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Looking Ahead: Key Policy Changes Shaping Massachusetts Health Care

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As one legislative session draws to a close and attention turns to the next two-year cycle, health care organizations face a policy landscape that is changing faster and with greater complexity than ever before. New developments at both the state and federal levels are reshaping the regulatory, reimbursement, and operational environment, requiring leaders to balance immediate priorities with long-term strategic planning. Organizations that take a proactive approach to monitoring policy trends, assessing emerging risks and opportunities, and preparing for future change will be better positioned to navigate uncertainty and thrive in an increasingly dynamic health care market.

Near-Term

Primary Care

Few issues could have a greater impact on the Massachusetts health care system over the next several years than the legislature's ongoing effort to increase investment in primary care. For providers, payers, and other health care stakeholders, the debate extends beyond how much additional funding should flow to primary care and raises broader questions about how that investment will be achieved, how quickly changes will take effect, and which organizations will be responsible for meeting new requirements.

Over the past three months, members of the House and Senate conference committee have been working to reconcile competing versions of primary care legislation. While both chambers share the goal of strengthening primary care and improving access, important differences remain regarding spending requirements, payment models, and provider obligations. With only weeks remaining in the legislative session, the outcome of these negotiations could have significant operational and financial implications for health care organizations across the Commonwealth.

Key provisions under negotiation include:

Primary Care Expenditure Target — Both chambers propose establishing a primary care expenditure target that would gradually increase the percentage of overall health care spending devoted to primary care. Under both proposals, spending would begin at 9% of total health care expenditures and eventually increase to 15%.

The most significant difference is the pace of implementation. The Senate proposes reaching the 15% target by 2030, while the House would phase in the increase through 2036. The House proposal also provides greater flexibility by avoiding annual interim spending targets, allowing policymakers to evaluate progress before reaching the next applicable benchmarks.

The Senate proposal goes further by creating an entity-level expenditure requirement, under which certain health care organizations would be required to meet primary care spending targets based on their own total expenditures. If ultimately adopted, this provision could have significant implications for organizational budgeting, care delivery strategies, and long-term financial planning.

Advanced Payment Model — Both proposals would establish an advanced primary care payment model built on prospective, capitated per-member-per-month payments. However, the House and Senate take very different approaches to the development and implementation of such a model.

The Senate envisions a statewide model developed by the Health Policy Commission (HPC) and applied uniformly across commercial insurers and the Group Insurance Commission (GIC). Participation would be mandatory for certain larger provider organizations, and 90% of payments would be required to remain at the practice level.

The House takes a more flexible approach, directing the Division of Insurance (DOI) to establish a framework for advanced primary care payment models while permitting insurers to submit alternative models for approval. Provider participation would remain voluntary under the House proposal.

While these issues may appear technical, the policy choices ultimately made by the conference committee will influence how primary care is financed, delivered, and measured throughout Massachusetts. Organizations that understand the direction of the negotiations and engage in the process will be better positioned to prepare for changes that may affect reimbursement, care models, and compliance obligations in the years ahead.

Long-Term

Federal Medicaid Changes

While policymakers remain focused on near-term legislative priorities, health care organizations should not lose sight of a much larger challenge on the horizon: the long-term impact of federal Medicaid reforms.

More than 16 months ago, the One Big Beautiful Bill Act was signed into law, initiating a series of Medicaid eligibility and financing changes that will continue to take effect through 2028. Although implementation remains ongoing, the potential impact on Massachusetts is significant. According to MassHealth estimates, approximately 300,000 residents could lose health insurance coverage, while the Commonwealth could experience a reduction of roughly $3.5 billion annually in federal health care funding once the changes are fully phased in.

It's worth noting that on November 13 the Centers for Medicare & Medicaid Services (CMS) informed state Medicaid directors they can opt into a grace period that allows states to avoid denying applications or disenrolling otherwise eligible individuals solely for failing to meet the new work requirement until June 30, 2027. This is optional – states must still verify whether applicants and enrollees meet the requirement or qualify for an exemption, but they can suspend penalties during the hold?harmless period. Medicaid work requirements still begin January 1, 2027, but states can delay enforcement until June 30, 2027 if they request the hold?harmless period from CMS by December 11, 2026. This new guidance could mitigate federal revenue impacts for the remainder of FY 2027; however, the full extent of the impact of delayed enforcement is unknown.

Recent analysis from the Massachusetts Taxpayers Foundation (MTF) suggests that while some individuals losing coverage may obtain insurance through other avenues, many are likely to rely on the Health Safety Net, the Commonwealth's payer of last resort. MTF estimates that approximately 135,000 additional individuals could seek care through the program and that every additional 50,000 Health Safety Net users could generate roughly $100 million in additional demand for services.

The consequences will extend well beyond Medicaid beneficiaries. For hospitals, community health centers, physician groups, and other providers, these trends create a challenging financial dynamic. Organizations may simultaneously face declining MassHealth revenues, increasing levels of uncompensated care, and growing demand for services from uninsured and underinsured patients. The cumulative effect could reshape financial planning, service delivery strategies, and investment decisions across the health care continuum.

The implications are equally significant for state policymakers. Federal health care funding represents nearly one-quarter of the Commonwealth's annual budget, with much of that funding supporting MassHealth. As Massachusetts enters a new legislative session, lawmakers, regulators, providers, and industry stakeholders will face difficult decisions regarding coverage, reimbursement, affordability, and access to care.

For health care organizations, the lesson is clear: monitoring policy developments is no longer enough. The organizations that will be best positioned to navigate the years ahead are those that actively assess emerging legislative and regulatory risks, anticipate policy shifts before they occur, and engage strategically in the policymaking process. As state and federal decisions increasingly shape financial and operational realities, informed advocacy and early engagement will become critical components of organizational success.

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