MASSACHUSETTS
HEALTH POLICY COMMISSION

HPC Board Meeting

January 16, 2025

Agenda

CALL TO ORDER

Approval of Minutes **(VOTE)**

Behavioral Health Workforce Center

Overview of New Health Care Legislation: *An Act enhancing the market review process and An Act relative to pharmaceutical access, costs, and transparency*

A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action – *Special Report from the HPC on Primary Care Workforce, Access, and Spending Trends*

Executive Director's Report

Adjourn

Agenda

Call to Order

APPROVAL OF MINUTES (VOTE)

Behavioral Health Workforce Center

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Executive Director's Report

Adjourn

VOTE

Approval of Minutes from the December 12, 2024 Board Meeting

MOTION

That the Commission hereby approves the minutes of the Commission meeting held on **December 12, 2024**, as presented.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

BEHAVIORAL HEALTH WORKFORCE CENTER

Overview of New Health Care Legislation: *An Act enhancing the market review process and An Act relative to pharmaceutical access, costs, and transparency*

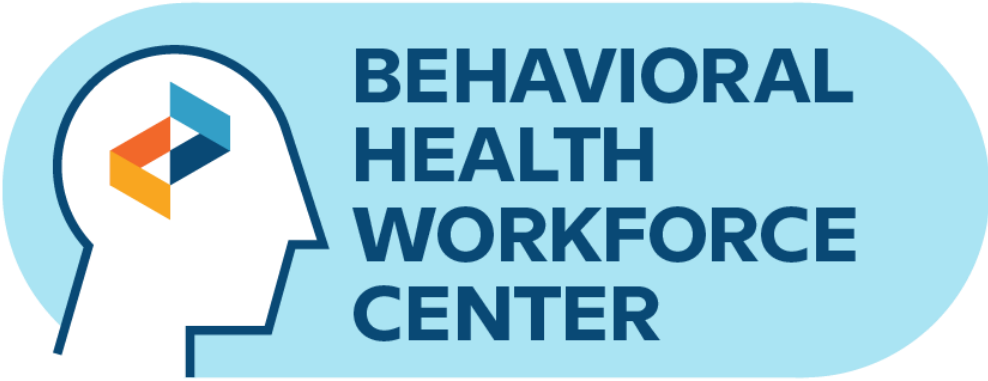
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The HPC Behavioral Health Workforce Center

- The **HPC Behavioral Health Workforce Center (BHWC)** was established in partnership with the Executive Office of Health and Human Services (EOHHS) to strengthen the state's capacity to identify and respond to current and ongoing behavioral health workforce needs.
- The BHWC will **drive state-wide efforts** and **leverage cross-sector partnerships** to achieve a unified vision for the Commonwealth's behavioral health workforce.
- Through development of **actionable, evidence-based strategies**, the BHWC will prepare state leaders to:
  - Build equitable education and training pipelines,
  - Improve workforce diversity and cultural competency,
  - Enhance professional pathways, and
  - Retain behavioral health providers within settings and communities that are accessible to all residents.



BHWC Advisory Group

- Through a procurement process, which launched in October and concluded in December 2024, the HPC has convened a new focused advisory group to support the work of the BHWC.
- The review and selection process yielded a highly qualified group of **30 providers, patient representatives, industry experts, policymakers, and community advocates**, who represent a wide array of subject matter expertise and lived experience.
- The purpose of the BHWC Advisory Group is to **share knowledge and diverse perspectives** through **collaborative engagement** with HPC leadership, which will **inform the BHWC's work and policy recommendations**.
- The BHWC Advisory Group will participate in quarterly meetings and occasional topic-specific sub-group meetings.
  - The BHWC Advisory Group's inaugural meeting is scheduled for **Tuesday, February 25, 2025.**

The HPC's Behavioral Health Workforce Center convened a 30-member Advisory Group to further the center's mission and goals.

Carla Azuakolam, MA – Brookline Center for Community Mental Health

Jill Borrelli, LICSW – WellSense Health Plan

Rebecca Butler, MSc, MSW, LCSW – Center for Addiction Medicine, Mass General Hospital

Tommy Claire, MBA, MPH – Behavioral Health Network

Karen Donelan, ScD, EdM – Heller School for Social Policy & Management, Brandeis University; Mass General Hospital

Liz Friedman, MFA – GPS Group Peer Support

Cara Fuchs, PhD, MPH – Boston University School of Medicine; Boston Medical Center

Elizabeth Ganz, JD – Association for Behavioral Healthcare

Rebekah Gewirtz, MPA – National Association of Social Workers, MA/RI

Samara Grossman, LICSW – Boston Public Health Commission

Brian Jenney, LMHC, LADC – VitalCore Health Strategies, MCI-Framingham

Kaitlyn Kenney Walsh, PhD – Blue Cross Blue Shield of MA Foundation

Michelle Larned, LICSW – Vinfen

Jessica Larochelle, MS – MA Association for Mental Health

Darcy Lichnerowicz, MBA – Southcoast Behavioral Health

Leena Mittal, MD – MCPAP for Moms

Cristina Montalvo, MD, MBA, MBS – Tufts Medical Center; Lowell General Hospital

Anita Morris, MSN – TEAM UP for Children Scaling & Sustainability Center, Boston Medical Center

Nancy Norman, MD, MPH – MA Behavioral Health Partnership; Health Equity Compact

Dede O'Shea, PhD, ABPP – Lahey Hospital

Lamar Polk, MPH, MSW, LICSW, CCM – Technical Assistance Collaborative

Pam Sager, JD – Parent Professional Advocacy League

Madison Schmitt, MEd – MA League of Community Health Centers

Jennifer Shacklewood, LICSW – Mystic Valley Elder Services

Leigh Simons, MPH – Massachusetts Health & Hospital Association

Gemima St. Louis, PhD – Center for Workforce Development, William James College

Ellana Stinson, MD, MPH, MBA – Boston Medical Center; New England Medical Association

Elizabeth Suarez, MA – Caregiver; The Community Builders

Christine Tebaldi, DNP, MPH, CNP, PMHNP – McLean Hospital, Mass General Brigham Behavioral and Mental Health

Diana Westerberg, PhD – Lynn Community Health Center

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Behavioral Health Workforce Center

OVERVIEW OF NEW HEALTH CARE LEGISLATION: *AN ACT ENHANCING THE MARKET REVIEW PROCESS AND AN ACT RELATIVE TO PHARMACEUTICAL ACCESS, COSTS, AND TRANSPARENCY*

A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action – *Special Report from the HPC on Primary Care Workforce, Access, and Spending Trends*

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Chapters 342 and 343 of the Acts of 2024 were signed into law on January 8, 2025.

An Act relative to pharmaceutical access, costs, and transparency

- Improves state oversight of the pharmaceutical industry, including pharmacy benefit managers (PBMs)
- Caps out-of-pocket costs for drugs to treat asthma, diabetes, and certain common heart conditions

An Act enhancing the market review process

- Strengthens state oversight of private equity investment in health care
- Requires statewide health planning with increased data collection and agency coordination



Key Legislative Components

HPC BOARD MEMBERSHIP AND APPOINTMENT CHANGES

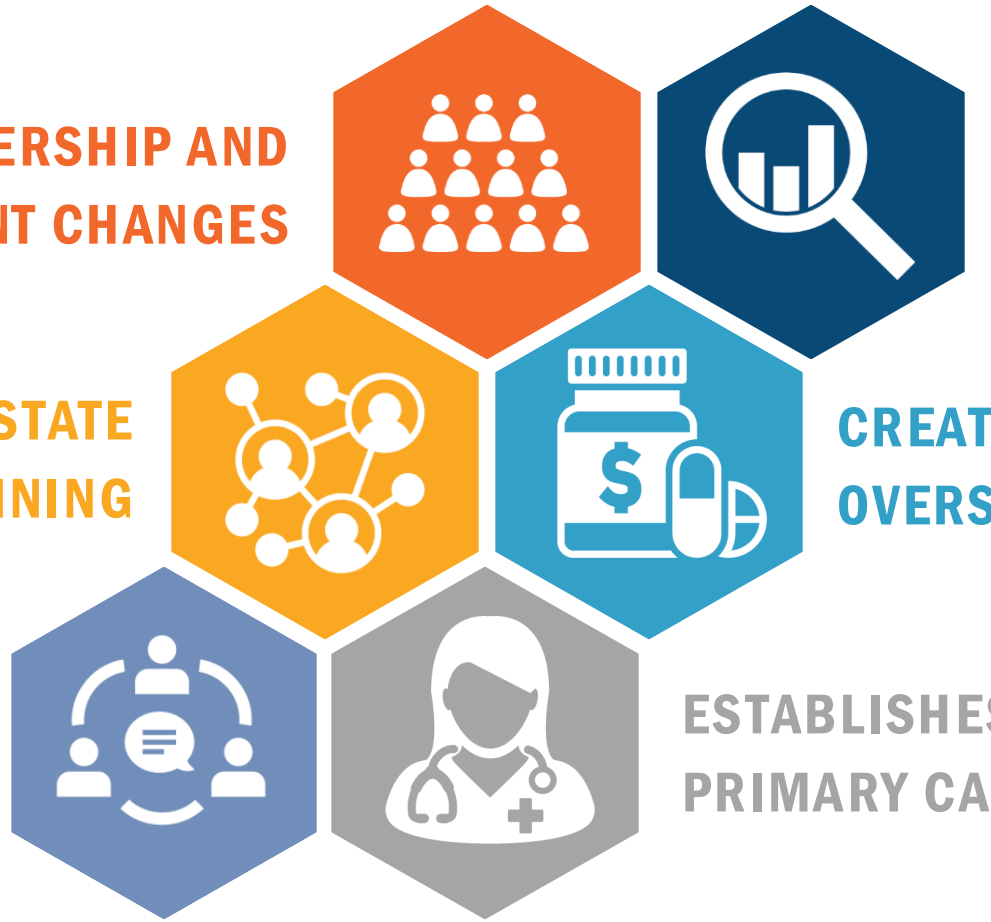
STRENGTHENS MARKET OVERSIGHT AUTHORITY

REVITALIZES STATE HEALTH PLANNING

CREATES PHARMACEUTICAL OVERSIGHT

ENHANCED INTERAGENCY COORDINATION

ESTABLISHES INTERAGENCY PRIMARY CARE TASK FORCE



HPC Board Membership and Appointment Changes

GOVERNOR
Maura Healey



- Chair with expertise in health care administration, finance, and management
- Expertise representing hospitals or hospital health systems ***NEW***
- Expertise in health plan administration and finance
- Registered nurse with expertise in care delivery innovation
- Expertise in representing the health care workforce. Selected from list of nominees by the President of the Senate ***MODIFIED***
- Expertise in pharmaceuticals, biotechnology, or medical devises. Selected from a list of nominees by the Speaker of the House ***NEW***
- Secretary of Health and Human Services
- Commissioner of Insurance ***NEW***

ATTORNEY GENERAL
Andrea Campbell



- Expertise as a health economist
- Expertise in behavioral health
- Expertise in health care consumer advocacy

HEALTH POLICY COMMISSION BOARD
Deborah Devaux, Chair



EXECUTIVE DIRECTOR
David Seltz



EXECUTIVE DIRECTOR'S ADVISORY COUNCIL

ADDITIONAL PROVISIONS:

- Appointed members of the HPC Board will receive an annual stipend.
- Initial appointments will be staggered terms of 2, 3, or 4 years.
- All board changes are effective July 1, 2025.

New Office of Pharmaceutical Policy and Analysis

- Establishes a new HPC Office of Pharmaceutical Policy and Analysis (OPPA) to **collect and analyze pharmaceutical spending data** and information, produce reports and analyses of pharmaceutical costs and access, and issue recommendations on matters related to prescription drug policy
- Directs OPPA to publish an **annual report** on trends related to access, affordability, and spending on pharmaceutical drugs in the Commonwealth addressing the **underlying drivers** of pharmaceutical drug spending
- Requires OPPA to produce an annual report on **pharmaceutical access and plan design**, including tiering, cost-sharing, and utilization management techniques

Expanded Pharmaceutical and PBM Oversight

- Caps **out-of-pocket costs for drugs** identified to treat asthma, diabetes, and prevalent heart conditions
  - Requires the HPC to **evaluate the new program** every two years, in consultation with CHIA, GIC, MassHealth, and DOI
- Permits **CHIA to collect data** on pharmaceutical drug spending from payers and PBMs to inform the HPC's reporting on prescription drug spending and access trends
- Authorizes DOI to **regulate and license PBMs** operating in the Commonwealth on a three-year cycle

New Office of Health Resource Planning

- Establishes a new HPC Office of Health Resource Planning charged with developing a state health plan during a five-year planning period to identify:
  - The **anticipated needs** for health care services, providers, programs, and facilities;
  - The **existing health care resources**, providers, programs, and facilities available to meet those needs;
  - The **projected resources** necessary to meet those anticipated needs;
  - **Recommendations for the appropriate supply and distribution of resources,** workforce, programs, capacities, technologies, and services on a statewide and regional basis; and
  - Recommendations for **any further legislative or regulatory state action**
- Directs the office to **conduct focused assessments of supply, distribution, and capacity** in relation to projected need of health care services and make recommendations to address the drivers of disparities and misalignment of need

HPC Health Resource Data Collection

- Permits the new Office of Health Resource Planning to provide direction to DPH to establish and maintain **an inventory of health care resources** in the Commonwealth
- Requires all **other state agencies** that license, register, regulate, or otherwise collect data concerning health care resources to support the office and DPH in collecting all necessary data and information
- Increases the registered provider organizations (RPO) reporting threshold to include revenue generated from **all payers**, not just commercial revenue, allowing the HPC and CHIA to collect data from providers that serve significant public payer patients
- **Expands the scope of the ownership, governance, and organizational information the HPC collects from RPOs** to include significant equity investors, real estate investment trusts, and management services organizations
- **Increases penalties for non-compliance with RPO and other CHIA reporting requirements** (to $25,000/week) and provides that the HPC and DPH may consider reporting non-compliance in CMIRs and licensure and DoN reviews, respectively

Expansions of HPC Market Oversight Authority

Expands the triggers for material change notice (MCN) reviews to include:

- **Significant expansion** in a provider's capacity;
- Transactions involving a **significant equity investor** that result in a change of ownership or control of a provider or provider organization;
- Significant acquisitions, sales, or **transfers of assets**, including real estate lease-backs; and
- Conversions of a provider from a non-profit entity to **for-profit**

Expands HPC authority to collect information from significant equity investors and other parties to a transaction, including by allowing the HPC to require financial statements and materials on an investor's capital structure be filed with the notice

Authorizes the HPC to require **additional reporting** for a period of five years after the completion of an MCN to assess post-transaction impacts

Adds to the factors the HPC examines in a cost and market impact review (CMIR) any related health planning data as well as the size and market share of any significant equity investors

Further Market Monitoring Tools

- Adds new stakeholders required to testify at the **HPC's Annual Cost Trends Hearing**, including significant equity investors, health care real estate investment trusts, management services organizations, pharmaceutical manufacturers, PBMs, and state agency partners
- **Directs DPH to consider, in its review of a Determination of Need (DoN) application**: the state health plan, the Commonwealth's cost containment goals, impacts on patients (including considerations of health equity), and comments and relevant data from CHIA and the HPC, including any CMIR report
- Codifies Department of Public Health (DPH) regulations to toll the DoN timeline for an independent cost analysis, CMIR, and performance improvement plan
- Authorizes DPH to seek an **impact analysis of a closure** of a hospital or essential health service from the HPC during its review of any such closure

Additional Provisions

DIVISION OF INSURANCE AFFORDABILITY STANDARDS

Requires DOI to consider affordability to consumers and purchasers of health insurance in the division's examination of rates submitted for approval by insurers

NEW DPH LICENSURE REQUIREMENTS

Directs DPH to establish regulations and practice standards for licensing office-based surgical centers and networks of urgent care centers

HEALTH EQUITY GRANTS

Adds "advance health equity" to the approved uses of the Health Care Payment Reform Trust Fund

QUALITY MEASURE ALIGNMENT TASKFORCE

Codifies the statewide advisory committee for the Standard Quality Measure Set, of which the HPC is a member

OPERATING ASSESSMENT

Adds pharmaceutical manufacturers, PBMs, and "non-hospital provider organizations" that are required to register with RPO to the HPC's and CHIA's operating assessments

New Primary Care Payment and Delivery Task Force

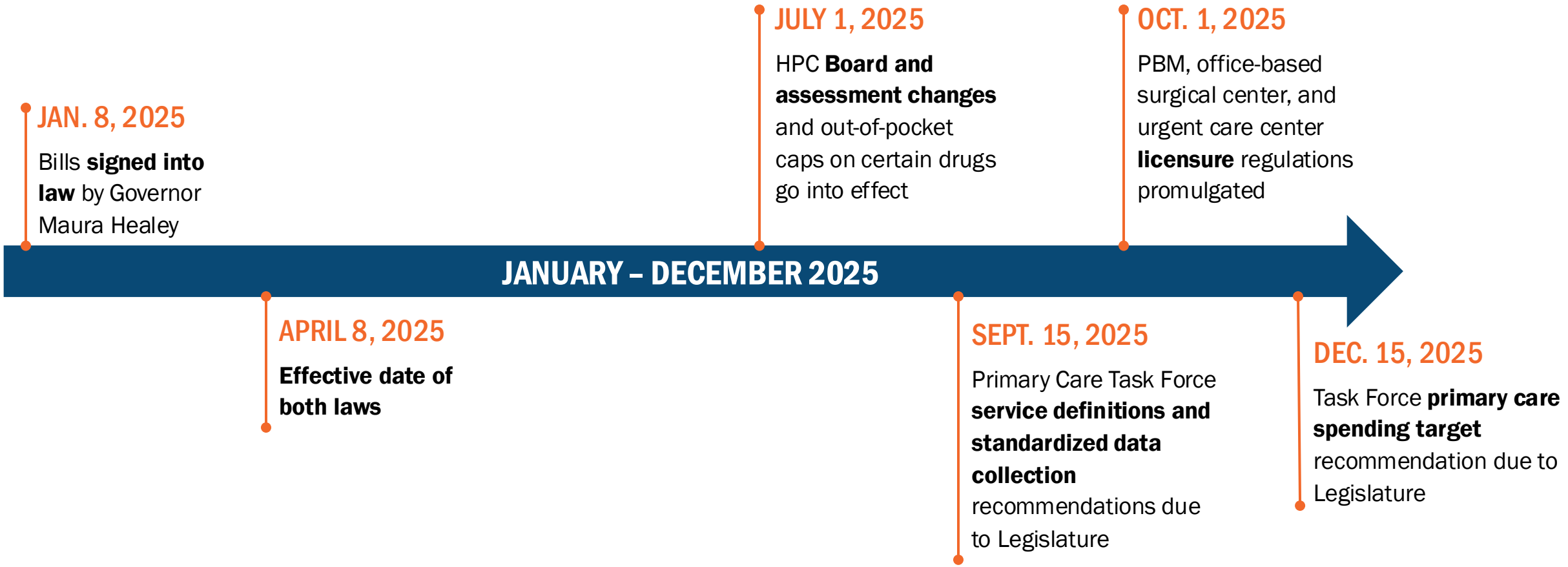
In partnership with EOHHS, the HPC will co-chair a **25-member task force** charged with studying and making recommendations to improve primary care **access**, **delivery**, and **financial sustainability** in the Commonwealth.

Specifically, the task force must:

- Issue recommendations related to definitions of services as well as **standardized practices for data collection**
- Make a recommendation to **establish a primary care spending target** for public and private payers in Massachusetts
- **Propose payment models to increase reimbursement for primary care services** and assess the impact of plan design on health equity and access to primary care services; and
- Issue recommendations to **improve service delivery to residents of the Commonwealth** and address primary care workforce needs.

The task force will be required to publish these recommendations by staggered deadlines over the next 16 months.

Key Dates In Chapters 342 and 343 of the Acts of 2024



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Overview of New Health Care Legislation: *An Act enhancing the market review process and An Act relative to pharmaceutical access, costs, and transparency*

A DIRE DIAGNOSIS: THE DECLINING HEALTH OF PRIMARY CARE IN MASSACHUSETTS AND THE URGENT NEED FOR ACTION – *SPECIAL REPORT FROM THE HPC ON PRIMARY CARE WORKFORCE, ACCESS, AND SPENDING TRENDS*

Executive Director's Report

Adjourn

A Dire Diagnosis:
The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action

Special Report from the HPC on Primary Care Workforce, Access, and Spending Trends

January 2025

MASSACHUSETTS
HEALTH POLICY COMMISSION

MASSACHUSETTS
HEALTH POLICY COMMISSION

- Who Provides Primary Care in Massachusetts?
- Concerning Trends in Primary Care Provision and Workforce in Massachusetts
- Concerning Trends in Primary Care Access in Massachusetts
- Root Causes: Why Is This Happening?
- Spotlight on Community Health Centers
- Where Do We Go From Here?

What is primary care?

- Primary care includes first-contact care for unknown problems, wellness and preventive care, and management and treatment of chronic illnesses and health conditions.
- It is provided by clinicians who often maintain long-term relationships with their patients and coordinate with specialists or other parts of the health care system.[1]
- Primary care is unique among categories of health care in that an increased supply of primary care is associated with better and more equitable population health.[2,3,4]
- Similarly, a high ratio of PCPs to specialists is associated with better health outcomes, higher-quality care, fewer ED visits and hospitalizations, and lower costs.[6,7]
- In both the U.S. and in MA, primary care spending represents about 7% of health care spending.[8,9]

1 Healthcare.gov. Primary care. Available at https://www.healthcare.gov/glossary/primary-care/
2 The National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Consensus Study Report Highlights. May. 2021.
3 Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015 JAMA Intern Med. 2019;179(4):506–514.
4 Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502.
5 Bazemore A., Merenstein Z., Handler L., Saultz J. W., The Impact of Interpersonal Continuity of Primary Care on Health Care Costs and Use: A Critical Review. The Annals of Family Medicine May 2023, 21 (3) 274-279.
6 Friedberg MW, Hussey PS, Schneider EC. Primary Care: A Critical Review of The Evidence on Quality and Costs of Health Care. Health Affairs. 2019;29(5) https://www.healthaffairs.org/doi/10.1377/hlthaff.2010.0025
7 Freedman Healthcare. Analysis of Massachusetts Primary Care Investment and Quality. July 2024. https://thepcc.org/wp-content/uploads/2024/09/MAPrimaryCare_07-2024_Final.pdf
8 Decker SL, Zuvekas SH. Primary Care Spending in the US Population. JAMA Intern Med. 2023 Aug 1;183(8):880-881.
9 Center for Health Information and Analysis. Primary Care in Massachusetts Databook. May 2024.

Primary care is facing many challenges in Massachusetts. Urgent policy action is needed.

- Despite being one of the highest-value categories of care, primary care represents a **declining share of health care spending in Massachusetts.**
- While primary care provision faces significant challenges throughout the U.S., Massachusetts has:
  - **High and growing rates of residents reporting difficulty accessing care**
  - **An aging primary care physician workforce**
  - **Among the smallest shares of the physician workforce in primary care**
  - **Among the smallest shares of new physicians entering primary care**
- This report follows the HPC's broader report on the health care workforce (March 2023) and seeks to elucidate the underlying trends surrounding primary care provision in Massachusetts and to make recommendations that would support a revitalization of primary care in the Commonwealth.

MASSACHUSETTS
HEALTH POLICY COMMISSION

WHO PROVIDES PRIMARY CARE IN MASSACHUSETTS?

- Concerning Trends in Primary Care Provision and Workforce in Massachusetts
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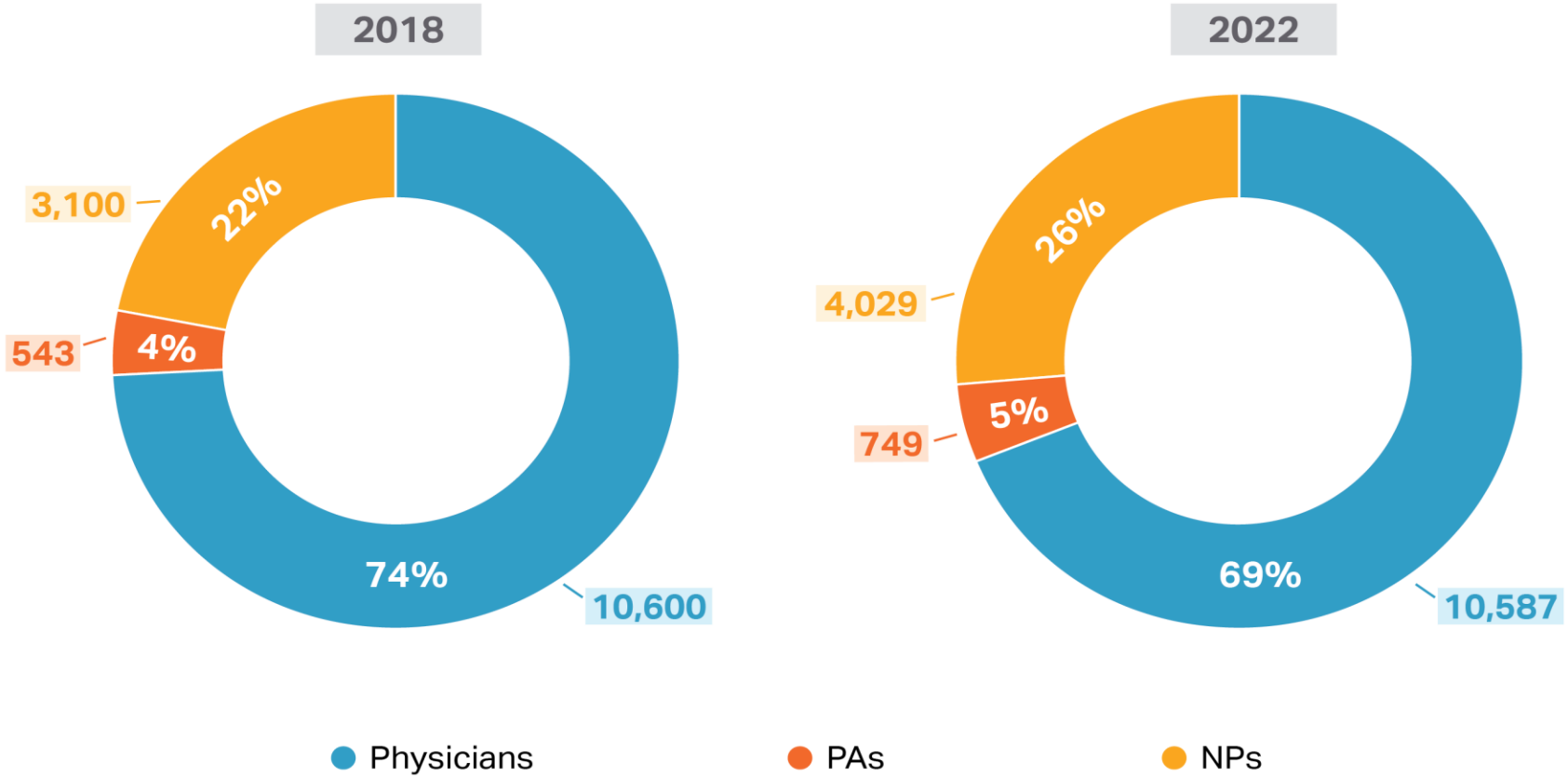
Primary care in Massachusetts may be delivered in a variety of different ways and by a variety of different organizations.

- **Prevalent Models of Primary Care Delivery**
  - Hospital-affiliated medical practices (e.g., Mass General Brigham, UMass, Baystate)
  - Non-hospital-affiliated provider organization medical practices (e.g., Atrius, Reliant, Revere Medical)
  - Independent, physician-owned private practices
  - Community health centers
- **Newer Models of Primary Care Delivery**
  - Retail clinics (e.g., MinuteClinic) and urgent care centers
  - Virtual-first or virtual-only providers who may either accept insurance or be cash-only (e.g., Firefly Health, Sesame)
  - Concierge practices owned by large retailers (e.g., OneMedical)
  - Private or hospital-affiliated medical practices operating in concierge models

Notes: Retail clinics and urgent care centers may provide primary care services as well as primary care-adjacent services such as injury care.

There were approximately 15,000 primary care providers in Massachusetts in 2022. The share who are NPs or PAs grew from 26% to 31% from 2018-2022.

FTE primary care providers in Massachusetts, 2018 and 2022



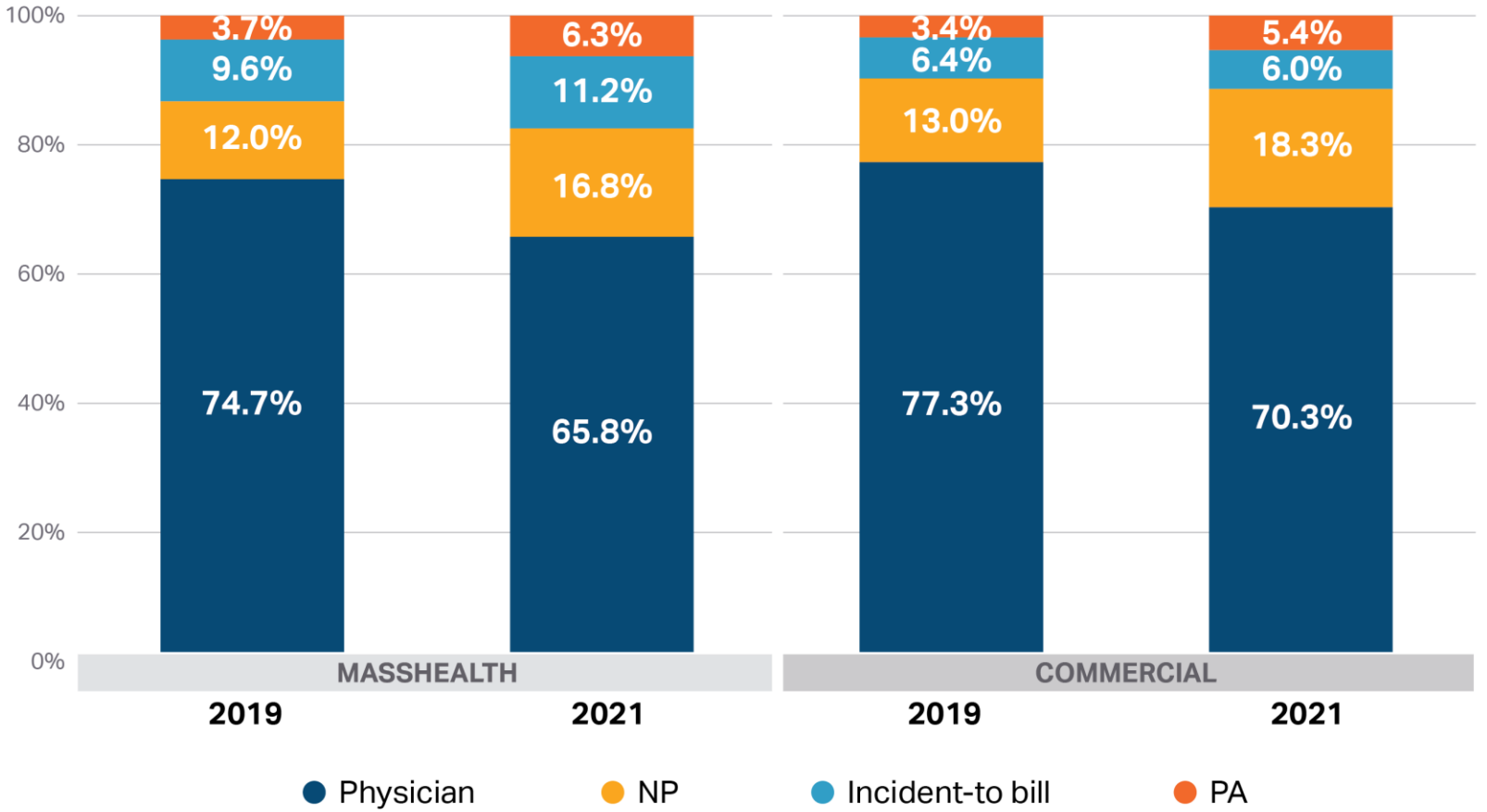
Notes: Physician counts may include residents, non-active physicians, or primary care physicians not working in direct patients care. Estimates are full time equivalents (FTEs) where FTE = 40 hours worked a week. PCPs/PAs in primary care are estimated by multiplying the ACS total provider count by the share of providers in primary care based on additional data sources (NCCPA State Profiles for PAs, AAMC State Physician Workforce Data Reports for physicians). NPs are estimated at 50% of total NPs in the ACS, based on estimates of primary care NPs in the HPC's Nurse Practitioner Brief and other estimates on the share of NPs in primary care. 2022 data from the Health Professions Data Series administered by the Massachusetts Board of Registration in Nursing with the DPH Health Workforce Center estimate NPs in primary care to be closer to one-third of all NPs.

Sources: HPC analysis of American Community Survey 5-year estimates, 2018 and 2022. National Commission on Certification of Physician Assistants State Profiles, 2018 and 2022. Association of American Medical Colleges. State Physician Workforce Data Report, 2019 and 2021.

1 Health Resources & Services Administration. Workforce Projections. 2024. https://data.hrsa.gov/topics/health-workforce/workforce-projections

The proportion of primary care visits provided by NPs and PAs is growing, reflecting changes in the statewide provider mix.

Percent of primary care visits by clinician type, 2019, 2021



Notes: Analysis restricted to members under age 65 with full year medical coverage and an identified PCP. NP category may include visits with other APRNs: includes NP (including women's health, primary care, pediatric, adult health, gerontology, obstetric, FNP, CNP, CPNP, ANP, PNP, DNP, GNP, AGNP, and CFNP), CNS (including FMCNS and RNCS), CNM, APN, and MSN. Provider types identified using national provider identifier (NPI) codes linked to taxonomy codes from National Plan and Provider Enumeration System (NPPES) and credentials and specialties from IQVIA. Members' PCP identified as clinician (physician, NP, or PA) associated with the most preventive visits; absent preventive visits, the clinician associated with the most problem-based visits; absent preventive or problem-based visits, the clinician associated with 3 or more prescriptions per member. Primary care visits identified as those with preventive or problem-based Current Procedural Terminology (CPT) codes taking place at ambulatory sites of care (emergency department, inpatient, and residential care settings excluded). Visits with incident-to billing identified with procedure modifier codes SA and SB. FQHCs not included in MassHealth data.

Exhibit sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2019-2021

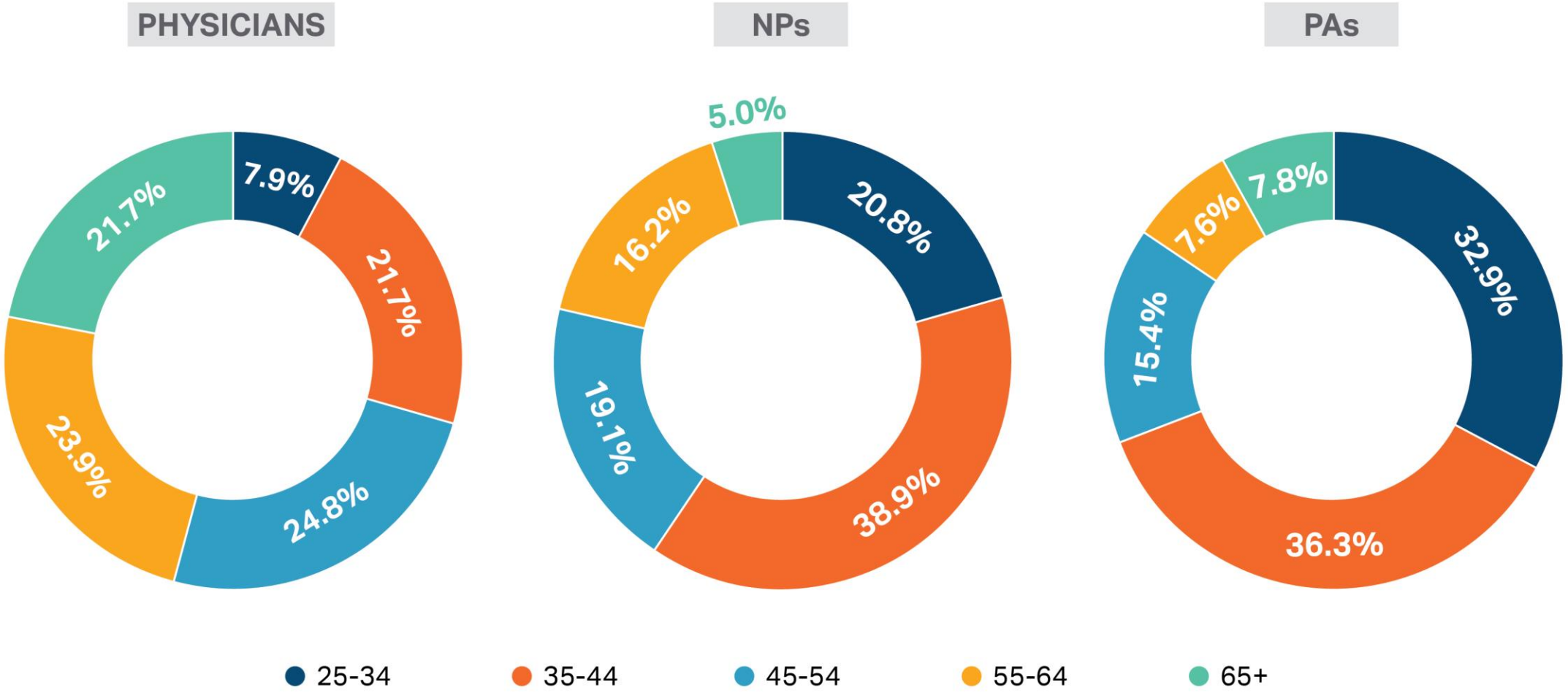
1 Provision of evaluation and management visits by nurse practitioners and physician assistants in the USA from 2013 to 2019: cross-sectional time series study. *BMJ* 2023;382:e073933

2 HPC Policy Brief: The Nurse Practitioner Workforce and Its Role in the Massachusetts Health Care Delivery System. Massachusetts Health Policy Commission, 2020.

3 HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database (APCD) v2021, 2019-2021

One in five physicians in office settings are 65 or older, and only 8% are younger than 35, reflecting an aging physician workforce. In contrast, 21% of NPs and 33% of PAs are under 35.

Providers working in office settings by age group, 2018-2022

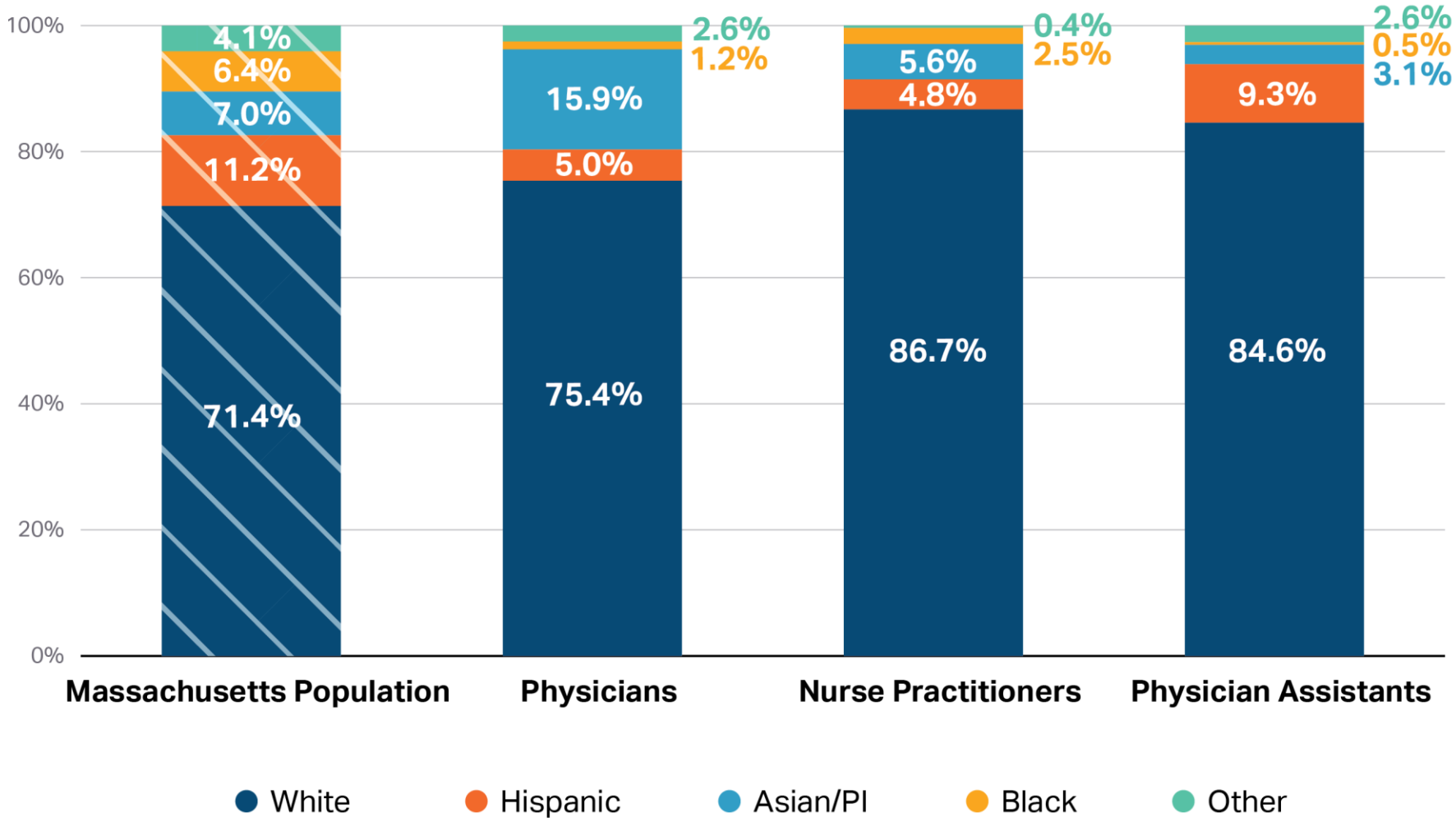


Notes: Includes physicians, nurse practitioners, and physician assistants that work in office settings. Sample weighted using person weight. The ACS groups nurse midwives in with NPs. Those not in the labor force were dropped from this sample. Residents are likely included as physicians because ACS occupations are reported as where the respondent worked last week for the greatest number of hours.

Sources: HPC analysis of American Community Survey 5-year estimates, 2018-2022

The race and ethnicity distribution of Massachusetts office-based providers suggests underrepresentation of Black and Hispanic clinicians.

Distribution of Massachusetts providers in office settings (2018-2022) and total population by race and ethnicity (2022)



Notes: Sample weighted using person weight. The "other" race category includes American Indian or Alaskan natives, individuals identifying as more than 1 race, and all other races. The ACS groups nurse midwives in with NPs. Those not in the labor force were dropped from this sample. Residents are likely included as physicians since ACS occupations are reported as where the respondent worked last week for the greatest number of hours.

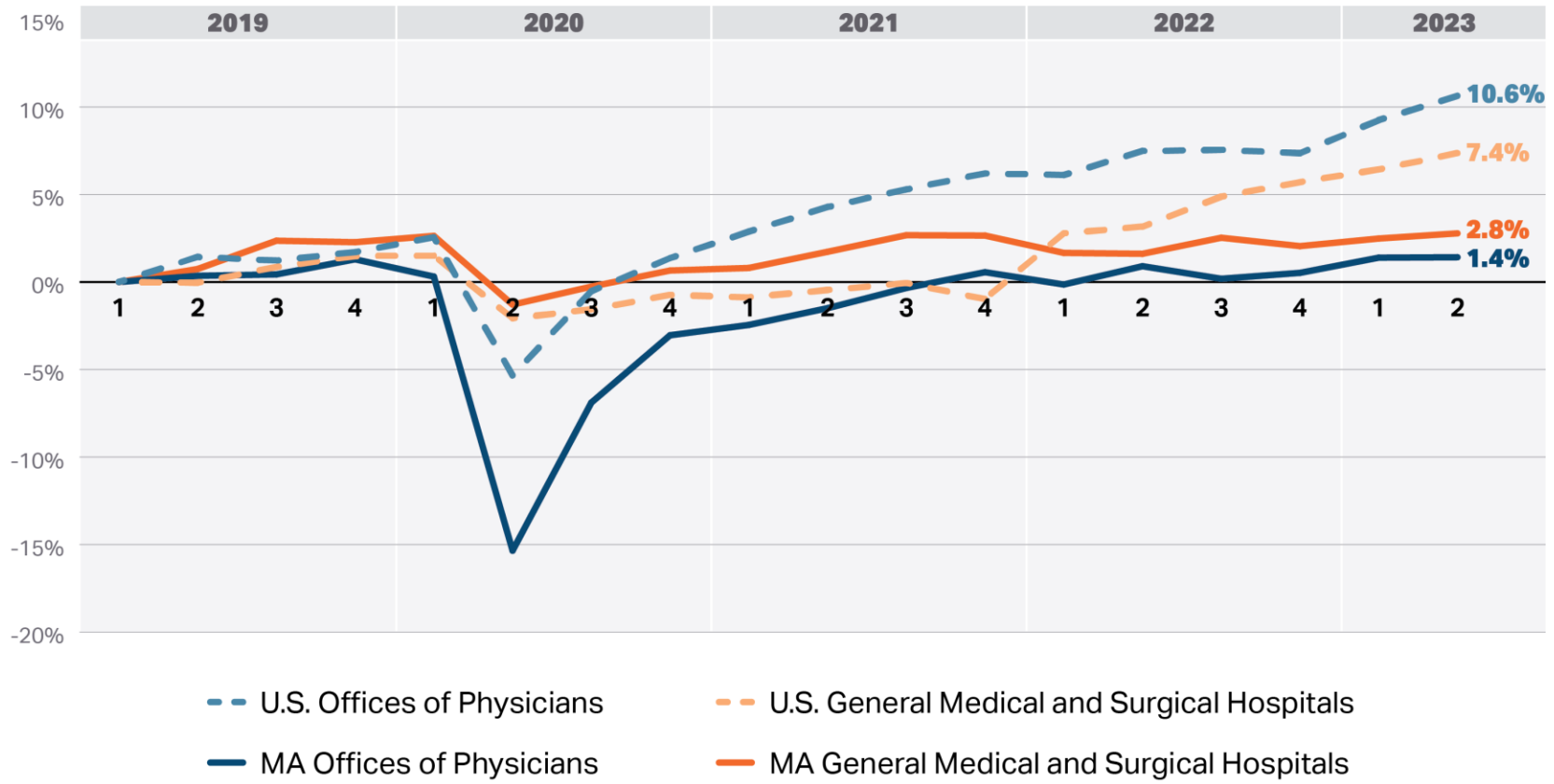
Sources: HPC analysis of American Community Survey 5-year estimates, 2018-2022

MASSACHUSETTS
HEALTH POLICY COMMISSION

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- **CONCERNING TRENDS IN PRIMARY CARE PROVISION AND WORKFORCE IN MASSACHUSETTS**
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Employment in physician office settings in Massachusetts has barely increased since 2019, in contrast to more than 10% growth nationwide.

Quarterly change in total employment relative to Q1 2019, Massachusetts vs United States, 2019-2023



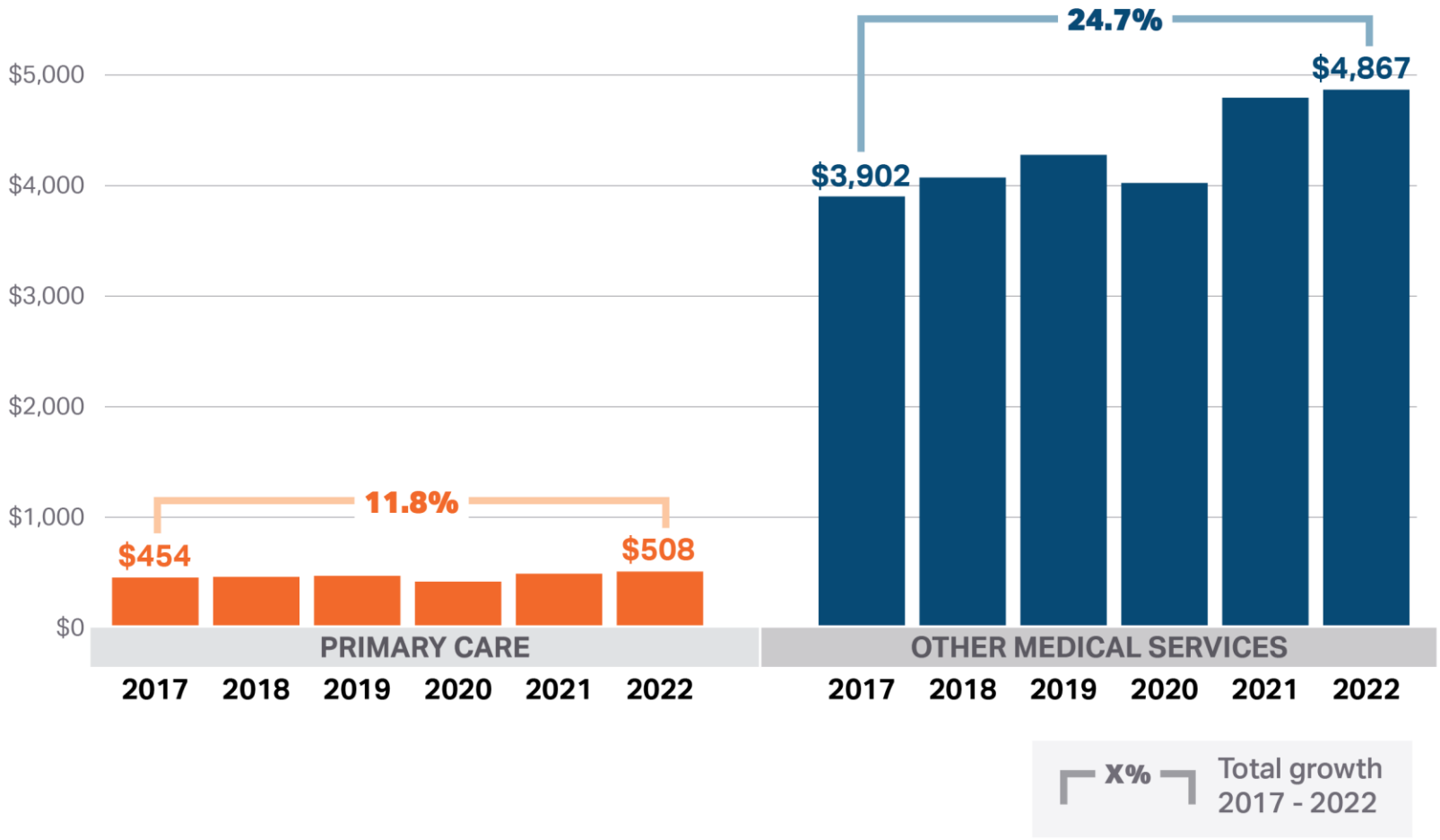
Notes: Offices of physicians includes establishments of health practitioners having an M.D. or D.O. primarily engaged in the independent practice of general or specialized medicine or surgery, excluding psychiatry and therefore mental health specialists. Offices of physicians includes offices in the facilities of others, such as hospital outpatient departments.

Sources: HPC analysis of Bureau of Labor Statistics, Quarterly Census of Employment and Wages, 2019-2023

1 Larry Green Center, Primary Care Collaborative, 3rd Conversation. Quick COVID-19 Primary Care Survey, Series 35.

Primary care spending in Massachusetts grew half as fast as spending on all other medical services from 2017-2022.

Commercial medical spending by category per member per year, 2017-2022

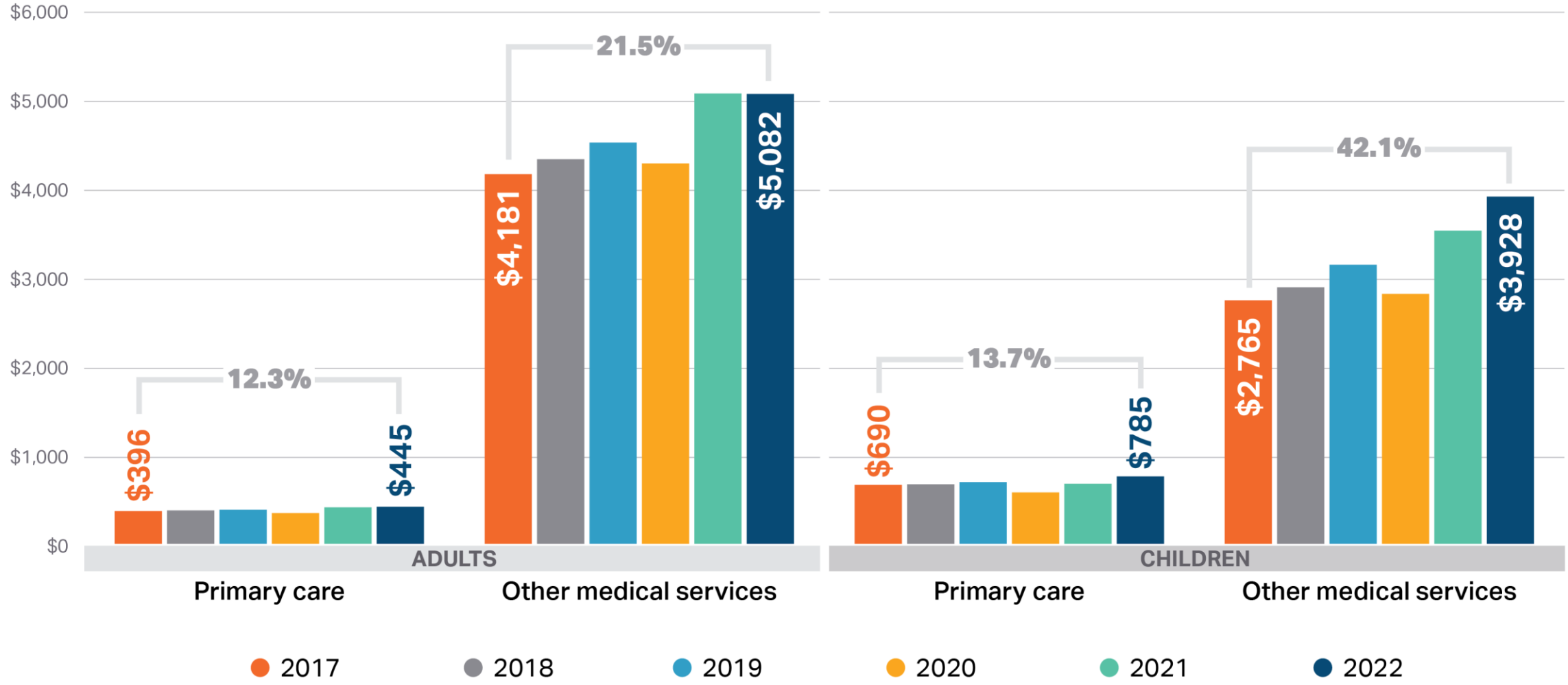


Notes: Analysis restricted to members under 65 and those with prescription drug coverage. Prescription drug spending is not included in "Other medical services". Primary care declined as a percentage of all commercial spending from 8.4% in 2017 to 7.5% in 2022 if prescription drug spending is included.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2022, 2018-2021 and V2021, 2017-2018.

Primary care spending grew half as fast for adults, and one-third as fast for children, compared to spending on all other medical services from 2017 to 2022.

Commercial medical spending by category per member per year for children vs adults, 2017-2022

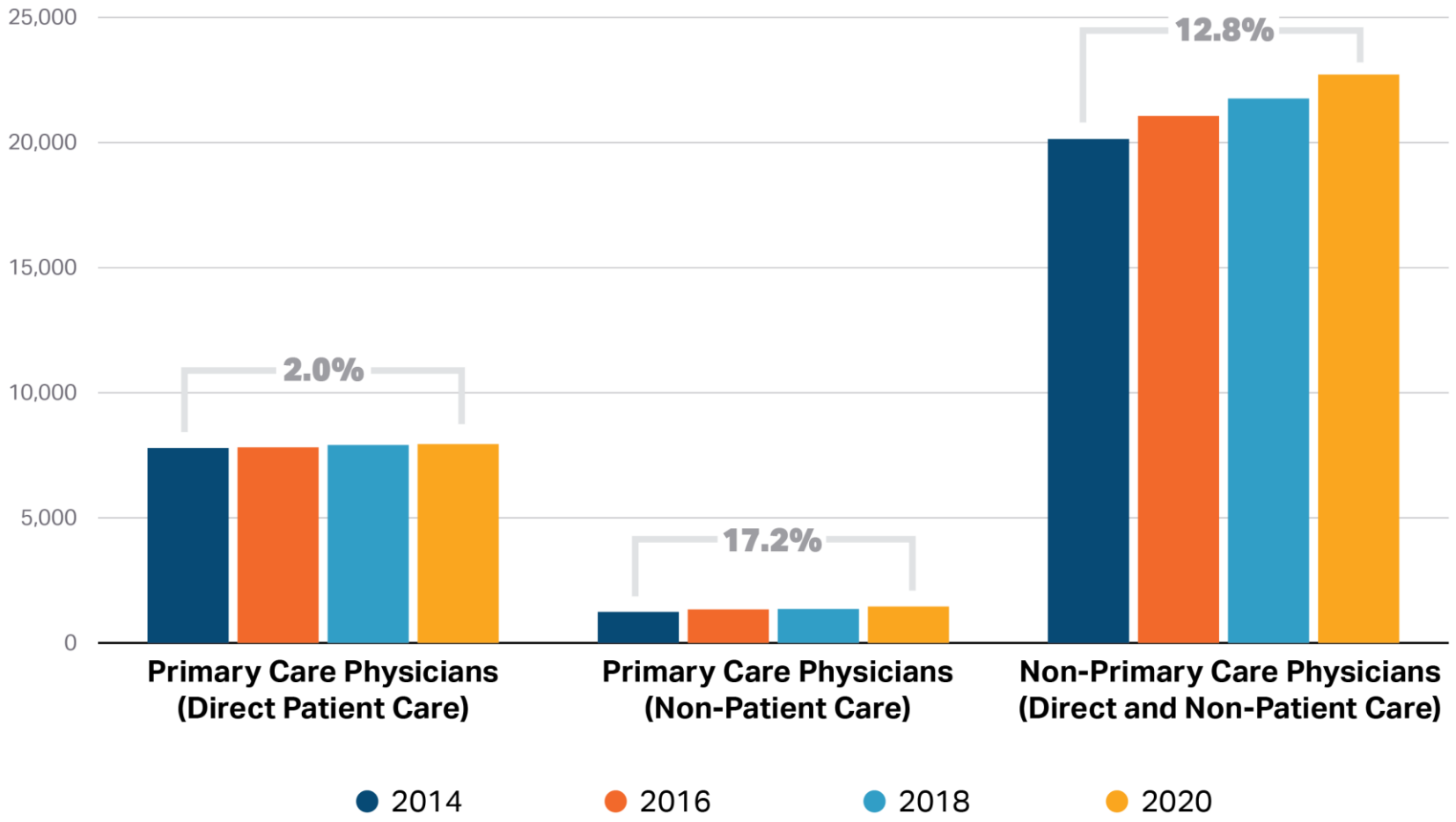


Notes: Analysis restricted to members under 65 (children ages 0-17, adults ages 18-64) and those with prescription drug coverage. Prescription drug spending is not included in "Other medical services."

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2022, 2018-2022 and V2021, 2017-2018.

The workforce of primary care physicians in direct patient care roles in Massachusetts has barely grown, even while the number of other types of physicians has increased.

Physician employment by setting, Massachusetts, 2014-2020

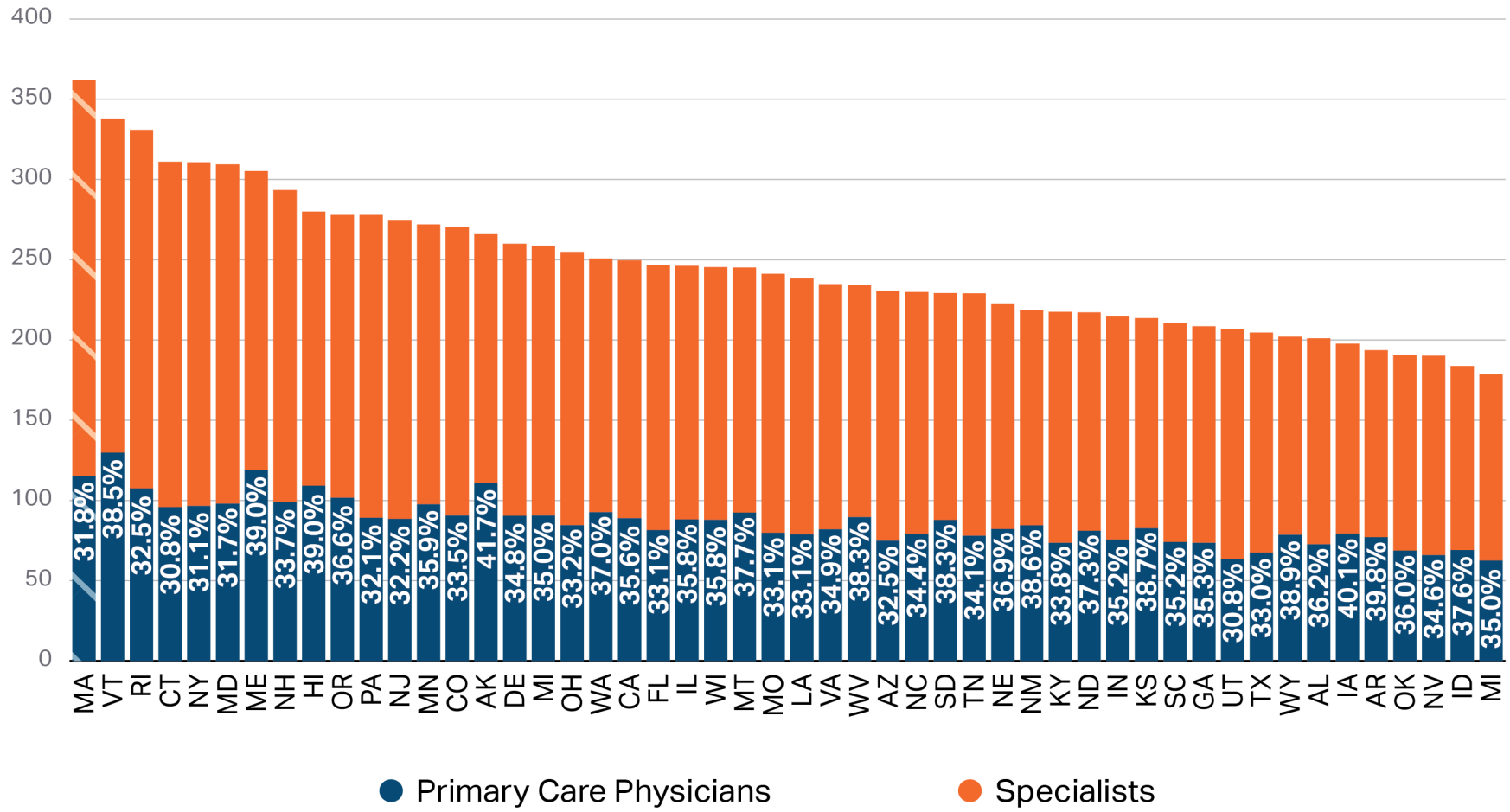


Notes: Physicians who are licensed by a state are considered active, provided they are working at least 20 hours per week Active physicians include those working in direct patient care, administration, medical teaching, research, or other nonpatient care activities. Physicians are counted as primary care physicians if their self-designated primary specialty is one of the following: adolescent medicine (pediatrics), family medicine, general practice, geriatric medicine (family practice), geriatric medicine (internal medicine), internal medicine, internal medicine/ pediatrics, or pediatrics.

Sources: Exhibit and 1: HPC analysis of data in Association of American Medical Colleges. State Physician Workforce Data Report, 2017-2021.

Although Massachusetts has the most total physicians per capita, Massachusetts also has the fifth lowest share of primary care physicians providing direct patient care.

Physicians per 100,000 state residents by type and share of primary care physicians by state, 2020



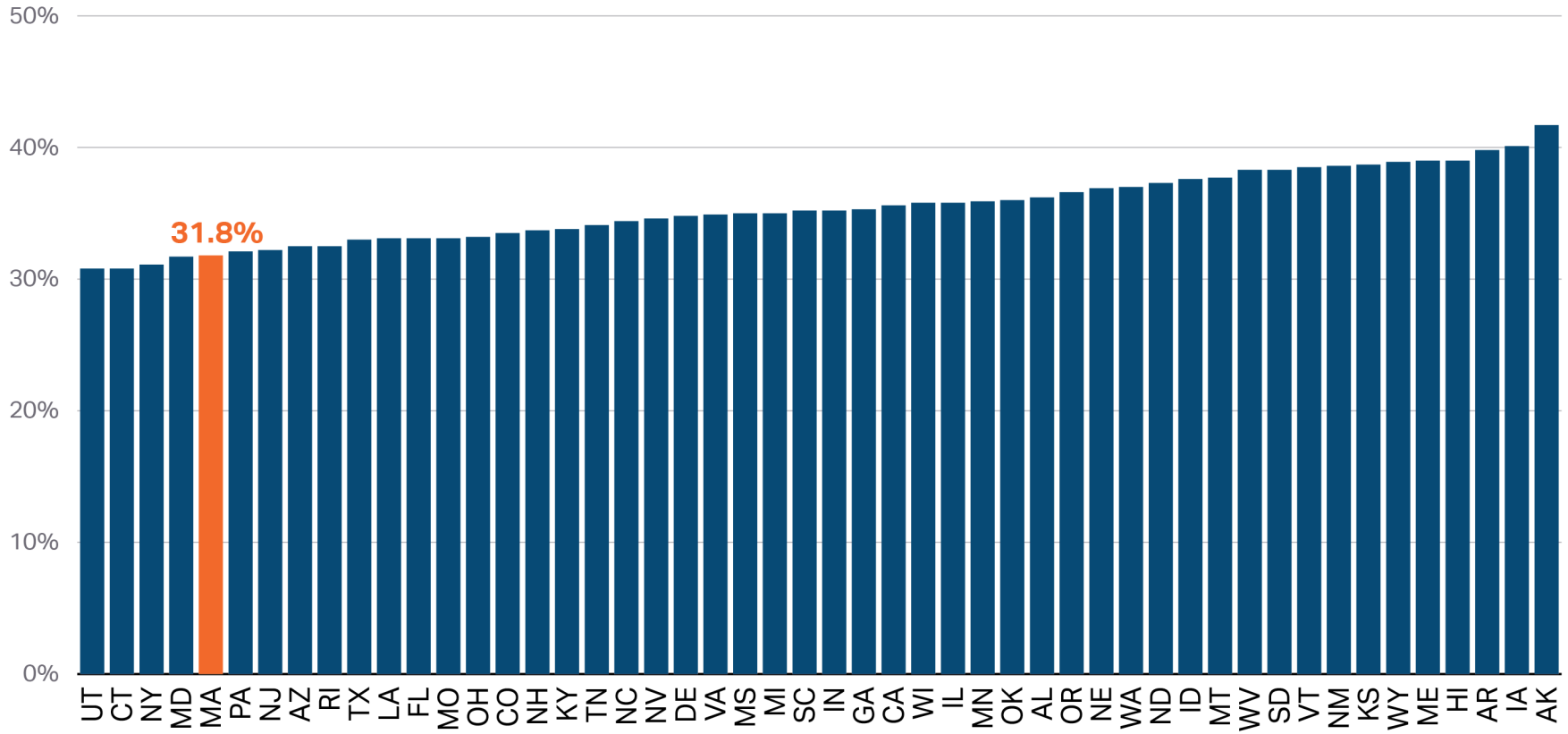
Notes: Physicians who are licensed by a state are considered active, provided they are working at least 20 hours per week. Physicians included are those working in direct patient care. Physicians are counted as primary care physicians if their self-designated primary specialty is one of the following: adolescent medicine (pediatrics), family medicine, general practice, geriatric medicine (family practice), geriatric medicine (internal medicine), internal medicine, internal medicine/ pediatrics, or pediatrics. Massachusetts has a relatively high ratio of internal medicine physicians to family medicine physicians compared to the rest of the country.

Sources: HPC analysis of Association of American Medical Colleges. State Physician Workforce Data Report, 2021

1 Friedberg, Mark W., Peter S. Hussey, and Eric C. Schneider. "Primary care: a critical review of the evidence on quality and costs of health care." Health Affairs 29.5 (2010): 766-772.

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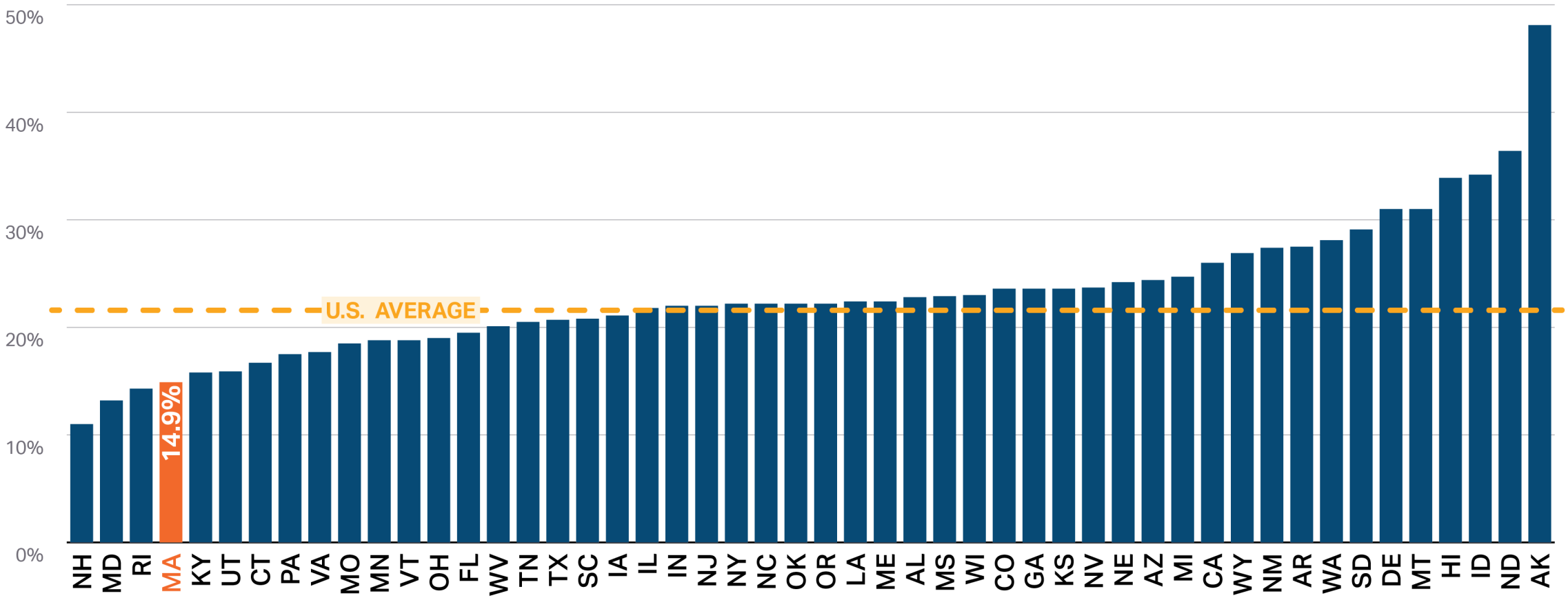
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Sources: HPC analysis of Association of American Medical Colleges. State Physician Workforce Data Report, 2021

1 Friedberg, Mark W., Peter S. Hussey, and Eric C. Schneider. "Primary care: a critical review of the evidence on quality and costs of health care." Health Affairs 29.5 (2010): 766-772.

In 2021, only 1 in 7 new physicians in Massachusetts entered primary care.

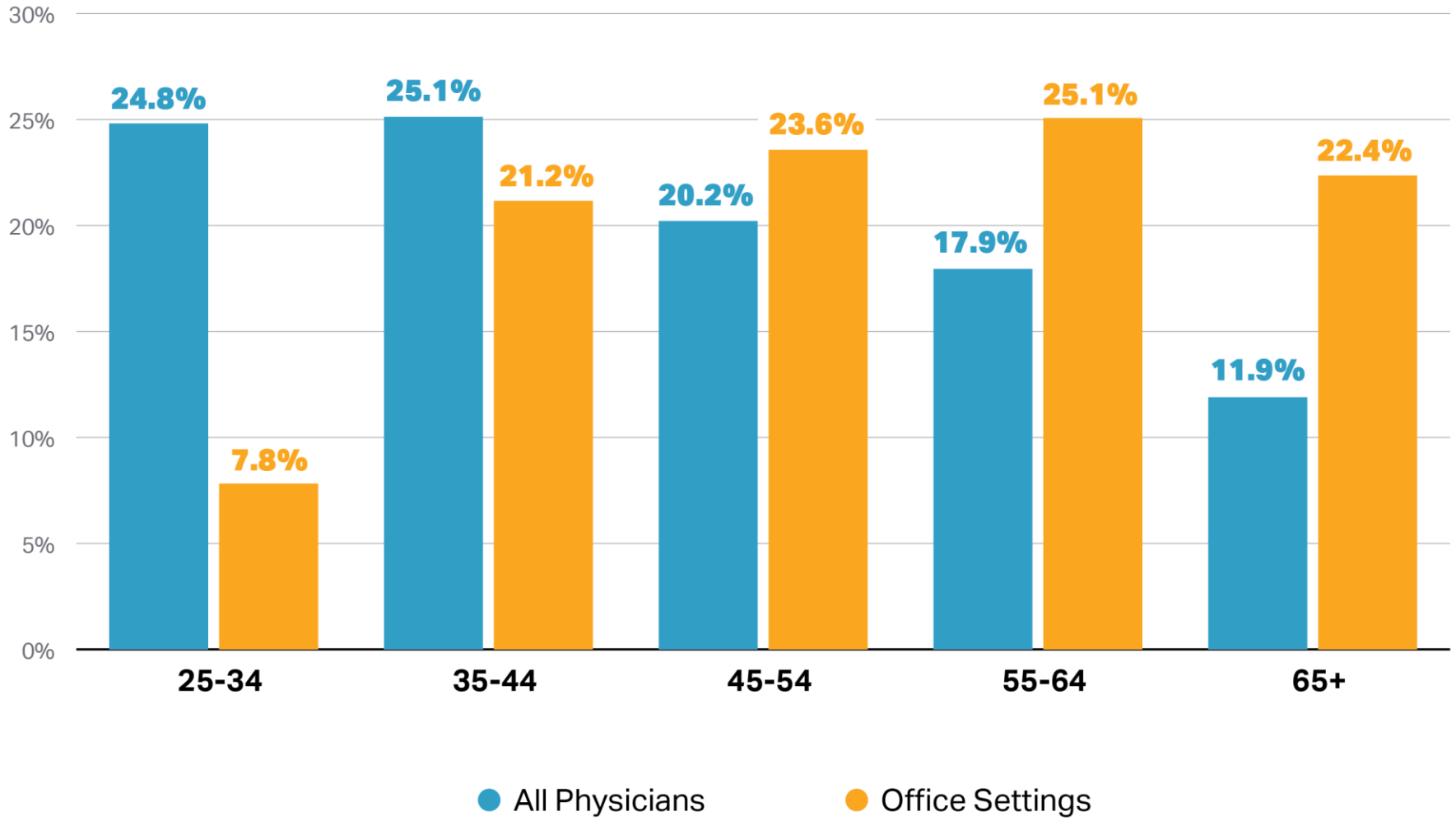
Share of new physicians entering primary care workforce by state, 2021



Sources: Milbank Memorial Fund. The Health of U.S. Primary Care: 2024 Scorecard Data Dashboard.

Nearly half of Massachusetts physicians working in office settings (as a proxy for primary care physicians) are 55 years old or older, in contrast to 30% in other settings.

Physician age groups by setting, Massachusetts, 2022

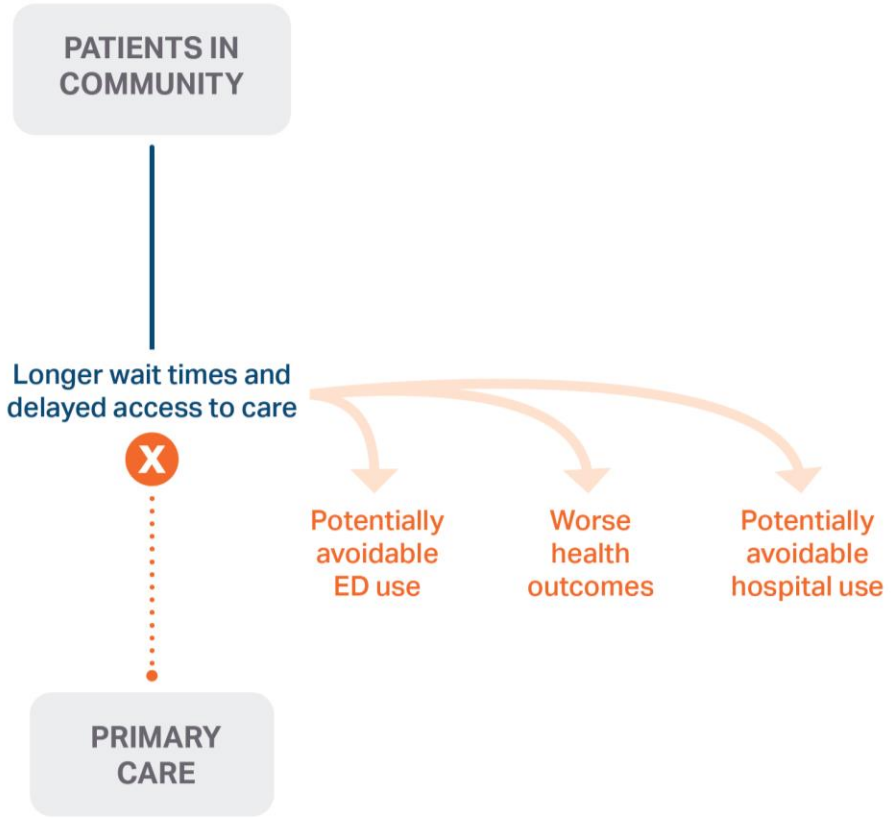


Notes: Results are weighted using the person weight. Office settings includes hospital outpatient departments.
Sources: Exhibit and 1: HPC analysis of American Community Survey 5-year estimates, 2022

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Lack of access to primary care is associated with potentially avoidable use of higher-acuity, higher-cost care settings and worse patient health outcomes.



- **Limited access to primary care can lead to potentially avoidable ED and inpatient hospital use and associated higher spending, as well as worse patient outcomes**, especially for patients managing chronic conditions.[1,2,3] Patients with distance, transportation, or language barriers to accessing primary care are also more likely to use the ED for non-emergent conditions.[4]
- In 2023, although over three-quarters of all Massachusetts residents reported a preventive care visit during the past year, **Hispanic residents, residents with lower incomes, and those with inconsistent insurance coverage were most likely to lack a recent preventive visit.**[5]
- As of 2023, **36.2% of Massachusetts residents with an ED visit in the past year reported that they could have been treated by a general physician if one had been available.**[6]

1 Daly, M.R., Mellor, J.M. and Millones, M. (2018), Do Avoidable Hospitalization Rates among Older Adults Differ by Geographic Access to Primary Care Physicians?. Health Serv Res, 53: 3245-3264.

2 Toren Davis, Albert Meyer, Janalynn Beste and Sonali Batish Decreasing Low Acuity Pediatric Emergency Room Visits with Increased Clinic Access and Improved Parent Education. The Journal of the American Board of Family Medicine July 2018, 31 (4) 550-557.

3 Gail L. Rose, Levi N. Bonnell, Jessica Clifton, Lisa Watts Natkin, Juvena R. Hitt and Jennifer O'Rourke-Lavoie. Outcomes of Delay of Care After the Onset of COVID-19 for Patients Managing Multiple Chronic Conditions. The Journal of the American Board of Family Medicine December 2022, 35 (6) 1081-1091

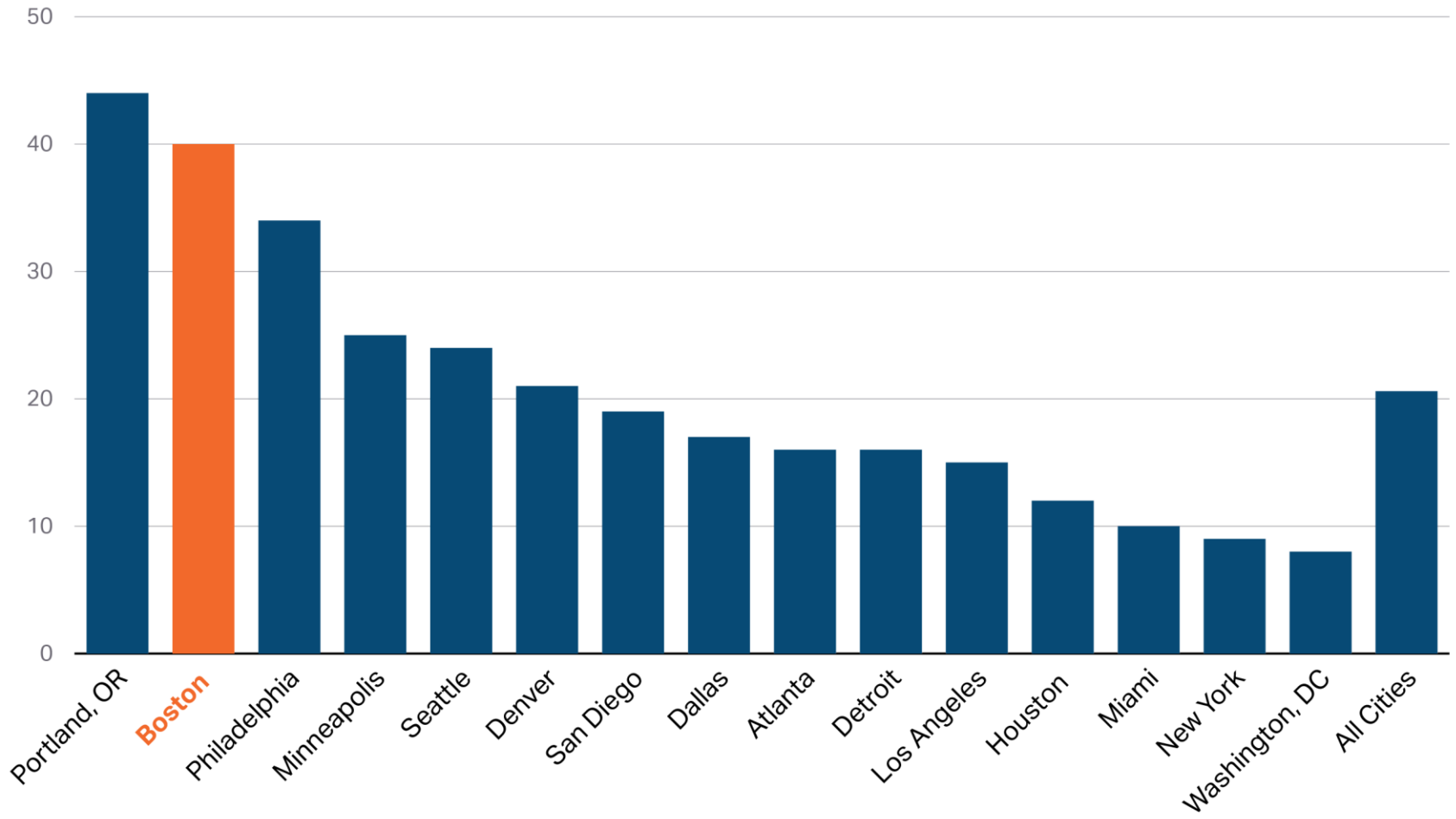
4 Jennifer Villani and Karoline Mortensen. Nonemergent Emergency Department Use Among Patients With a Usual Source of Care. The Journal of the American Board of Family Medicine November 2013, 26 (6) 680-691;

5 Center for Health Information and Analysis. Findings from the 2023 Massachusetts Health Insurance Survey. June 2024.

6 Center for Health Information and Analysis. Primary Care in Massachusetts Databook. January 2023.

Of fifteen U.S. metro areas studied, Boston had the second-longest wait times for a new patient appointment for a physical in 2022.

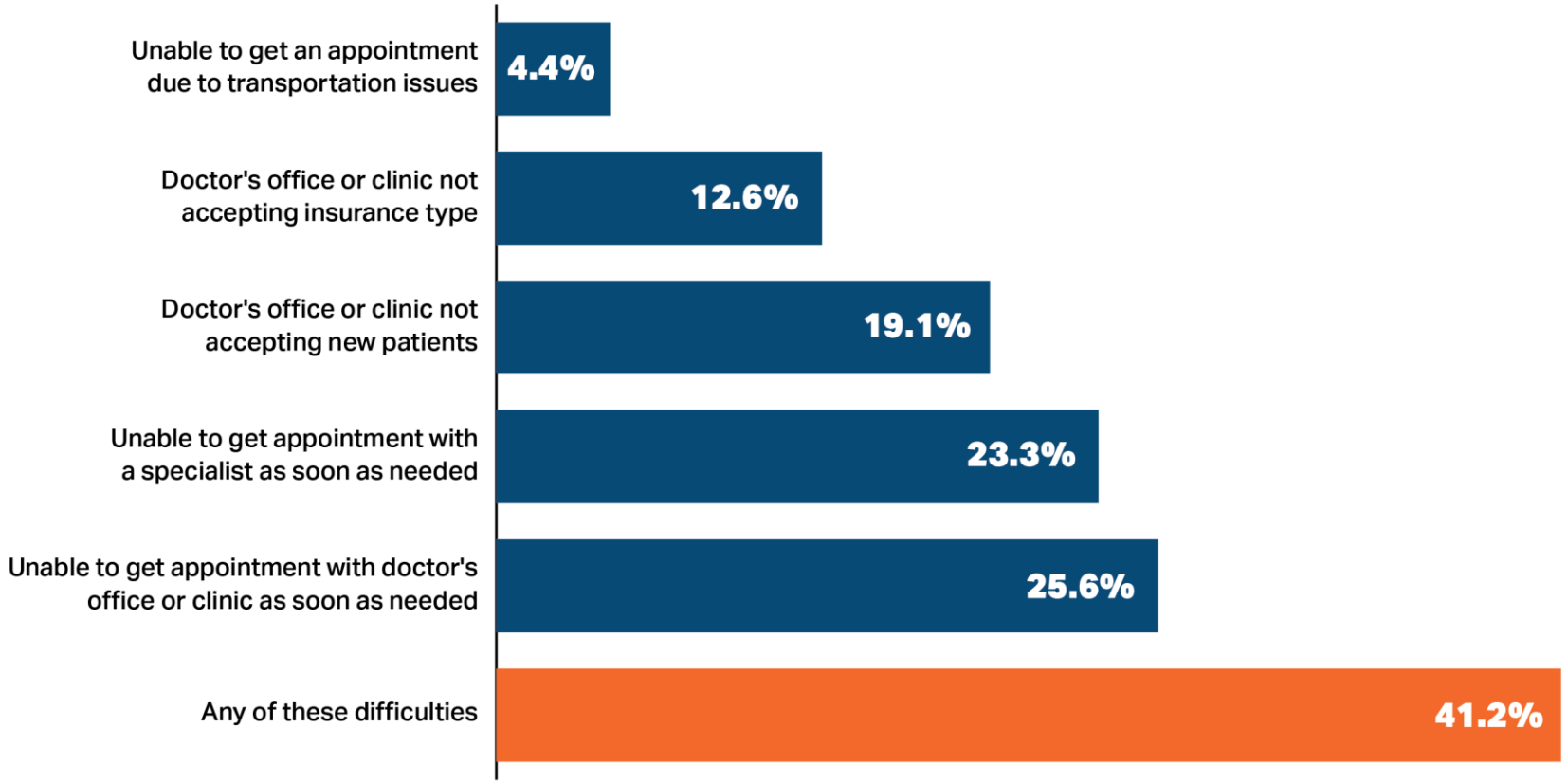
Average wait time in days for a new patient appointment for a physical by metropolitan area, 2022



Sources: AMN Healthcare and Merritt Hawkins. 2022 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates. 2022.

In 2023, 41% of Massachusetts residents reported difficulty accessing care, with the most-cited reason being inability to get an appointment at a doctor's office or clinic when needed.

Difficulties accessing care over the past 12 months by type of difficulty, 2023



- As of 2021, 34% of Massachusetts residents reported any of these difficulties accessing care.[1]
- A separate, multi-year survey of Massachusetts patients found that access to primary care became more difficult every year from 2019 to 2023 for both adults and children.[2]

Notes: The categories listed above are not mutually exclusive. Residents were asked to select all applicable options.

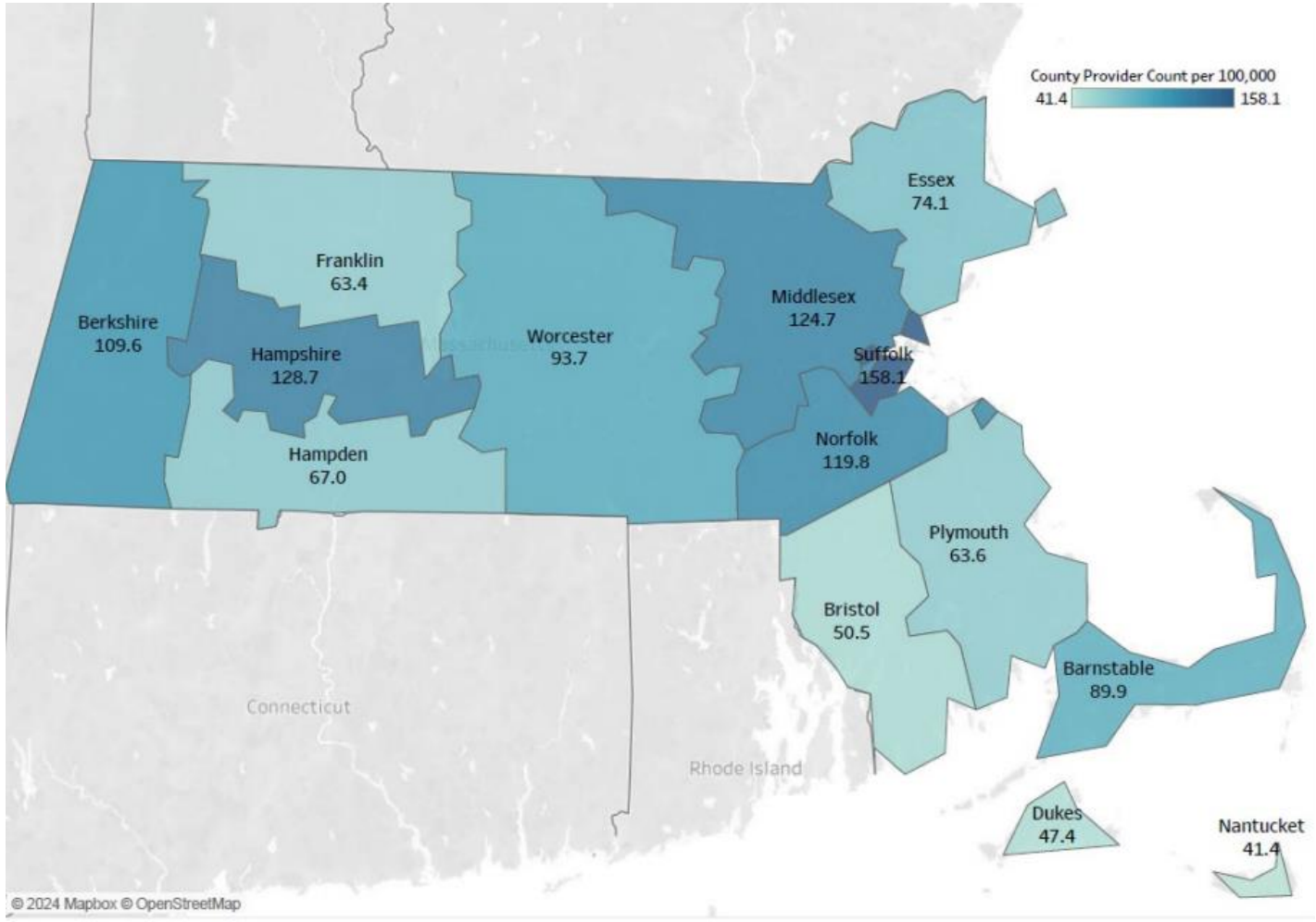
Sources: Center for Health Information and Analysis, Findings from the 2023 Massachusetts Health Insurance Survey, 2024.

1 Center for Health Information and Analysis, Findings from the 2021 Massachusetts Health Insurance Survey, 2022.

2 Massachusetts Health Quality Partners. Patient Experience Scores for Adults Improve Since Before the Pandemic, Except in One Key Area: Access. February 2024.

The availability of primary care physicians varies widely across the Commonwealth.

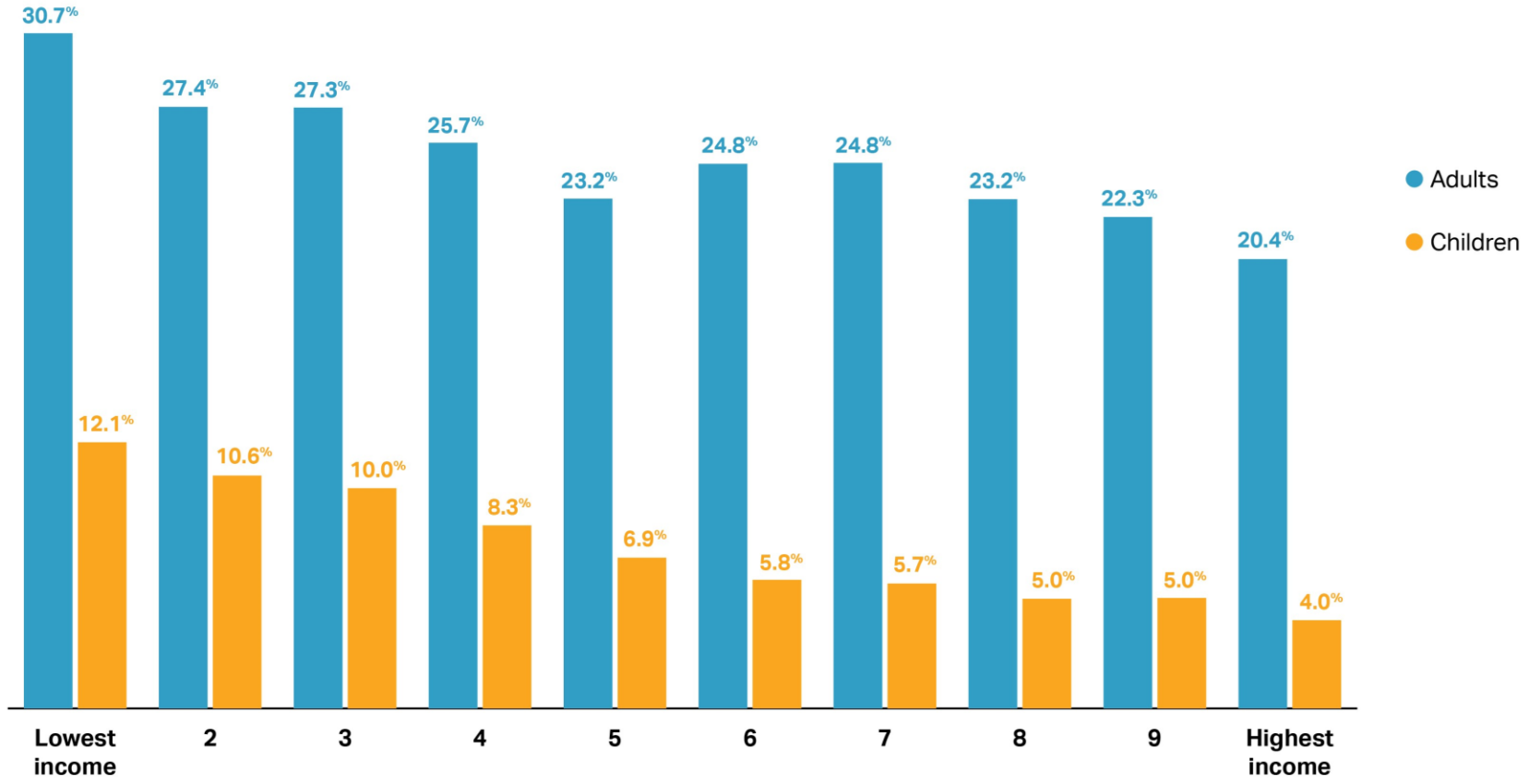
Primary care physicians per 100,000 Massachusetts residents



Notes: Includes active MDs and DOs providing direct patient care. Excludes medical residents.
Sources: HPC analysis of Area Health Resource File 2022-2023 Dataset. See https://masshpc.gov/sites/default/files/2024-05/20240509_MOAT%20Presentation%20vFinal.pdf

Commercially-insured children living in low-income areas were three times more likely to have no primary care visits than children in the highest-income areas.

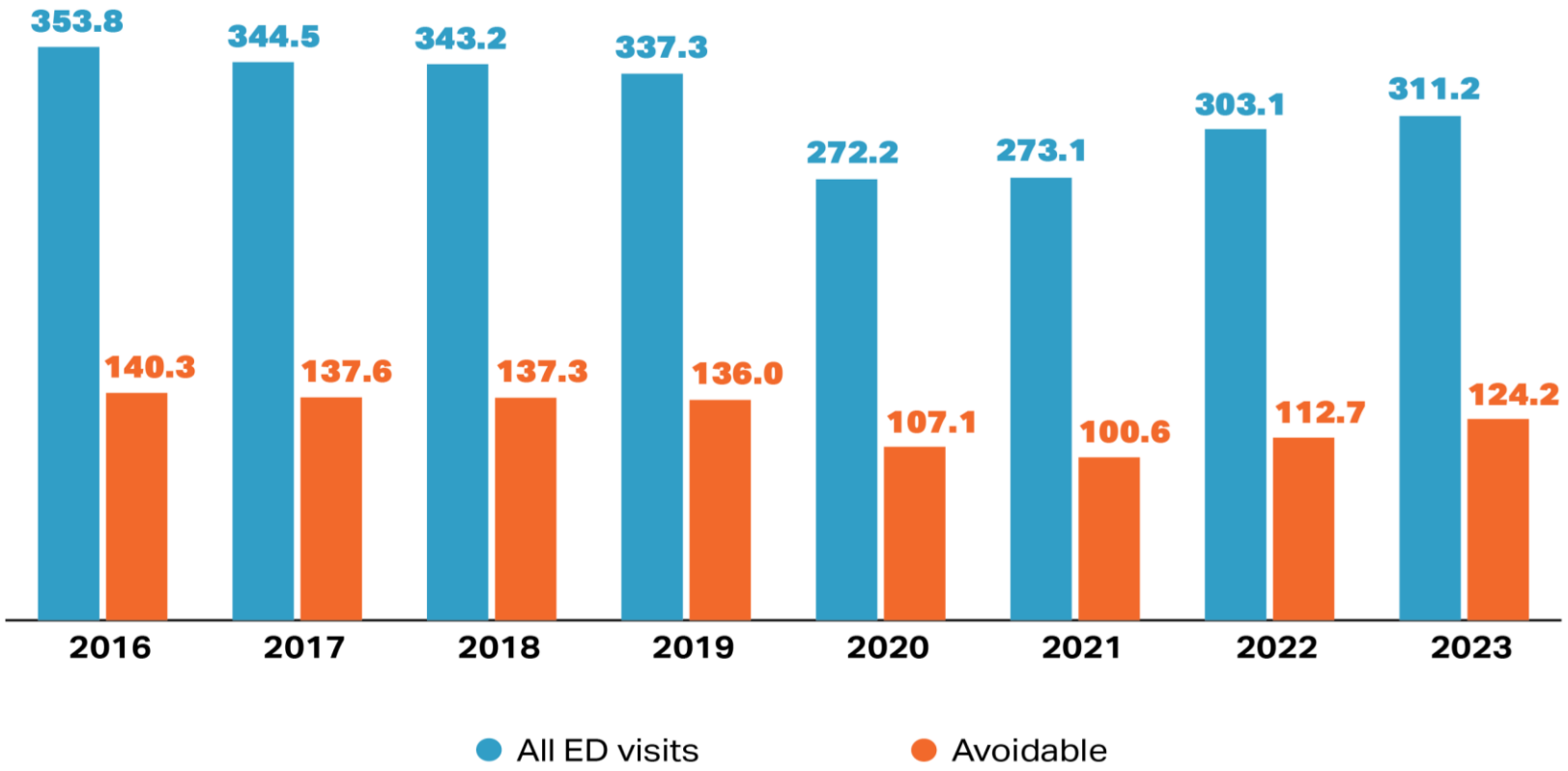
Percent of commercial members with no primary care visits by community income decile, 2022



Notes: Analysis restricted to members under 65 with full year medical and prescription drug coverage. Children are defined as those under 18 years old. Adults are those aged 18 to 64. Income groupings represent population-weighted deciles based on median income of zip code sourced from U.S. Census Bureau American Community Survey 5-year estimates.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2022, 2022.

Roughly 40% of emergency department visits continue to be for conditions that could have been treated in a primary care setting or prevented with timely primary care.

All ED visits and potentially avoidable ED visits per 1,000 residents, 2016-2023



Notes: 'Avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into the following categories: Emergent - ED care needed and not avoidable; Emergent - ED care needed but avoidable; Emergent - primary care treatable; and Non-emergent - primary care treatable. "Avoidable" is defined here as ED visits that were emergent - primary care treatable or non-emergent - primary care treatable. Behavioral health ED visits were identified based on a principal diagnosis related to mental health and/or substance use disorder using the Clinical Classifications Revised Software (CCSR) diagnostic classifications. To improve classification rate, diagnosis codes unclassified by the Billings algorithm were truncated and shortened codes were re-classified. Please see the technical appendix for additional details.

Sources: 'HPC analysis of Center for Health Information and Analysis Emergency Department Database, CY2016 – 2022

1 Center for Health Information and Analysis, Findings from the 2023 Massachusetts Health Insurance Survey, 2024.

2 Center for Health Information and Analysis. Primary Care in Massachusetts Databook. January 2023.

- A 2023 survey of Massachusetts residents found that of those who had an ED visit for a nonemergency condition, **66.1% sought care in the ED because they were unable to get an appointment at a doctor's office or clinic** as soon as needed.[1]
- There are **persistent disparities in potentially avoidable ED use**. As of 2023, 47.9% of Black non-Hispanic residents and 51.3% of Hispanic residents reported that their most recent ED visit was for a non-emergency condition, compared to 26.5% of White non-Hispanic residents.[2]

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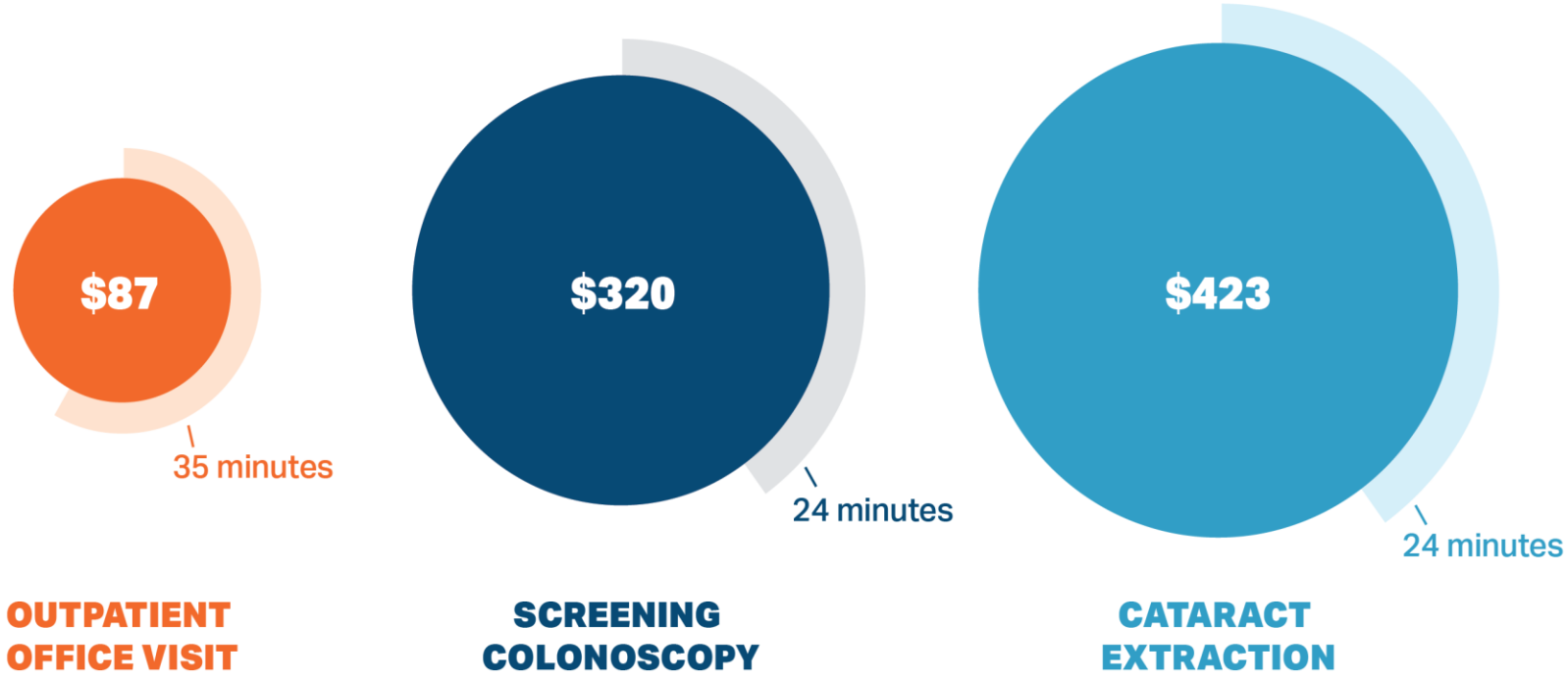
Key factors driving the current challenges in primary care include reimbursement models and administrative burden.

1. **Primary care is a relatively low-reimbursed medical field, which can:**
   - Disincentivize new graduates from entering
   - Make primary care practices hard to sustain
   - Disincentivize the health industry from investing in primary care
   - Limit the hiring and retention of support staff

2. **Impacts of administrative burden:**
   - Can make the work of primary care more time-consuming, less rewarding, and more frustrating, leading to burnout
   - Contributes to providers' reduction in patient care hours or even leaving the field

Medicare payment rates for primary care services are substantially lower than for specialist services, and are often used as the basis for commercial and Medicaid rates.

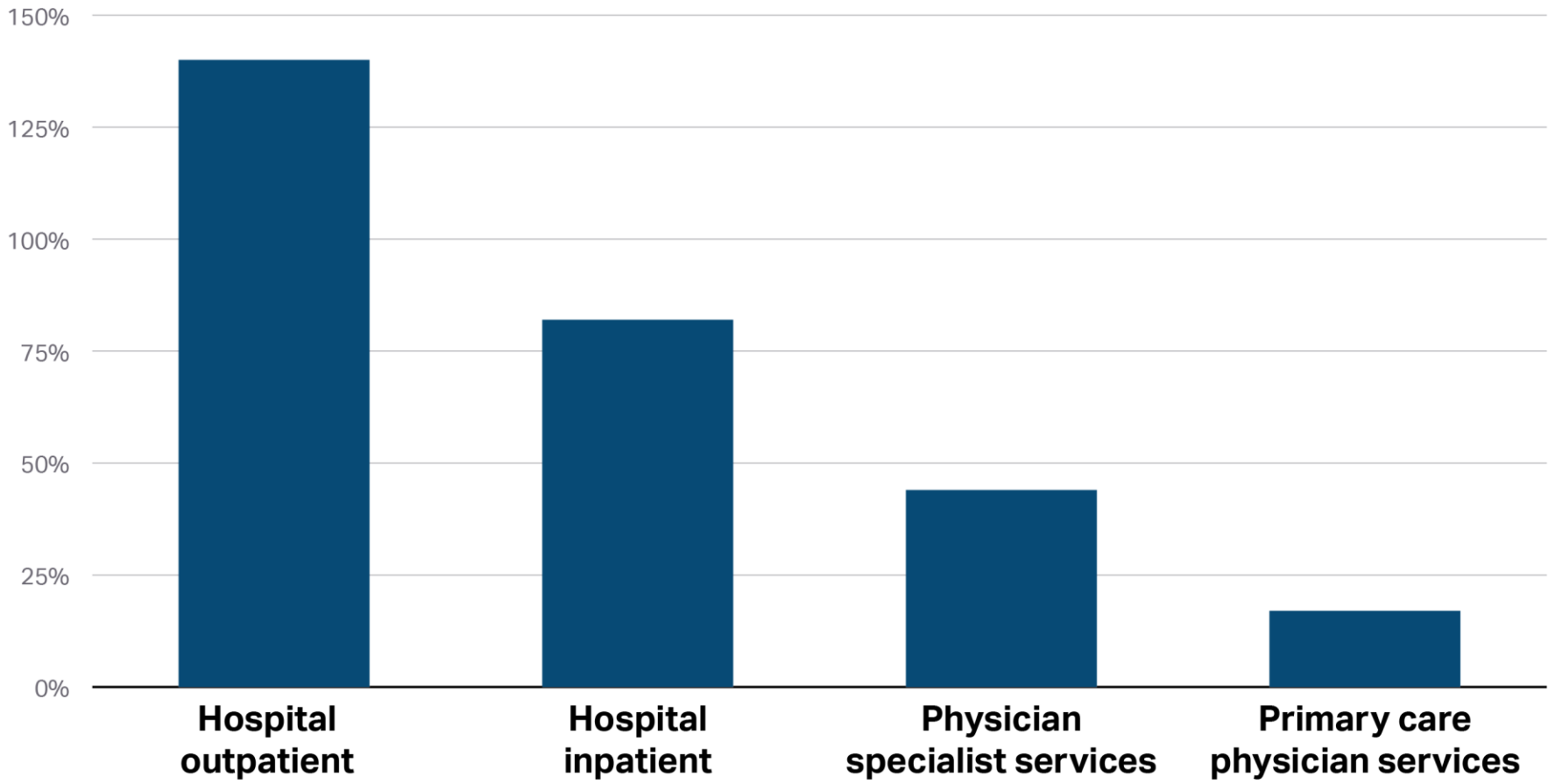
Compensation of hourly Medicare physician revenue for selected services, 2013



Sources: 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/ Outpatient office visit is for Current Procedural Terminology code 99214.

Commercial payment rates further exacerbate the undervaluing of primary care services inherent in Medicare payment rates.

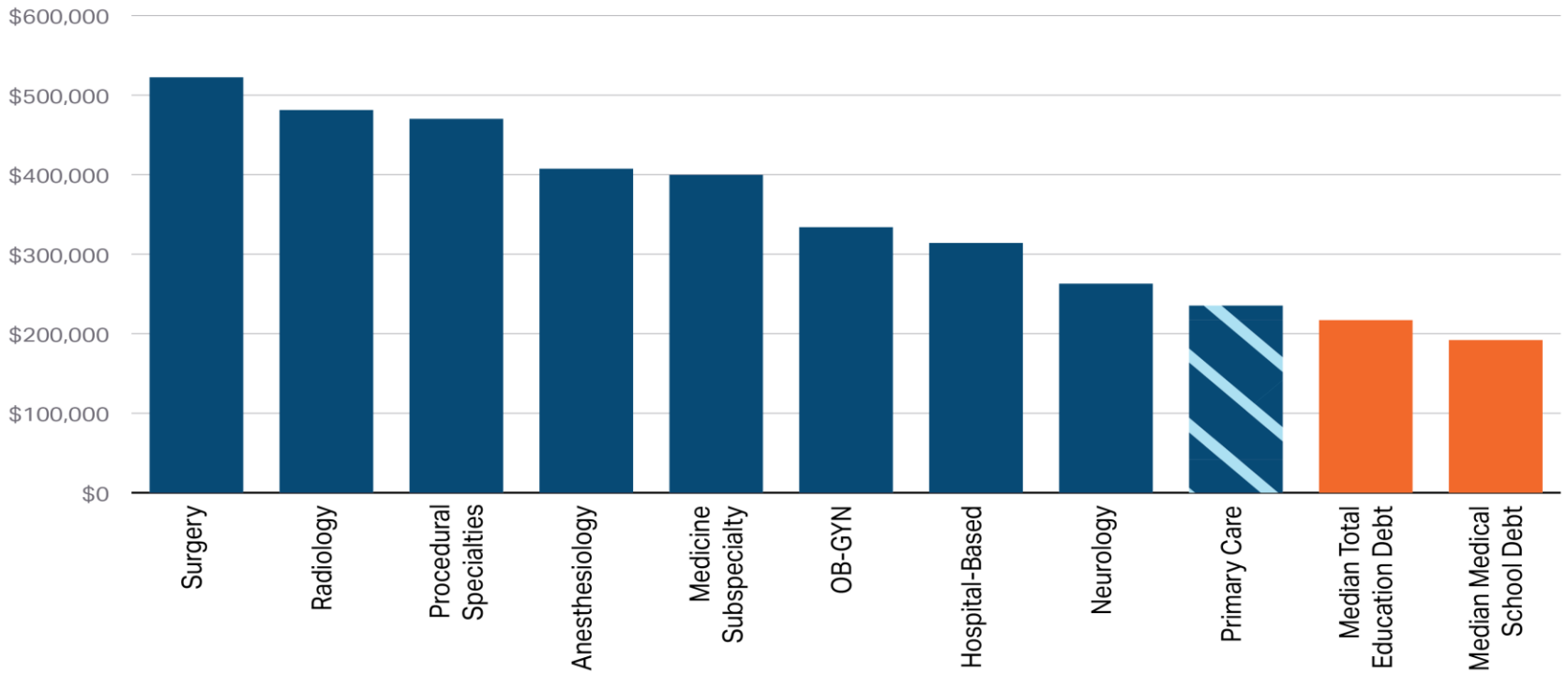
Percentage by which average commercial prices (national) exceed Medicare prices, by category of care



Notes: Data in the above figure represent an aggregate of research studies mostly performed over the 2010s.
Sources: Congressional Budget Office. The prices that commercial health insurers and Medicare pay for hospitals' and physician's services. Jan, 2022.

Physician specialists typically earn much more than primary care physicians, which can disincentivize new physicians from going into primary care.

Median wage income for physicians by specialty and median total education and medical school debt, United States, 2017



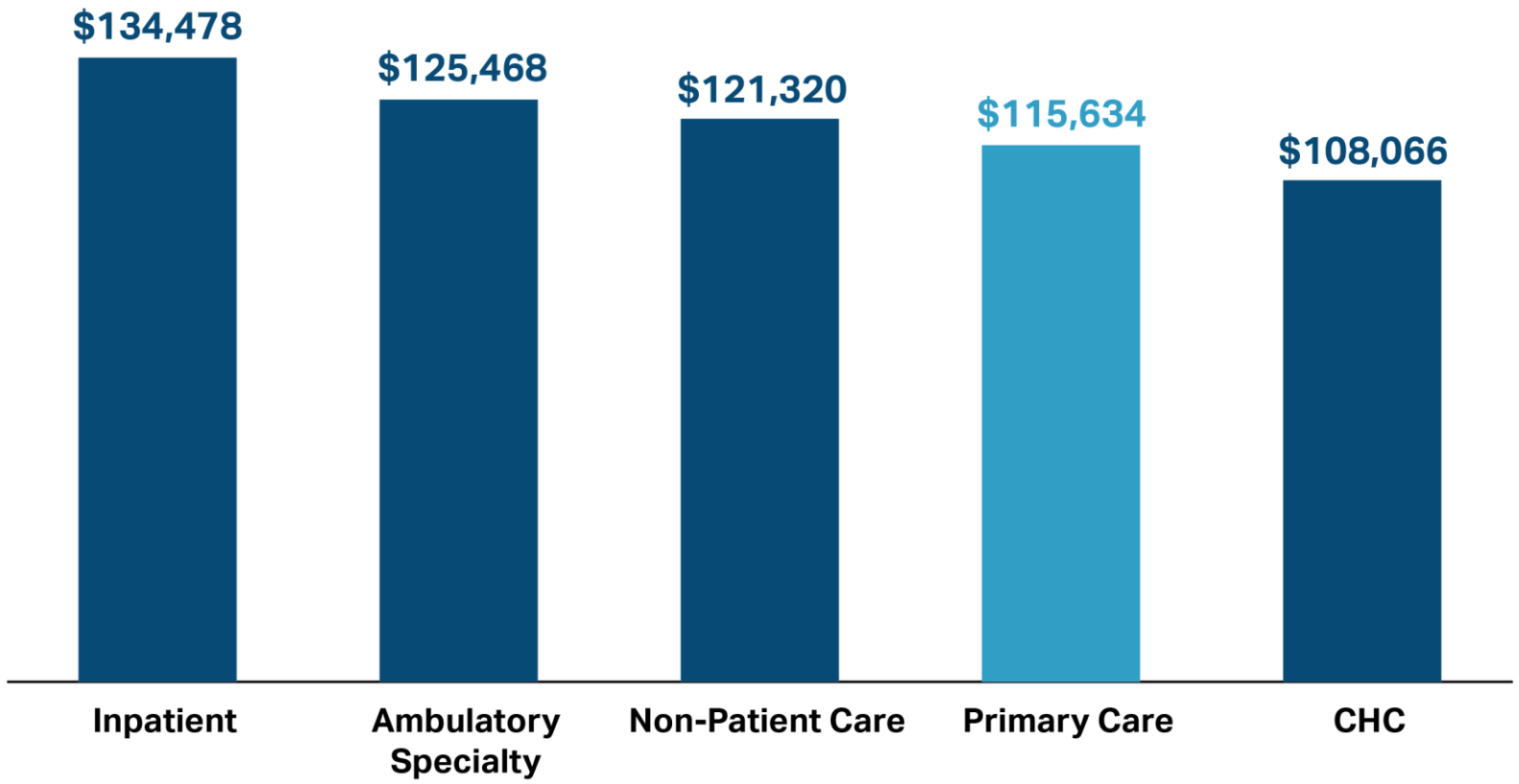
- About one-fifth (21.4%) of medical graduates surveyed reported that their level of education debt influenced their choice of specialty.[1]

Sources: Gottlieb J. D., et al. Who Values Human Capitalists' Human Capital? The Earnings and Labor Supply of U.S. Physicians. Becket Friedman Institute for Economics working paper. 2023. Hanson, Melanie. "Average Medical School Debt" EducationData.org, September 17, 2023.
Notes: Wage estimates are in 2017 dollars. Primary care includes general practice, family practice, internal medicine, hospice and palliative care, sports medicine, psychiatry, pediatric medicine, geriatric medicine, pain management, addiction medicine, preventive medicine, and sleep medicine. Hospital-based includes pathology, physical medicine and rehabilitation, emergency medicine, hospitalist, and pharmacology. Procedural specialties include otolaryngology, dermatology, ophthalmology, and urology. See Gottlieb 2023 for additional definitions. Medical school and education debt are 2017 estimates of the median debt of indebted students. Median education debt includes both medical school and premedical education debt.

1 Association of American Medical Colleges. Medical School Graduation Questionnaire, 2021 All Schools Summary Report. 2021.

Advanced-practice providers also have financial disincentives to enter primary care.

Average annual earnings for Massachusetts nurse practitioners by setting, 2022



- Similarly, PAs earn higher wages in hospital settings compared to physician offices, and often have significant education debt. As of 2017, 84% of PAs nationwide had education debt, with a median debt amount of $100,000. [1,2]

Notes: CHC = Community Health Center. Results are weighted using the sample weight. Ambulatory specialty includes NPs working in all non-hospital based outpatient settings besides primary care. Primary includes NPs working in hospital outpatient departments.

Sources: National Sample Survey of Registered Nurses, U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2022.

1 HPC analysis of Bureau of Labor Statistics, Occupational Employment and Wage Statistics, 2022

2 Physician Assistant Education Association, Student Report 2: Data from the 2017 Matriculating Student and End of Program Surveys, 2018.

Lack of adequate support is also challenging for primary care providers.

- Physicians cite inadequate mental health care access for patients, lack of support for non-medical tasks, and staff turnover – especially among support staff – as major challenges.[1,2]
  - Research has found that providing **evidence-based primary care without an adequate care team requires nearly 27 hours of work per day**.[3]
- Other challenges include unrealistically high daily patient volumes, and the mismatch between the prevailing acute, episodic payment model and the prevention- and screening-focused care that PCPs seek to provide.
- One family physician interviewed described "burnout" and "moral injury" from "being asked to do more than what we are literally able to do"

  "The visits are too short, so I'm running late…after a long day, I come to an inbox of a second day's worth of work… I could have five messages a day for one common medication for a patient [that wasn't covered]."
- Evidence on the use of artificial intelligence models to assist with clinician administrative tasks is mixed.[4,5,6]



1 Massachusetts Medical Society. Supporting MMS Physicians' Well-Being Report: Recommendations to Address the On-Going Crisis. March 2023.
2 Boone C, Zink A, Wright BJ. Value-Based Contracting in Clinicial Care. JAMA Health Forum. 2024; 5
3 Porter J, Boyd C, Skandari MR, Laiteerapong N. Revisiting the time needed to provide adult primary care. Journal of General Internal Medicine. 2022. 8:14-155. https://link.springer.com/article/10.1007/S11606-022-07707-X
4 Garica P, Ma SP, Shah S. Artificial Intelligence-Generated Draft Replies to Patient Inbox Messages. Health Informatics. 2024. (3) https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2816494
5 English E, Laughlin J, Sippel J. Utility of Artificial Intelligence-Generative Draft Replies to Patient Messages. Health Informatics. 2024. 7(10). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2824738
6 Rotenstein LS, Wachter RM. Are Artificial Intelligence–Generated Replies the Answer to the Electronic Health Record Inbox Problem? Health Informatics. 2024. 7(10). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2824739

In addition to lower pay, primary care physicians face high administrative burden and lack of adequate support, fueling burnout and workforce sustainability challenges.

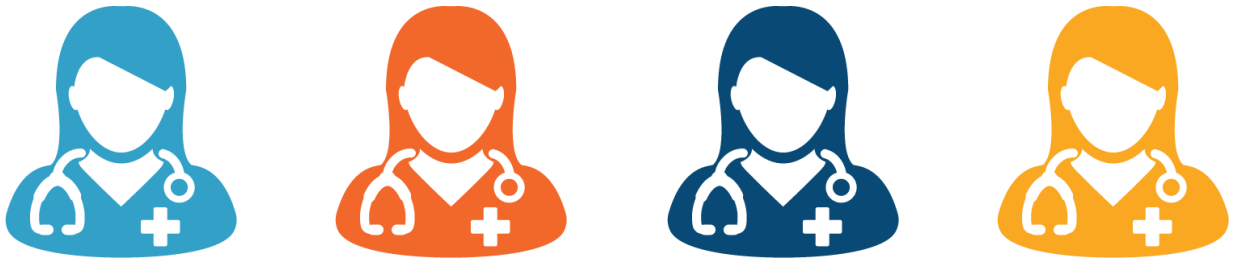
- Physicians and stakeholders report that **poor job quality and sustainability**, including burnout, are often more significant factors than pay in their decision to reduce their clinical hours, leave patient care entirely, or not to go into primary care at all.[1]
- Administrative burden, including **substantial work outside of regular working hours**, is a key job sustainability challenge in primary care. This includes high-touch asynchronous messaging (such as patient portal emails), EHRs, quality measure reporting, and prior authorization.[2,3,4,5,6]
- Physicians also cite inadequate mental health care access for patients, **lack of support for non-medical tasks,** and staff turnover – especially among support staff – as major challenges.[4,7]
- A June 2022 survey of Massachusetts physicians found that **55% experienced symptoms of burnout**. Self-reported burnout and wellbeing were worst among female physicians and physicians of color.[9]
- Burnout and job exit fuels a cycle of workforce sustainability challenges, including larger patient panels for those remaining, and rising costs due to high turnover.[10]



1 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
2 Stillman M., Death by Patient Portal. JAMA. June 30, 2023. doi:10.1001/jama.2023.11629
3 National Academies of Sciences, Engineering, and Medicine. 2019. Taking action against clinician burnout: A systems approach to professional well-being. Washington, DC: The National Academies Press. https://doi.org/10.17226/25521.
4 Massachusetts Medical Society. Supporting MMS Physicians' Well-Being Report: Recommendations to Address the On-Going Crisis. March 2023.
5 Melnick et al. Perceived Electronic Health Record Usability as a Predictor of Task Load and Burnout Among US Physicians: Mediation Analysis. Journal of Medical Internet Research. 22 December 2020.
6 Saag, H.S., Shah, K., Jones, S.A. et al. Time: Working After Work in the Electronic Health Record. Journal of General Internal Medicine. 34:1695–1696 (2019). https://doi.org/10.1007/s11606-019-05055-x
7 Boone C, Zink A, Wright BJ. Value-Based CPajamaontracting in Clinicial Care. JAMA Health Forum. 2024; 5(8).https://jamanetwork.com/journals/jama-health-forum/fullarticle/2822685
9 Massachusetts Medical Society. Supporting MMS Physicians' Well-Being Report: Recommendations to Address the On-Going Crisis. March 2023.
10 Testimony for the 2023 Health Care Cost Trends Hearing, Available at https://www.mass.gov/info-details/testimony-for-the-2023-health-care-cost-trends-hearing

Advanced-practice providers in primary care also face job sustainability challenges.

- Advanced-practice providers can experience the same kind of burnout as their physician colleagues.[1] NPs cite pay and benefits and stressful work environments among their top reasons for leaving or considering leaving their jobs.[2]
- While PAs usually receive primary care training, the share working in primary care in Massachusetts fell from 18% in 2018 to 16% in 2022.[3] Similarly, the share of NPs working in office-based settings (a proxy for primary care) fell from 26% to 21% during that same period.[4]
- **Without improving job sustainability in primary care, bringing in different types of clinicians to serve as PCPs may not resolve access issues related to a lack of providers.**



1 Cunningham T, Gonzalez-Guarda RM. Burned Out on Burnout—The Urgency of Equity-Minded Structural Approaches to Support Nurses. JAMA Health Forum. 2023;4(12):e235249. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2813265
2 Hnath JG, Rambur B, Grabowski DC. Earnings, job satisfaction, and turnover of nurse practitioners across employment settings. Health Affairs Scholar. 2023;1(3). https://academic.oup.com/healthaffairsscholar/article/1/3/qxad044/7273866
3 HPC analysis of National Commission on Certification of Physician Assistants State Profiles, 2018-2022
4 HPC analysis of American Community Survey 5-year estimates, 2018-2022

Greater clinician workforce diversity would be beneficial for patients.

- Research suggests that patients tend to be more satisfied with their care and have more positive health care interactions when their care providers have backgrounds or life experiences matching their own.[1,2]
- **Race/Ethnicity.** About 6% of U.S. physicians are Hispanic and 5% are Black, compared to 19% and 12% of U.S. residents, respectively.[3] In MA, 5% of in-office physicians are Hispanic and under 2% are Black, compared to, respectively, 11% and 6% of the state population.[4] Black, Hispanic, and Native American clinicians are underrepresented among numerous other health care professions as well, including APRNs and PAs.[5] Research indicates that racial concordance between patients and clinicians may contribute to improved patient-provider communication and lower spending.[6,7]
- **Disability.** People with disabilities represent one-fifth to one-quarter of the U.S. population, but a much smaller share of physicians.[8] Increasing the number of physicians with disabilities who require practice accommodations, such as height-adjustable exam tables, could also increase care accessibility for patients who need similar accommodations. Disabled physicians may also be less likely to hold stereotypes or erroneous assumptions about their disabled patients' lives and care preferences, and may help to dispel biases among their colleagues.[9,10]
- **Gender.** Women made up just over one-third of U.S. physicians as of 2017. Female physicians tend to spend more time with their patients and on electronic messaging than male physicians, and tend to have better quality metrics and patient health outcomes.[8,11,12]

1 American Association of Medical Colleges and University of California San Fransisco. Accessibility, Inclusion, and Action in Medical Education: Lived Experiences of Learners and Physicians with Disabilities. 2018.
2 Artiga, S., et al. Survey on Racism, Discrimination and Health: Experiences and Impacts Across Racial and Ethnic Groups. Keiser Family Foundation. 2023.
3 Reed, T. Medical schools eye workarounds after SCOTUS affirmative action ruling. Axios. June 30, 2023.
4 HPC analysis of American Community Survey 5-year estimate, 2018-2022
5 Salsberg E, Richwine C, Westergaard S, et al. Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce. *JAMA Netw Open.* 2021;4(3):e213789.
6 Shen, M.J., Peterson, E.B., Costas-Muñiz, R. *et al.* The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature. *J. Racial and Ethnic Health Disparities* **5**, 117–140 (2018).
7 Jetty, A., Jabbarpour, Y., Pollack, J. *et al.* Patient-Physician Racial Concordance Associated with Improved Healthcare Use and Lower Healthcare Expenditures in Minority Populations. *J. Racial and Ethnic Health Disparities* **9**, 68–81 (2022).
8 Silver, J. K., et al. Physician Workforce Disparities and Patient Care: A Narrative Review. Health Equity. Vol. 3, No. 1. 2019.
9 Iezzoni, L. I. Why Increasing Numbers of Physicians with Disability Could Improve Care for Patients with Disability. AMA Journal of Ethics. Vol. 18, No. 10: 1041-1049. 2016.
10 Iezzoni LI, Rao SR, Ressalam J, Bolcic-Jankovic D, Agaronnik ND, Donelan K, Lagu T, Campbell EG. Physicians' Perceptions Of People With Disability And Their Health Care. Health Aff (Millwood). 2021 Feb;40(2):297-306.
11 Rotenstein L., Gitomer, R., and Landon, B. Pursuing Gender Equity by Paying for What Matters in Primary Care. The New England Journal of Medicine. 2023.
12 Wallis CJD, Jerath A, Aminoltejari K, et al. Surgeon Sex and Long-Term Postoperative Outcomes Among Patients Undergoing Common Surgeries. *JAMA Surg.* 2023;158(11):1185–1194.

The challenges facing traditional primary care have created an opportunity for new entrants and new care models.

- Emerging models of care delivery include the adoption of **concierge models** among both traditional primary care practices and new corporate entrants, as well as **fully or mostly virtual models of care**. Some new primary care models depart from the traditional provider-patient relationship model while others aim to enhance it with elements such as 24/7 access or virtual-first care.
- In addition to the increasing **consolidation** of primary care practices into larger health systems, there are increasing **changes in ownership** of primary care delivery, such as by large retailers.
- According to one estimate**, over the next decade**, newer primary care providers could capture around **30% of the U.S. market**.[1]
- New care models may help to address challenges in traditional primary care via features such as smaller patient panels and enhanced administrative support for clinicians as well as enhanced access for members. Although models requiring technology fluency or costly membership fees may be inaccessible for many, promising aspects of these care models could likely be replicated in traditional practices with changes to payment for primary care.

1 Ney E, Berger E, Fry S. Primary Care 2030: Innovative Models Transform the Landscape. Bain & Company. July 11, 2022. https://www.bain.com/insights/primary-care-2030/

Concierge models offer improved job sustainability for clinicians, but may contribute to broader primary care access challenges.

- **Concierge practices** use the conventional long-term patient-provider model, but with much smaller patient panels than traditional practices (200-600 patients vs. 2,500-5,000) and charge high monthly or annual membership fees alongside accepting insurance and any associated cost-sharing.[1,2]
  - While the literature often cites annual concierge practice membership fees of about $2,000, some Boston-area concierge practices charge $10,000 per year.[1,3,4]
- The concierge model provides **enhanced access to care for members**, often including in-person primary care and 24/7 virtual visits or messaging, and may make the work of providing primary care **more sustainable for clinicians** via smaller patient panels and enhanced administrative support. The small patient panels and costly fees may also contribute to broader primary care access challenges, including by limiting who can access concierge clinicians and potentially concentrating patients with lower incomes in increasingly overburdened traditional practices. Providers changing to concierge models is also associated with an increase in patient health spending.[1,3,5,6]
- The prevalence of concierge primary care practices has increased over time, including among practices affiliated with major hospitals.[7]

Notes. Direct primary care is a distinct model from concierge medicine. See American Academy of Family Physicians. Data brief: 2024 direct primary care. https://www.aafp.org/dam/AAFP/documents/practice_management/direct-primary-care-2024-data-brief.pdf

1 Konstantinovsky M. Many Doctors are Switching to Concierge Medicine, Exacerbating Physician Shortages Scientific American. 2021.https://www.scientificamerican.com/article/many-doctors-are-switching-to-concierge-medicine-exacerbating-physician-shortages.

2 Concierge Medicine Today. National Stats for the Media, 2025. https://conciergemedicinetoday.net/for-the-media#stats

3 Alhawshani S, Safeer K. A literature review on the impact of concierge medicine services on individual healthcare. Journal of Family Medicine and Primary Care. 2024. 13(6):2183-2186. https://journals.lww.com/jfmpc/fulltext/2024/13060/a_literature_review_on_the_impact_of_concierge.2.aspx

4 e.g., Mass General Hospital Concierge Medicine FAQ. 2024. https://www.massgeneral.org/concierge-medicine/about/faq

5 Dalen JE, Alpert JS. Concierge Medicine is Here and Growing!! The American Journal of Medicine. 2017. https://www.amjmed.com/article/S0002-9343(17)30358-3/pdf

6 Leive A, David G, Candon M. On resource allocation in heatlh care: the case of concierge medicien. Journal of Health Economics. 2023. 90. https://doi.org/10.1016/j.jhealeco.2023.102776

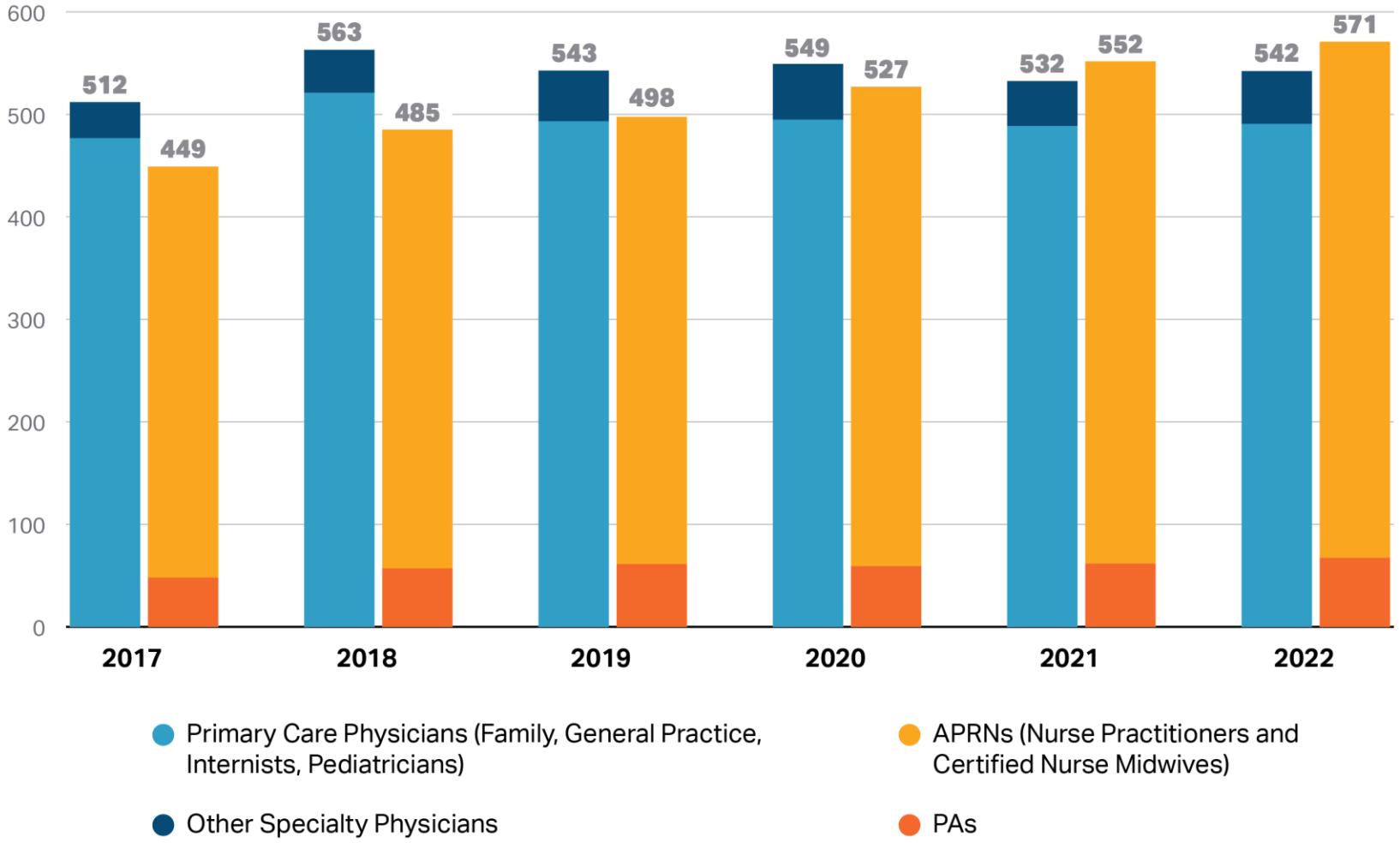
7 Galewitz P. Hospitals Cash In on a Private Equity-Backed Trend: Concierge Physician Care. KFF Health NEws. April 1, 2024. https://kffhealthnews.org/news/article/concierge-medicine-physician-practices-hospitals-private-equity/

MASSACHUSETTS
HEALTH POLICY COMMISSION

- Who Provides Primary Care in Massachusetts?
- Concerning Trends in Primary Care Provision and Workforce in Massachusetts
- Concerning Trends in Primary Care Access in Massachusetts
- Root Causes: Why Is This Happening?
- **SPOTLIGHT ON COMMUNITY HEALTH CENTERS**
- Where Do We Go From Here?

In Massachusetts community health centers, the number of nurse practitioners and physician assistants now exceeds the number of physicians.

Number of full-time equivalent (FTE) providers in community health centers, Massachusetts, 2017 - 2022

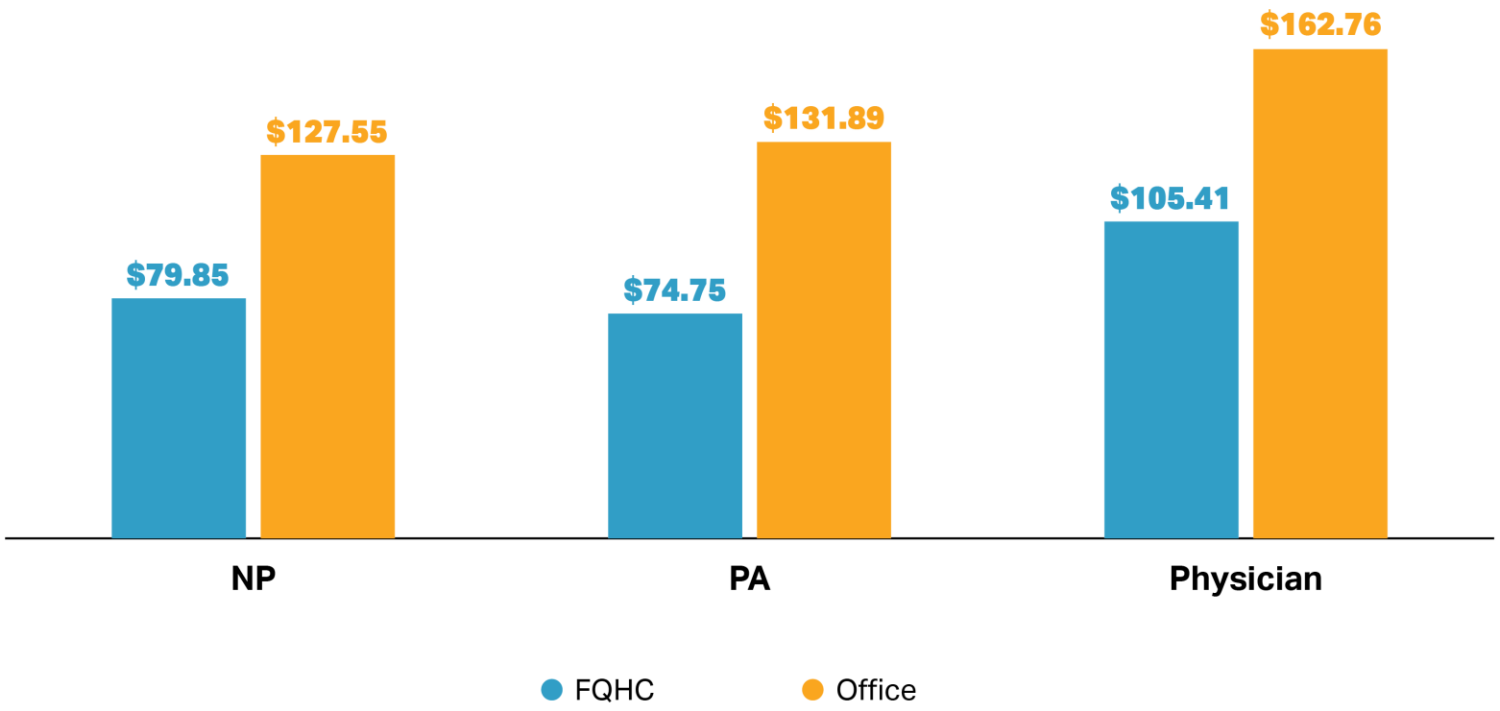


Notes: Data labels are totals for each bar.

Sources: Uniform Data System (UDS) Table 5, Health Resources & Services Administration, 2017-2022.

FQHCs, a subset of community health centers, are particularly challenged with lower commercial payment rates than other settings.

Average commercial payment rate for an established patient office or other outpatient visit (20-29 minutes) by setting and provider type, 2022



Notes: CPT code 99213 (established patient office or other outpatient visit (20-29 minutes))
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2022, 2022

1 Centers for Medicare & Medicaid Services. FQHC PPS Overview. 2024. https://www.cms.gov/medicare/payment/prospective-payment-systems/fqhc_pps
2 MassHealth. Community Health Centers and the MassHealth ACO Primary Care Sub-Capitation Program. December 2022. https://www.mass.gov/doc/community-health-centers-and-the-masshealth-aco-primary-care-sub-capitation-program-0/download

- Many but not all CHCs are also federally-qualified health centers (FQHCs).
- FQHCs come with federally designated requirements and unique public funding, including Medicare prospective payment with enhanced rates for preventive physicals and annual wellness visits and MassHealth prospective payment. Primary care services for MassHealth ACO members at all Massachusetts CHCs are covered via primary care sub-capitation.[1,2]

Community health centers are less able to compete on wages, which can lead to high staff turnover.

- CHCs receive relatively low reimbursement and are less able to offer competitive salaries than hospitals or other large organizations, including non-health care sectors such as hospitality or retail, which may compete with CHCs for entry-level and non-clinical staff.
- Non-competitive salary and burnout were top workforce challenges reported among CHCs as of 2023; over 80% of CHCs reported asking current staff to work additional hours due to staffing shortages. Massachusetts CHCs also reported 16-17% vacancy rates among physicians, PAs, and nurses.[2]
- Less ability to compete on wages can create a cycle of turnover, overwork for remaining staff, burnout, and further turnover. This can undermine effective team-based care due to the constant need to train new hires.

Loan repayment programs have been a unique and successful retention strategy at CHCs – for instance, nearly **one-third of advanced-practice providers surveyed report loan repayment participation as a key motivator for working in a CHC.**[3] Some Massachusetts loan repayment programs have ended, while others continue or have been reinitiated with different funding sources.[4,5]

1 HPC analysis of Uniform Data System (UDS), Five-year MA awardee files. Health Resources & Services Administration, 2022.
2 Center for Health Information and Analysis. 2023 Massachusetts Health Care Workforce Dashboard. https://www.chiamass.gov/massachusetts-healthcare-workforce-survey#dashboard
3 Massachusetts League of Community Health Centers and ForHealth Consulting at UMass Chan Medical School. Recruitment and Retention of the Advanced Practice Provider Workforce in Massachusetts Community Health Centers: Report of Survey Results. June 2023.
4 One example of a program that is no longer active is the Student Loan Repayment Program, which was a Delivery System Reform Incentive Payment Program (DSRIP) investment, funded by MassHealth and EOHHS, resulted in a retention rate of about 90% of participating providers in the first three years of the program.
5 The Massachusetts League of Community Health Centers. Workforce Program Descriptions. 2023.

MASSACHUSETTS
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- Spotlight on Community Health Centers
- **WHERE DO WE GO FROM HERE?**

The work of primary care has become unsustainable. Action is urgently needed to repair and support primary care in the Commonwealth.

- **Reduce Sources of Administrative Burden and Burnout for Primary Care Clinicians.** Action is needed from the Massachusetts Legislature, public and private payers, and health care delivery organizations to reduce the sources of administrative burden and burnout for primary care clinicians.

- **Strengthen the Primary Care Provider Pipeline.** Of particular importance for underserved areas and populations, it is necessary to reduce barriers to practice, including those for advanced-practice providers, by funding programs that can increase the primary care provider pipeline.

- **Increase Spending for Primary Care.** This includes higher payment rates, rebalanced payment towards primary care, and greater use of capitated payments, to increase wages for primary care clinicians and fund support teams to reduce clinician administrative burden.

Reduce Sources of Administrative Burden and Burnout for Primary Care Clinicians

- The Commonwealth maintains a set of **aligned quality measures**, and payers should seek to limit or eliminate measures that may be duplicative of those represented in the aligned measure set, as well as carefully consider the added value of any additional measures in light of added administrative burden for providers.[1]
- The Commonwealth should balance any new responsibilities for primary care providers that may come with increased investment in primary care.
- Payers should redesign their program requirements in **quality measures, billing and coding, and prior authorization** to minimize administrative burden for clinicians, including by facilitating clinician involvement in the creation and discontinuation of quality measures, aligning billing and coding documentation requirements among payers to minimize claims reprocessing and denials, and limiting the use of prior authorization and aligning rules and processes for its use.[2]
- Health care delivery organizations should **increase wages for care team staff** such as care management staff, medical assistants, community health workers and other roles, to reduce turnover and support building and retaining more effective care teams to better support both patients and clinicians, including alleviating clinician administrative burden.
- Health care delivery organizations should **create healthy work environments that support professional wellbeing**, including by changing features of organizations to better support and retain clinicians from historically underrepresented groups.[2,3]

1 Executive Office of Health and Human Services. EOHHS Quality Measure Alignment Taskforce. https://www.mass.gov/info-details/eohhs-quality-measure-alignment-taskforce

2 Committee on Systems Approaches to Improve Patient Care by Supporting Clinician Well-Being. National Academies of Sciences, Engineering, and Medicine. 2019. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. Washington, DC: The National Academies Press. https://doi.org/10.17226/25521.

3 Nigam JAS, Barker RM, Cunningham TR, Swanson NG, Chosewood LC. Vital Signs: Health Worker–Perceived Working Conditions and Symptoms of Poor Mental Health — Quality of Worklife Survey, United States, 2018–2022. CDC Morbidity and Mortality Weekly Report. November 3, 2023 / 72(44);1197–1205. https://www.cdc.gov/mmwr/volumes/72/wr/mm7244e1.htm?s_cid=mm7244e1_w

Strengthen the Primary Care Provider Pipeline

- The Commonwealth has made strides with the recent passage of the **Physician Pathway Act**, facilitating medical practice for experienced physicians trained in other countries.[1]
- The Commonwealth should consider **resuming and broadening the scope of Medicaid funding for graduate medical education (GME)** to include training for all types of primary care clinicians with a focus on training in community-based settings.[2,3]
  - Massachusetts discontinued Medicaid GME in 2010, and is currently one of seven states whose Medicaid programs do not opt to cover GME costs for clinician training.[2,3]
  - Workforce investments such as **loan repayment programs and residency programs** for NPs and PAs can be effective ways to remove barriers to entry and bolster retention for all types of primary care clinicians.
- Massachusetts could **enable continuous practice for PAs by shifting the supervisory requirement** from an individual physician to the employer or practice. Further independence would be in line with current policy, as the PA practice acts in Massachusetts already support PAs in practicing to the fullest extent of their training.[4]
  - As part of the COVID-19 public health emergency, Massachusetts issued a temporary executive order allowing PAs to practice without physician supervision in early 2022.[5]
  - Other states have recently updated PA practice requirements; for example, New Hampshire enacted legislation in 2024 to no longer require signed collaborative practice agreements with physicians for PAs with at least 8,000 hours of clinical experience to practice.[6]

1 Passed as part of a larger economic development bill: https://www.mass.gov/news/governor-healey-signs-economic-development-bill-to-strengthen-massachusetts-global-leadership-in-climatetech-life-sciences-and-ai

2 Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Graduate Medical Education That Meets the Nation's Health Needs. Washington (DC): National Academies Press (US); 2014 Sep 30. 3, GME Financing. https://www.ncbi.nlm.nih.gov/books/NBK248024/

3 Association of American Medical Colleges. Medicaid Graduate Medical Education Payments: Results from the 2022 50-State Survey. https://store.aamc.org/downloadable/download/sample/sample_id/590/

4 California Health Care Foundation and Healthforce Center at UCSF. California's Physician Assistnats: How Scope of Practice Laws Impact Care. September 2018.

5 The Commonwealth of Massachusetts Executive Office of Health and Human Services Department of Public Health. Executive order: COVID-19 Public Health Emergency Order No. 2022-02 Issued January 14, 2022. This order is no longer in effect as of the end of the Commonwealth's public health emergency on May 11, 2023, see https://www.mass.gov/news/healey-driscoll-administration-announces-end-of-covid-19-public-health-emergency-in-massachusetts

6 Timmins A. New Hampshire eases regulation of physician assistants. Seacoastonline. Aug 1, 2024. https://www.seacoastonline.com/story/news/2024/08/01/new-hampshire-eases-regulation-of-physician-assistants/74616478007/

Increase Spending for Primary Care

- Increased investment in primary care should involve both **shifts in payment models** and **changes in the balance of medical spending** in the Commonwealth.[1]
- Payers should shift toward **capitated payment models** for primary care and support **independent primary care practices and community health centers** through enhanced payment.[2] Public and private payers could also provide upfront support to smaller practices for staffing and infrastructure investments that would facilitate offering more comprehensive care.
  - Capitation should include upward adjustments for social and neighborhood risk factors and should not be based entirely on historical fee-for-service spending, nor should it reward upcoding.
- In 2023, MassHealth launched a new primary care sub-capitation payment model for primary care providers participating in its Accountable Care Organization (ACO) program. This model moves reimbursement for primary care at participating practices from fee-for-service to a **per-member-per-month capitated payment**, with the goal of providing **consistent revenue for primary care practices and CHCs** while providing funds for enhanced team-based care not covered by a traditional fee-for-service office visit payment.[3,4]
  - The sub-capitation program also offers enhanced payment to practices offering more comprehensive services.[5]
  - As of 2022, the share of primary care spending in the MassHealth MCO/ACO program slightly exceeded that of the commercial market.[6]
- Additionally, FQHCs are paid for Medicare services via prospective payment that uses a national rate with geographic adjustments, and with **enhanced rates for preventive physicals and annual wellness visits.**[7]

1 Phillips RS, Altman W, Friedman C, Song Z. A Value-Based Primary Care Model That Doubles Primary Care Investment. Health Affairs Forefront. Dec 16, 2024. https://www.healthaffairs.org/content/forefront/value-based-primary-care-model-doubles-primary-care-investment
2 e.g., Blue Cross Blue Shield of Massachusetts. Blue Cross Blue Shield of Massachusetts to Boost Investment in Small Independent Primary Care Practices. April 8, 2024.https://www.prnewswire.com/news-releases/blue-cross-blue-shield-of-massachusetts-to-boost-investment-in-small-independent-primary-care-practices-302110393.html
3 Milbank Memorial Fund. How Massachusetts Medicaid Is Paying for Primary Care Teams to Take Care of People, Not Doctors to Deliver Services. Aug 15, 2023. https://www.milbank.org/news/how-massachusetts-medicaid-is-paying-for-primary-care-teams-to-take-care-of-people-not-doctors-to-deliver-services/
4 MassHealth. MassHealth Primary Care Sub-Capitation: Program Overview. 2024. https://www.mass.gov/info-details/masshealth-primary-care-sub-capitation-program-overview
5 MassHealth. MassHealth Primary Care Sub-Capitation: Care Delivery Transformation. 2024. https://www.mass.gov/info-details/masshealth-primary-care-sub-capitation-care-delivery-transformation
6 Center for Health Information and Analysis. Primary Care in Massachusetts. Databook May 2024.
7 Centers for Medicare & Medicaid Services. FQHC PPS Overview. 2024. https://www.cms.gov/medicare/payment/prospective-payment-systems/fqhc_pps

Learning from Other States

- **California** has approved benchmarks for primary care investment, calling for gradual increases in the share of spending on primary care, and for primary care to represent **15% of total health care spending** by 2034.[1]
- **Colorado** has instituted payment system reforms to reduce health care costs by increasing use of primary care, including requiring **payer adoption of state primary care investment targets.**[2,3]
- **Oregon** requires most public and private payers to allocate at least **12% of their health care spending to primary care.**[4,5]
- **Rhode Island** requires insurers to dedicate at least **10.7% of their medical spending on primary care**.[6]
- **Washington** has set a target of **12% of health care spending on primary care**, and is implementing a Primary Care Transformation Initiative, including aligning public and commercial payers to support primary care, and increasing investment and reimbursement for primary care.[7,8]

Notes. See https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf for more examples of state efforts to invest in primary care.
As of 2022, primary care represented 7.5% of medical spending in Massachusetts, or $508 per member per month on average, with 2.3% annual growth in primary care spending since 2017. Other medical spending grew by 4.5% each year, while pharma spending grew by 5.2%.

1 California Department of Health Care Access and Information. California Sets Benchmarks for Primary Care Investment to Promote High-Quality, Equitable Health Care. Oct 22, 2024. https://hcai.ca.gov/california-sets-benchmarks-for-primary-care-investment-to-promote-high-quality-equitable-health-care/
2 Colorado General Assembly. Investments In Primary Care To Reduce Health Costs. HB19-1233. (Colorado 2019). https://leg.colorado.gov/bills/hb19-1233
3 Colorado Division of Insurance. Primary Care Payment Reform Collaborative. 2024. https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/primary-care-payment-reform
4 Oregon Academy of Family Physicians. Primary Care Payment Reform Bill Signed into Law. https://oafp.org/wp-content/uploads/Primary-Care-Payment-Reform-Bill-Signed-into-Law.pdf
5 Oregon Health Authority, APAC, and Department of Consumer and Business Services. Primary Care Spending in Oregon 2020. https://visual-data.dhsoha.state.or.us/t/OHA/views/PrimaryCareSpendinginOregon2020/Home
6 Rhode Island Office of the Health Insurance Commissioner. Next Generation Affordability Standards: Concepts, Rationale,
and Additional Information. https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-05/OHIC%20Next%20Generation%20Affordability%20Standards%20Concept%20Paper.pdf
7 Washington State Health Care Authority Policy Division. Report to the Legislature. Primary Care Expenditures: Health Care Cost Transparency Board Preliminary Report. Dec 1, 2022. https://www.hca.wa.gov/assets/program/leg-report-hcctb-preliminary20221202.pdf
8 Zerzan-Thul J. State Efforts to Increase Primary Care Access. Washington State Health Care Authority. Presentation to the House Health Care and Wellness Committee. Sept 23, 2024. https://www.hca.wa.gov/assets/program/primary-care-leg-presentation-09232024.pdf

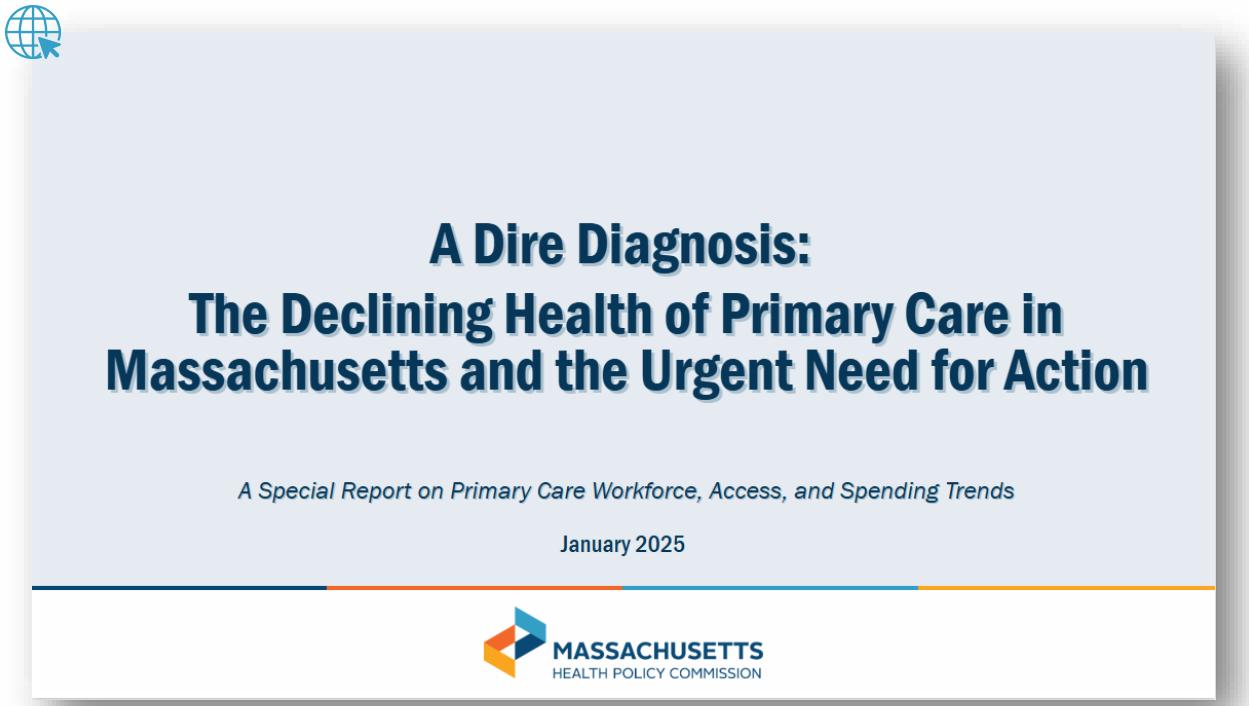
Next Steps: New Primary Care Payment and Delivery Task Force

- In partnership with the Massachusetts Executive Office of Health and Human Services, the HPC will co-chair a **25-member task force** – the Primary Care Payment and Delivery Task Force – charged with studying and making recommendations to improve primary care **access, delivery,** and **financial sustainability** in the Commonwealth.
- Specifically, the task force must:
  - Issue recommendations related to definitions of services as well as **standardized practices for data collection**
  - Make a recommendation to **establish a primary care spending target** for public and private payers in Massachusetts
  - **Propose payment models to increase reimbursement for primary care services** and assess the impact of plan design on health equity and access to primary care services; and
  - Issue recommendations to **improve service delivery to residents of the Commonwealth** and address primary care workforce needs.
- The task force will be required to publish these recommendations by staggered deadlines over the next 16 months.



The full report is now available on the HPC's website.

Please visit www.masshpc.gov to find the full report, *A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action – A Special Report on Primary Care Workforce, Access, and Spending Trends*



Agenda

Call to Order

Approval of Minutes **(VOTE)**

Behavioral Health Workforce Center

Overview of New Health Care Legislation: *An Act enhancing the market review process and An Act relative to pharmaceutical access, costs, and transparency*

A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action – *Special Report from the HPC on Primary Care Workforce, Access, and Spending Trends*

EXECUTIVE DIRECTOR'S REPORT

Adjourn

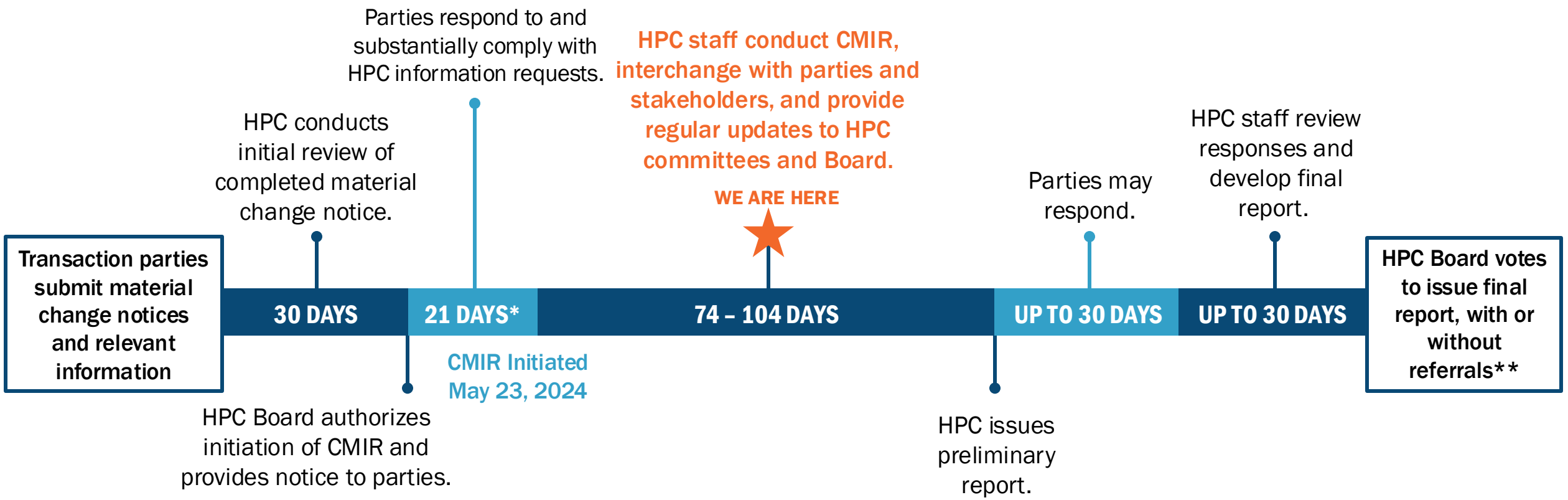
Since 2013, the HPC has reviewed 184 market changes.

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Physician group merger, acquisition, or network affiliation	41	22%
Formation of a contracting entity	40	22%
Clinical affiliation	36	20%
Acute hospital merger, acquisition, or network affiliation	31	17%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	30	16%
Change in ownership or merger of corporately affiliated entities	5	3%
Affiliation between a provider and a carrier	1	1%

Cost and Market Impact Reviews in Progress

A proposed clinical affiliation between **Dana-Farber Cancer Institute, Beth Israel Deaconess Medical Center**, and the **Harvard Medical Faculty Physicians**. On May 23, 2024, the HPC formally initiated the CMIR process.

Timeline for Cost and Market Impact Report (CMIR) Review



* The parties may request extensions to this timeline which may likewise affect the timing of the report
** The parties must wait 30 days following the issuance of the final report to close the transaction

Elected Not to Proceed

- The proposed acquisition of **Springfield Anesthesia Service, Inc.**, a privately owned physician practice located in Western Massachusetts specializing in anesthesia delivery, by **Baystate Medical Practices**, a subsidiary of Baystate Health.
- The proposed acquisition of **Commonwealth Pathology Partners, P.C.**, a private practice pathology group employing 16 clinical and laboratory pathologists and additional pathology staff, by **Mass General Brigham**.

Material Change Notice Currently Under Review

The proposed acquisition of **Vibra Hospital of Western Massachusetts**, the for-profit owner and operator of both an inpatient long term acute care hospital and a skilled nursing facility in Rochdale, Massachusetts, by **Everest Hospital, LLC**, a newly formed Massachusetts corporation in coordination with Nielk Equities, LLC.

HPC Summer Fellowship Program



The HPC Summer Fellowship is a **10-week paid opportunity** for graduate students with an interest in health policy.

Summer Fellows work alongside colleagues in each HPC department to complete a research project or other deliverable. Past projects have included:

- Conducting a landscape analysis to inform the HPC's new **Behavioral Health Workforce Center**;
- Utilizing the APCD to **research price differences** between self-insured plans and fully-insured plans; and
- Identifying best practices for **integrating equity** into the evaluation of investment programs.

The 2025 program will run from **June 2 – August 15**, and applications will be accepted through **Tuesday, January 21**.

masshpc.gov/about/job-opportunities

Agenda

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Approval of Minutes **(VOTE)**

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Executive Director's Report

ADJOURN