not mask a reduction in resources reaching frontline care.

Oversight & Technical Expertise

Both bills offer reasonable approaches to agency oversight. The Senate would establish an Office of Primary Care Policy and Payment within the Health Policy Commission, while the House assigns responsibilities among the HPC, CHIA, and DOI. The MMS defers to the Legislature on the precise administrative structure that would best preserve the substantive mechanisms described above. Whichever structure is selected, the final bill should establish a technical advisory body with robust physician representation and members who bring discrete expertise in primary care delivery, practice operations, and primary care payment and financing. Physician representation should reflect adult and pediatric care, and variation across practice settings including independent practices, community health centers, multispecialty groups, and system-affiliated practices.

Reducing Administrative Burden

The MMS supports eliminating prior authorization for all primary care services consistent with DOI's recently finalized prior authorization regulations, and this protection should not be limited to services delivered under an advanced payment model. At a minimum, it should apply to the full scope of primary care contemplated by H.5630, including preventive services, routine evaluation and management, chronic disease management, care coordination, vaccine and injection administration, integrated behavioral health services, and preventive obstetric and gynecologic services. Limiting this administrative reform to providers participating in a particular payment model would unnecessarily limit associated improvements in patient access to care and reduce the incentive for carriers to simplify their administrative requirements more broadly.

We also support Section 34 of H.5630, which establishes transparency and patient-safety guardrails for the use of artificial intelligence and other automated tools in utilization review. In particular, the final bill should preserve the requirements that automated tools consider the patient's individual clinical circumstances, that such automated tools never serve as the sole basis for an adverse determination, and that adverse determinations be

made by a licensed physician or other licensed health care professional following individualized clinical review.

Additional reporting should be carefully designed to avoid creating new administrative burdens for primary care practices. We generally support greater transparency through the RPO program, including information on workforce, patient panels, access, and the flow of primary care dollars. However, reporting should be limited to information necessary to administer the law, use existing data wherever possible, include clear and consistent definitions, and avoid duplicative site-level submissions. Small and independent practices should remain protected from disproportionate requirements.

Similarly, quality measures used in advanced payment models should be limited, evidence-based, actionable in the primary care setting, and aligned with the existing statewide standard quality measure set. The final bill should avoid creating a separate set of measures or reporting processes that would add burden without improving patient care.

Strengthening the Primary Care Workforce

The MMS supports the Senate provision establishing MassHealth graduate medical education payments for postgraduate training in community-based primary care, behavioral health, and other shortage areas. We also support the House's Health Care Workforce Transformation Fund, including the initial \$25M transfer and the requirement that at least 80% of available funding through fiscal year 2036 support primary care training, recruitment, retention, and geographic distribution.

Workforce investments should be available across practice settings. To level the playing field and support the viability of independent practices, physician practices must have the same opportunity as larger systems and community health centers to participate in loan repayment, residency grants, preceptorships, scholarships, and related programs. Eligibility criteria should expressly include independent primary care practices that serve substantial public-payer populations, including practices with patient panels that are at least 30% public payer. Supporting training and careers in these settings will help preserve community-based access and allow independent practices to compete for a limited workforce.

Federally Qualified Health Center Payment Parity

The MMS supports requiring commercial carriers and the GIC to reimburse federally qualified health centers at no less than applicable MassHealth payment levels. To that end, we recommend adopting the House implementation mechanism, which ties reimbursement to the applicable encounter rate and prospective payment system methodology and provides for technical consultation with MassHealth. Adequate and predictable reimbursement is essential to the ability of health centers to serve patients with complex needs and sustain access in underserved communities.

Pharmacy Access and Physician In-Office Dispensing

Last year, HPC found that 8.3% of Massachusetts residents, approximately 580,000 people, live in a pharmacy desert, an increase of roughly 90,000 residents since 2019. Another 525,000 residents live in an area that would become a pharmacy desert if its sole pharmacy closed. The MMS therefore supports the provisions in H.5630 that define and assess pharmacy deserts and require advance notice before certain pharmacy closures. Pharmacy closures have a direct impact on patients' ability to obtain medications and adhere to treatment.

We also support authorizing physicians to dispense certain medications directly from their offices, consistent with proposals in S.2732 and H.1160. In-office dispensing is not simply a matter of convenience. Particularly in communities with limited pharmacy access, it can remove a significant barrier to treatment and increase the likelihood of better patient outcomes, while preserving appropriate safety and recordkeeping requirements.

Patients First Extension

MMS supports the House provision extending to January 1, 2029, the implementation timeline of certain state provider disclosure requirements related to network participation, allowed amounts, and facility fees. We appreciate the Legislature's similar prior action, recognizing the need to align with federal standards under the No Surprises Act (NSA). Given that the federal rules are not yet finalized, we urge adoption of this further delay to avert unnecessary administrative burden and confusion. Specifically, lack of action would subject physicians, practices, and health care systems to duplicative and potentially conflicting compliance obligations that would create unnecessary administrative burden while providing no additional benefit to patients.

Provider Choice

Finally, we urge the conference committee not to include the provider immunization brand-choice provisions contained in H.5630. These provisions would override the successful, expert-driven vaccine selection process led by the Massachusetts Vaccine Purchasing Advisory Council and make vaccine demand more difficult to forecast. Broad brand choice would increase administrative complexity, heighten the risk of waste from unused inventory and expiration, and weaken the Commonwealth's ability to negotiate favorable pricing. The existing framework preserves clinical input while allowing the Department of Public Health to manage the universal immunization program efficiently and sustainably.

Thank you for your consideration of these recommendations and for your continued commitment to strengthening primary care in Massachusetts.

Sincerely,

Rebecca W. Brendel, MD, JD