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

January 2025

MASSACHUSETTS
HEALTH POLICY COMMISSION

Executive Summary

- Primary care in the Commonwealth is facing many challenges, including burnout for providers and access barriers for patients. Residents of lower income communities are most likely to have no primary care use.
- Administrative burden – including electronic health record-related tasks, the proliferation of quality measures, patient correspondence, and prior authorization – makes the work of providing primary care increasingly unsustainable. Likewise, low payment rates for primary care, relative to specialty and hospital-based care, disincentivize new physicians from entering the field and disincentivize the health industry from prioritizing primary care.
- As a result, few physicians are going into primary care, and many report reducing their hours or exiting patient care, leaving larger patient panels for remaining providers. Nurse practitioners (NPs) and physician assistants (PAs) are increasingly involved in primary care, but Massachusetts has been slow to integrate them into practice, and financial and job-quality considerations may lead them to opt for hospital-based or specialty careers.
- Community health centers – an essential source of primary care for patients who are medically underserved – are experiencing an exacerbated version of the trends and obstacles facing primary care across the Commonwealth.
- Primary care challenges are driving changes in practice ownership, such as consolidation into larger health systems, and new models of care delivery, including concierge and virtual care delivery models.
- The HPC highlights policy options to improve the sustainability of primary care in Massachusetts,including increasing payment levels and capitated funding models, actions to reduce administrative burden and burnout, and strengthening the primary care provider workforce pipeline.

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 delivery faces significant challenges throughout the United States, 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.

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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
- What Is the Role of New Primary Care Business Models In Workforce and Access Challenges?
- Where Do We Go From Here?
- Data Sources and Acknowledgements

Who provides primary care?

- The core clinicians who provide primary care in the U.S. are **physicians** (such as general internists, family medicine physicians, and pediatricians), **nurse practitioners, and physician assistants**.
  - Other key roles include clinical pharmacists, medical assistants, scribes, and registered nurses.
- **Primary care physicians (PCPs)** are either medical doctors (M.D.) or doctors of osteopathic medicine (D.O.) who complete a family medicine residency or an internal medicine residency following graduation from a U.S. or international medical school.
- **Nurse Practitioners (NPs)** are registered nurses with a bachelor of science degree in nursing and additional master's degree or doctoral-level training.
- **Physician Assistants (PAs)** are licensed clinicians who practice medicine under a supervising physician. PAs complete a master's-level program that includes both classroom instruction and clinical rotations.
- State **scope of practice laws** govern the scope and authority of NPs and PAs. Recent Massachusetts policy changes have facilitated independent practice for advanced-practice nurses, but only temporarily for physician assistants.
  - Massachusetts legislation passed in early 2021 expanded full practice authority, including the ability to bill independently, to all Massachusetts advanced-practice nurses (including nurse practitioners).[1]
  - As part of the COVID-19 public health emergency, a temporary executive order allowing PAs to practice without physician supervision was issued in early 2022.[2]

1 An act promoting a resilient health care system that puts patients first. Chapter 260. 2020.

2 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

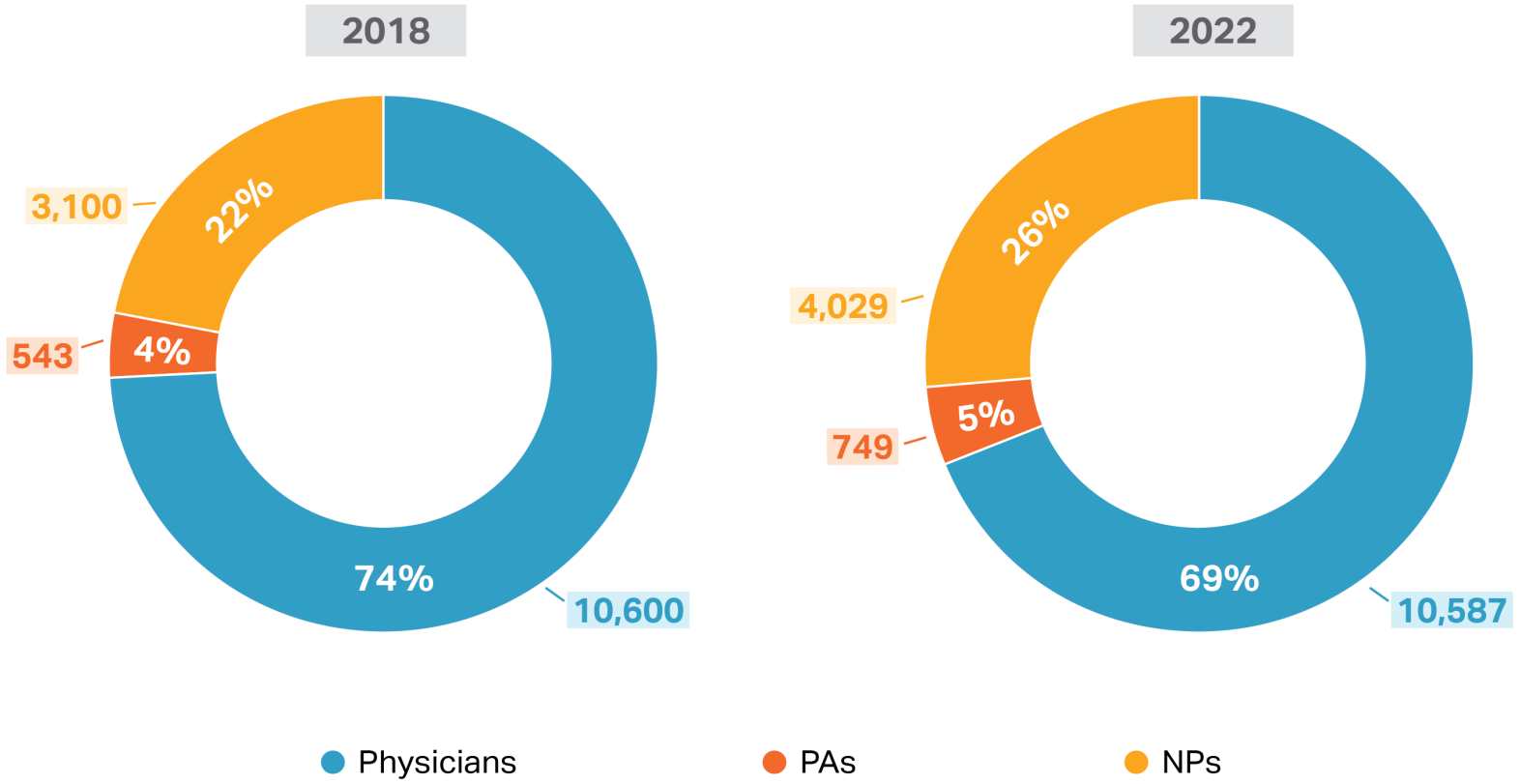
Primary care in Massachusetts may be delivered in a variety of different ways and by a variety of different organizations.

- **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



- Workforce projections from the federal Health Resources & Services Administration suggest that this trend is likely to continue nationally, with flat primary care physician workforce growth and an increasing workforce of primary care NPs and PAs.[1]

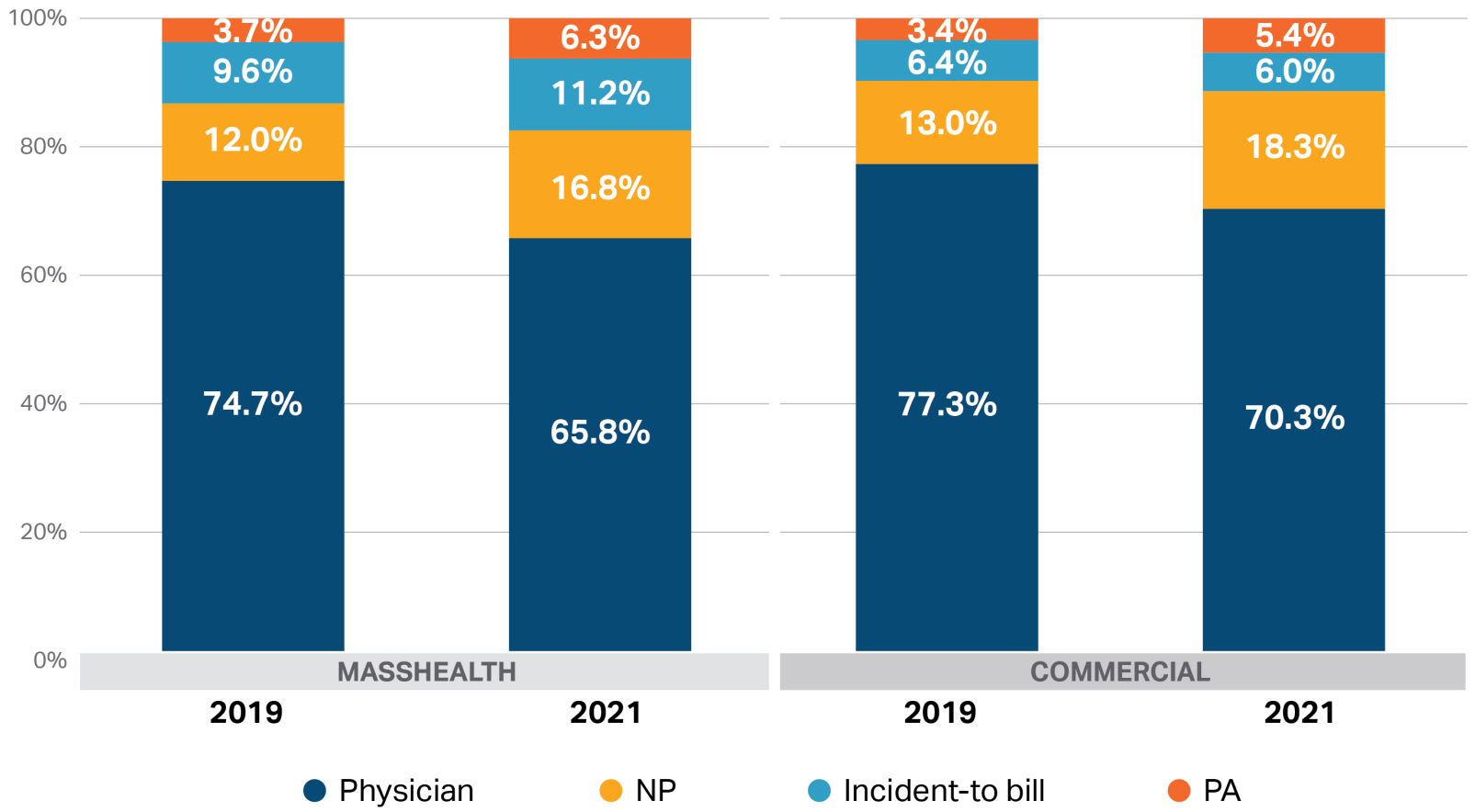
Notes: Physician counts may include residents, non-active physicians, or primary care physicians not working in direct patients care. Estimates are full time equivalents (FTEs) where FTE = 40 hours worked a week. PCPs/PAs in primary care are estimated by multiplying the ACS total provider count by the 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



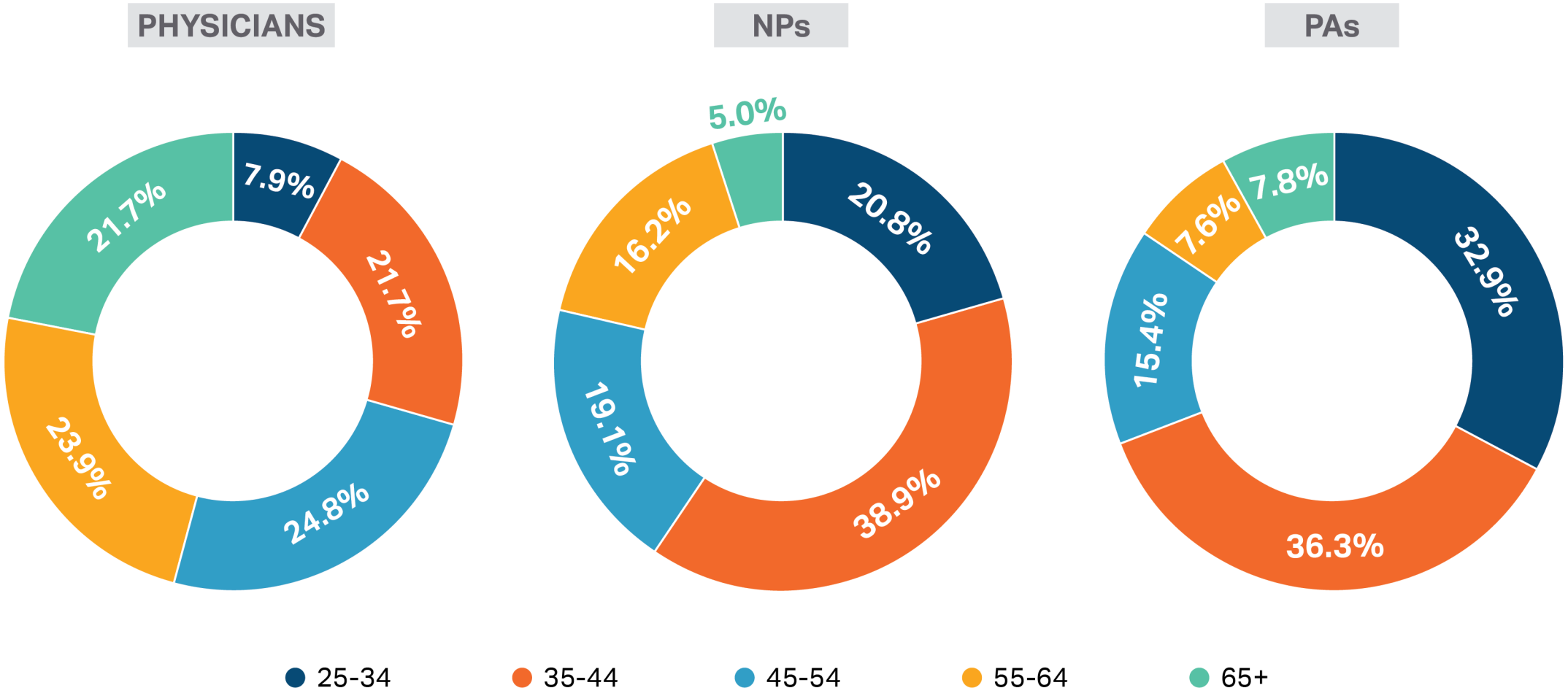
- **Incident-to billing** is a practice in which care provided by a non-physician is billed by a co-located physician (for whom the payment is generally higher). The results presented here likely undercount the extent of the practice and therefore undercount the true proportion of care provided by advanced-practice providers.
- A growing share of primary care visits are delivered by advanced-practice providers both in Massachusetts and nationally.[1,2,3]

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

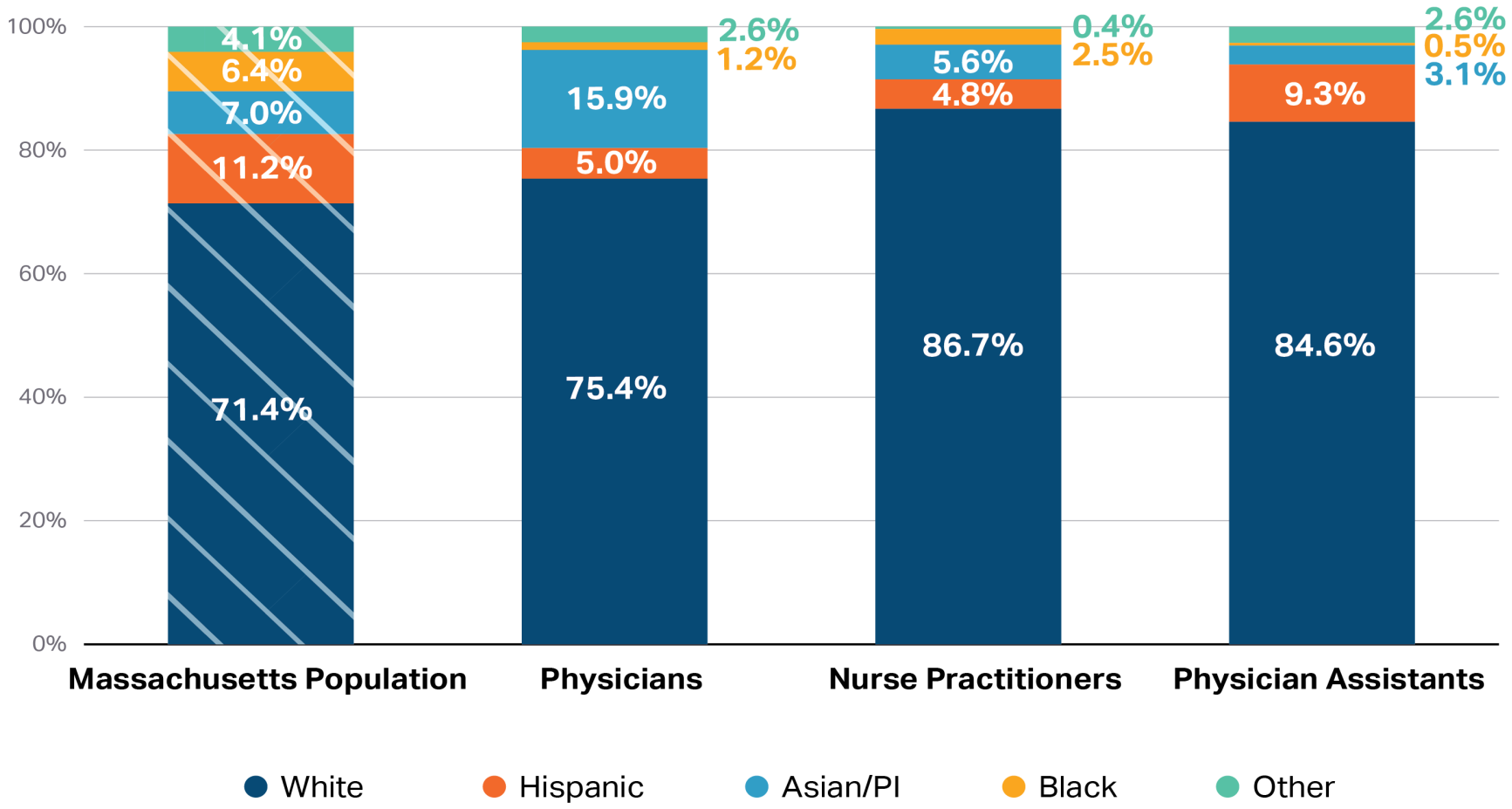


Notes: Includes physicians, nurse practitioners, and physician assistants that work in office settings. Sample weighted using person weight. The ACS groups nurse midwives in with NPs. Those not in the labor force were dropped from this sample. Residents are likely included as physicians because ACS occupations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

- An HPC analysis suggests that the workforce of office-based physicians, NPs, and PAs in Massachusetts has less diversity than the full statewide workforces of each role.
- A relatively large proportion of office-based physicians are immigrants (25.2%) versus 9.4% and 4.2% among NPs and PAs, respectively.
- 2% of physicians and 2.4% of NPs reported some type of disability, compared to 14% of the full Massachusetts population.

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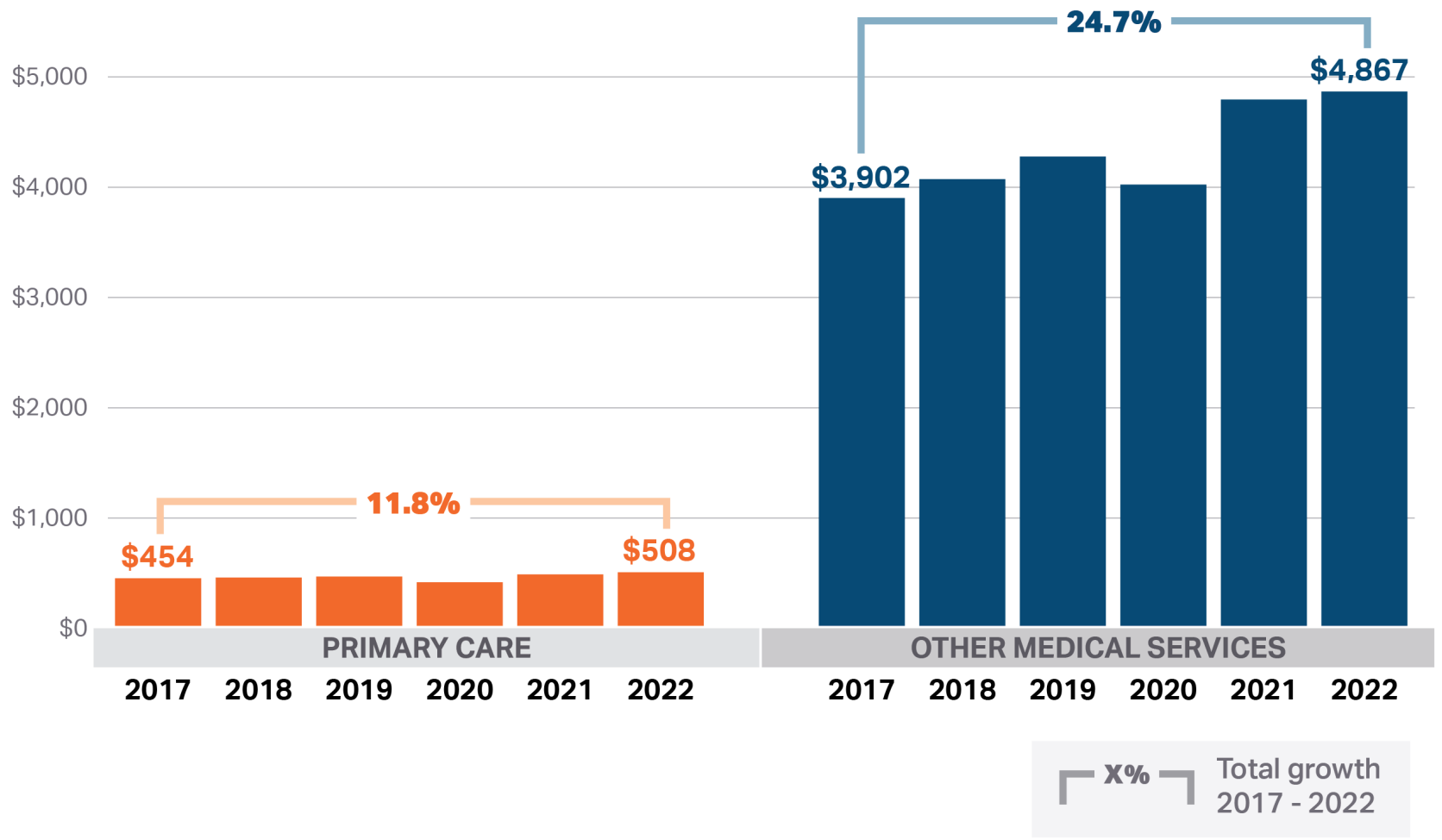
Stagnant Spending and Declining Physician Entry

- Spending on primary care is low, and being far outpaced by growth in spending on other medical care and prescription drugs. **Thus, the share of health care spending devoted to primary care is declining.**[1]
- Physicians are turning away from primary care in Massachusetts. Already a state with among the **lowest shares of physicians working in primary care**, Massachusetts has an **aging primary care physician workforce**, and among the **lowest shares of new physicians entering the field.**[2-4]

1 HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2022, 2018-2021 and V2021, 2017-2018.
2 HPC analysis of Association of American Medical Colleges. State Physician Workforce Data Report, 2021
3 American Community Survey 5-year estimate, 2022
4 Milbank Memorial Fund. The Health of U.S. Primary Care: 2024 Scorecard Data Dashboard.

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

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



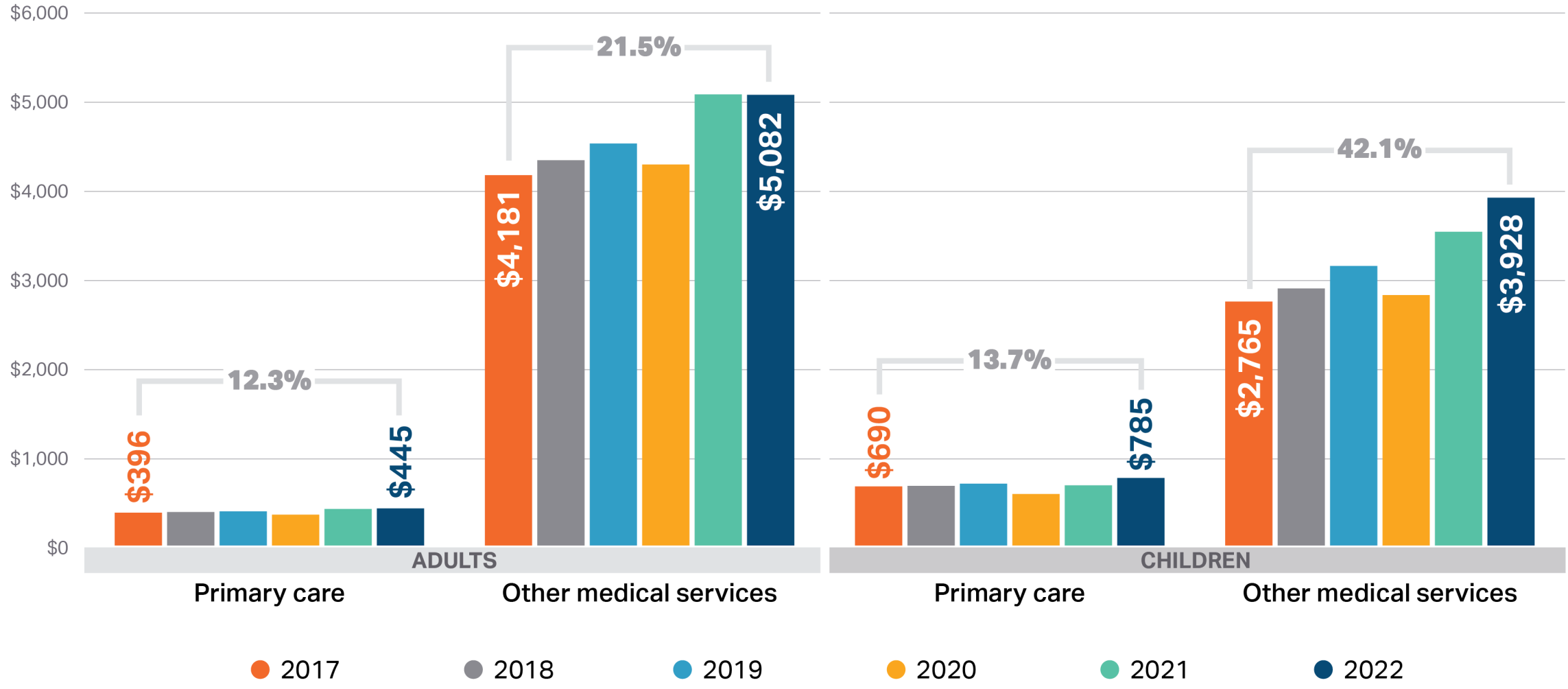
- Primary care declined as a percentage of all commercial spending between 2017 and 2022, from 8.4% to 7.5%.

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.

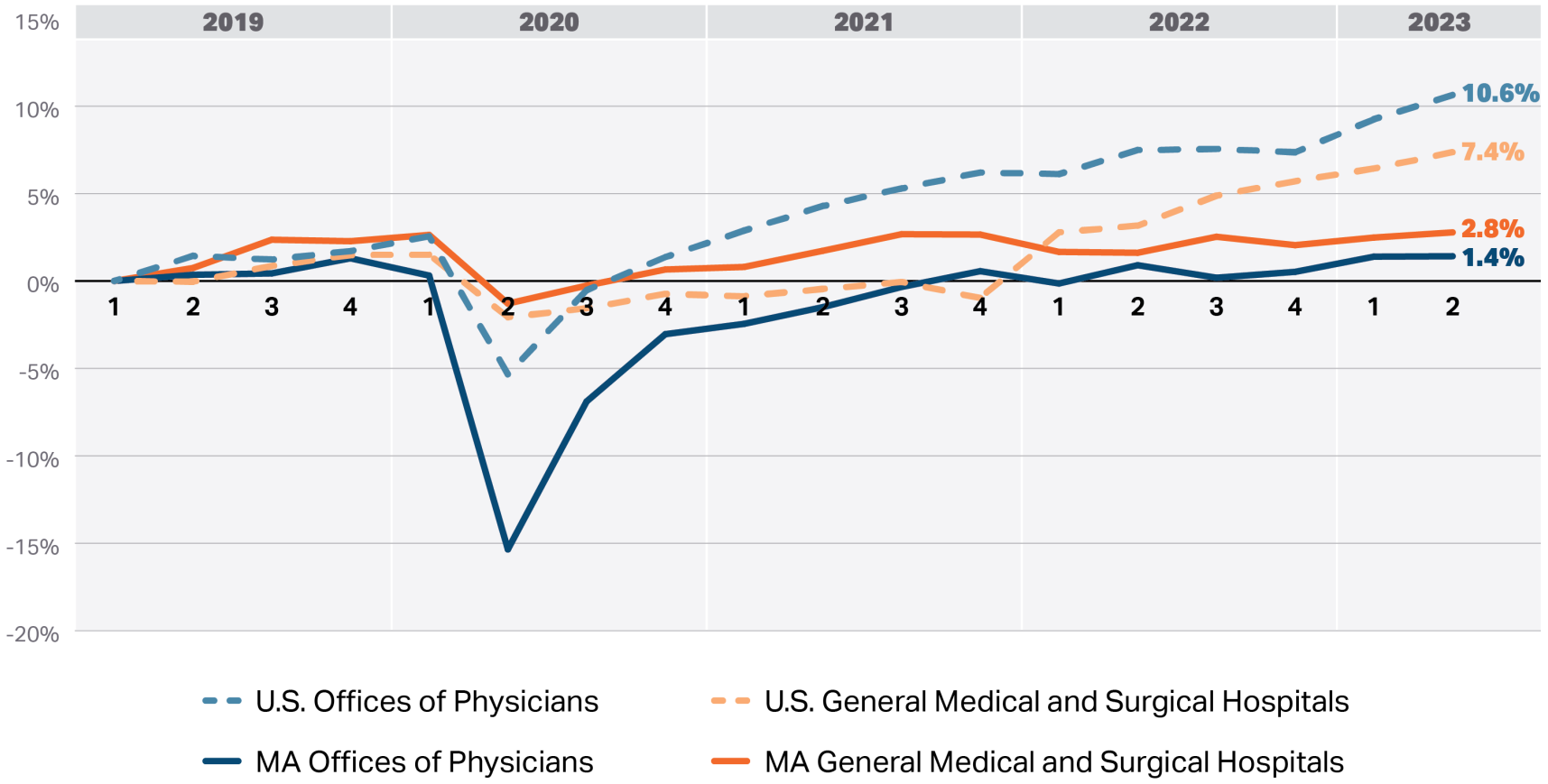
Commercial medical spending by category per member per year for children vs adults, 2017-2022



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.

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



- At the start of the COVID-19 pandemic, employment in physician offices plummeted due to lay-offs, furloughs, and retirements, among other reasons; employment in hospitals dropped to a far lesser extent.
- In Massachusetts, the drop in physician office employment in 2020 was triple the loss in the U.S. overall (15.3% versus 5.3%), and the recovery has been far slower.
- Hospital employment has increased faster than physician office employment in Massachusetts, in contrast to the national trend.
- As of 2022, fewer than a quarter of U.S. primary care practices reported being fully staffed.[1]

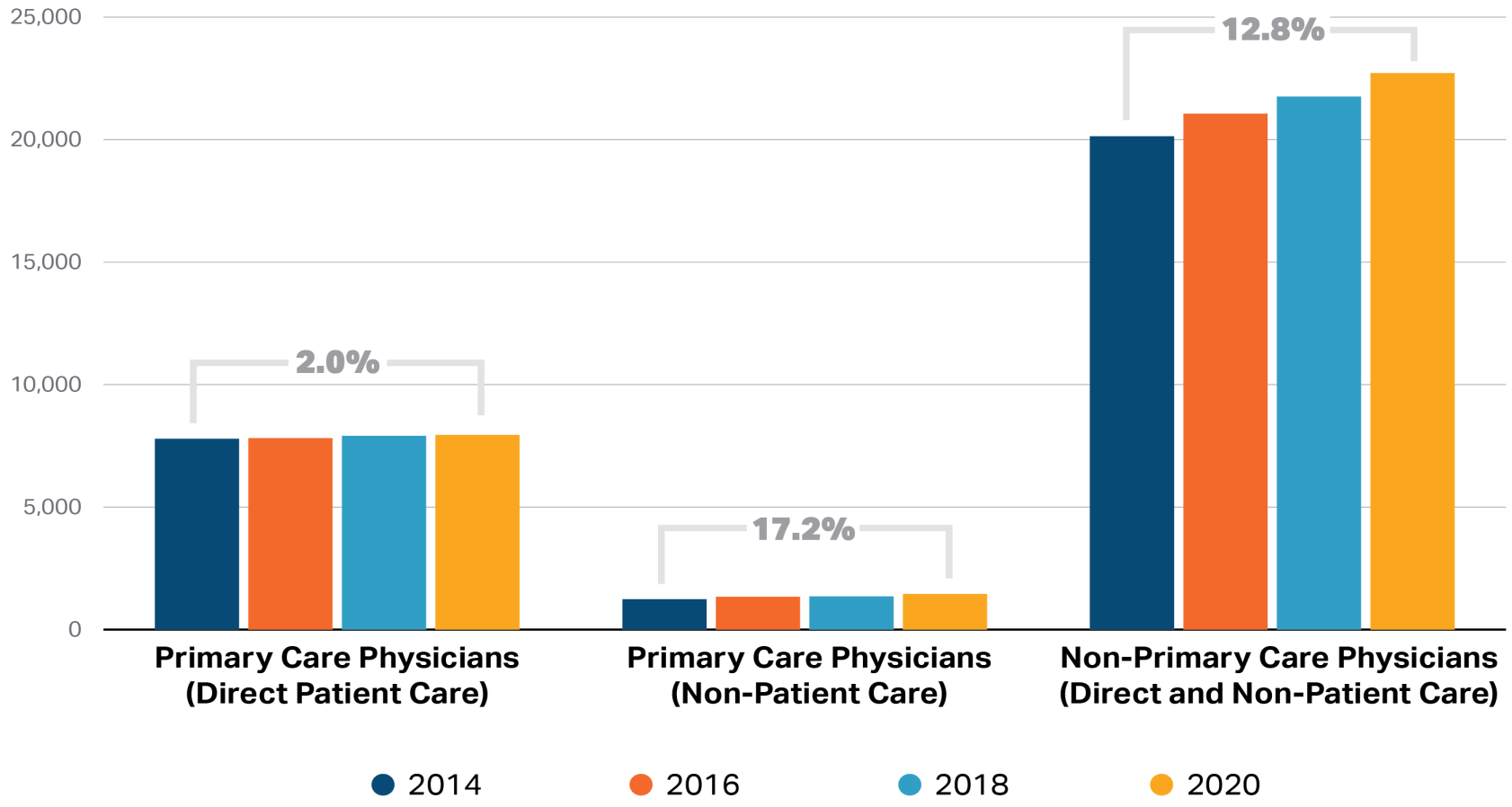
Notes: Offices of physicians includes establishments of health practitioners having an M.D. or D.O. primarily engaged in the independent practice of general or specialized medicine or surgery, excluding psychiatry and therefore mental health specialists. Offices of physicians includes offices in the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

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



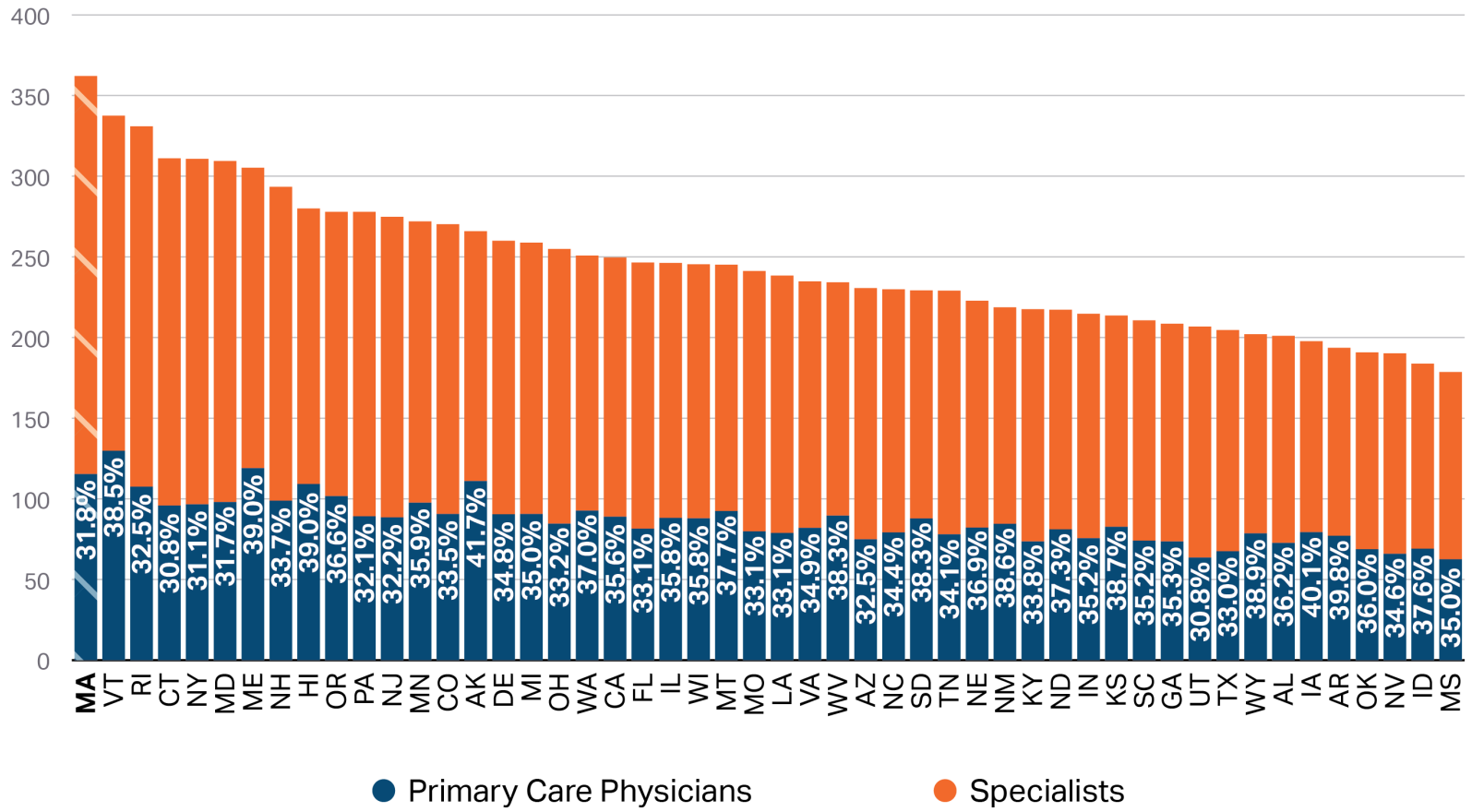
- Total physician employment per 100,000 Massachusetts residents has grown slowly, increasing 7.8% between 2014 and 2020.[1]
- Primary care physicians in direct patient care as a share of total physicians has declined from 2014 to 2020 (26.7% to 24.7%), while the share of specialty physicians has increased (69.0% to 70.7%).[1]

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 highest 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.

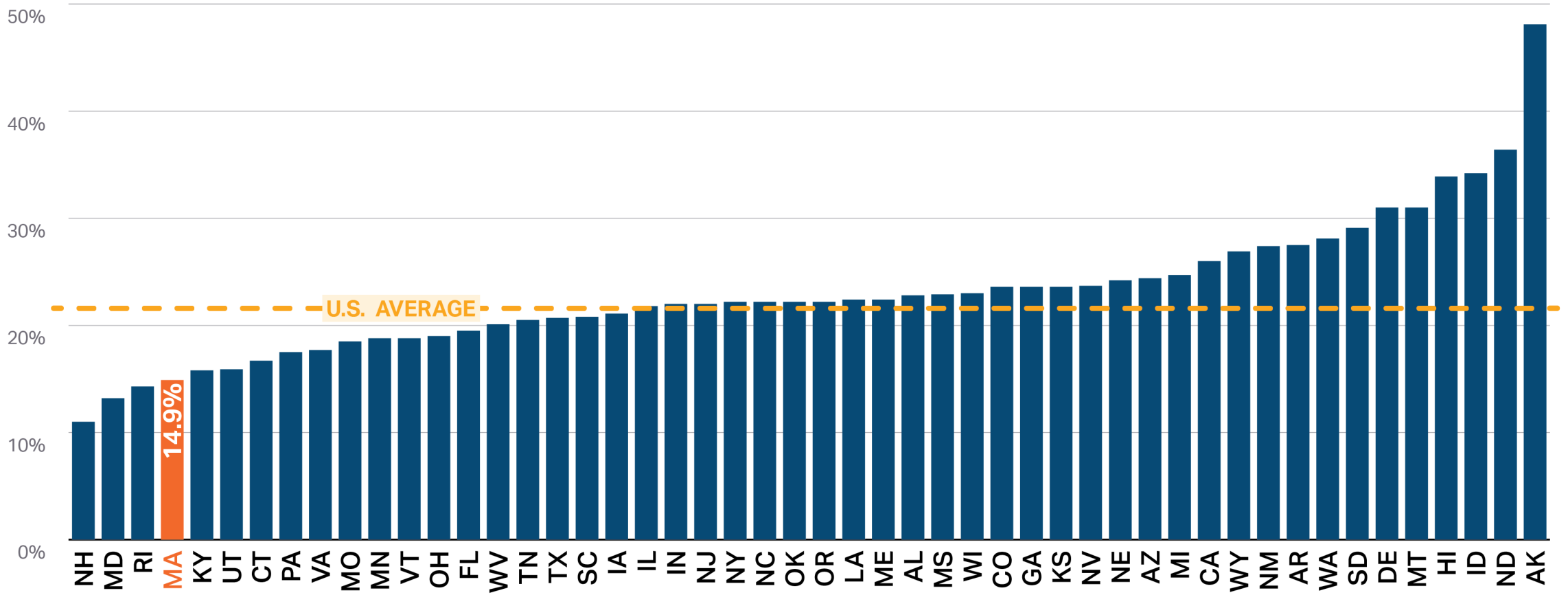
Sources: HPC analysis of Association of American Medical Colleges. State Physician Workforce Data Report, 2021

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.

- Although Massachusetts has the 3rd largest per-capita number of primary care physicians working in direct patient care, primary care physicians represent a relatively small share of all physicians in the Commonwealth, indicating a health system orientation towards specialty care.
- Studies have found states with a higher proportion of physicians who are primary care physicians tend to have "superior health outcomes, including lower mortality; fewer emergency department visits, hospitalizations, and procedures per capita; and lower costs."[1]

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

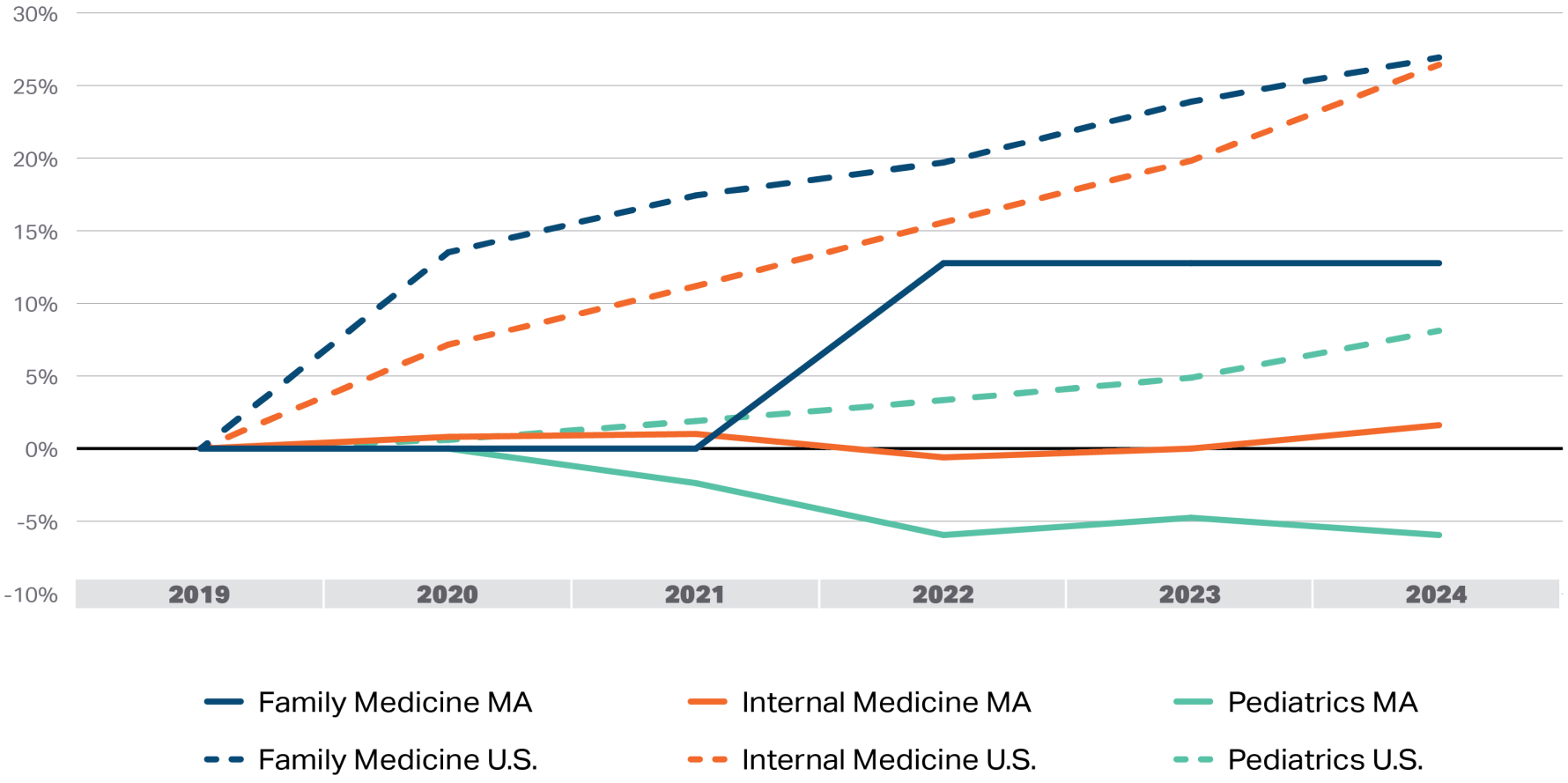
Share of new physicians entering primary care workforce by state, 2021



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

Primary care residency positions in Massachusetts are growing much more slowly than in the U.S. overall in recent years. Pediatric residency positions are declining.

Percent change in primary care residency positions relative to 2019, Massachusetts vs United States, 2019-2024



- The share of U.S. internal medicine residents planning a career in primary care has continuously fallen over time and has dropped by half in the last decade: from 19.9% as reported in 2009-2011 surveys to 9.4% in 2019-2021 surveys.[1]
- As of 2024, there were 16 internal medicine residency programs in Massachusetts, and 6 for family medicine.[2]

Notes: The number of PGY-1 family medicine and internal medicine residency positions in Massachusetts was 53 and 504, respectively, in 2024.

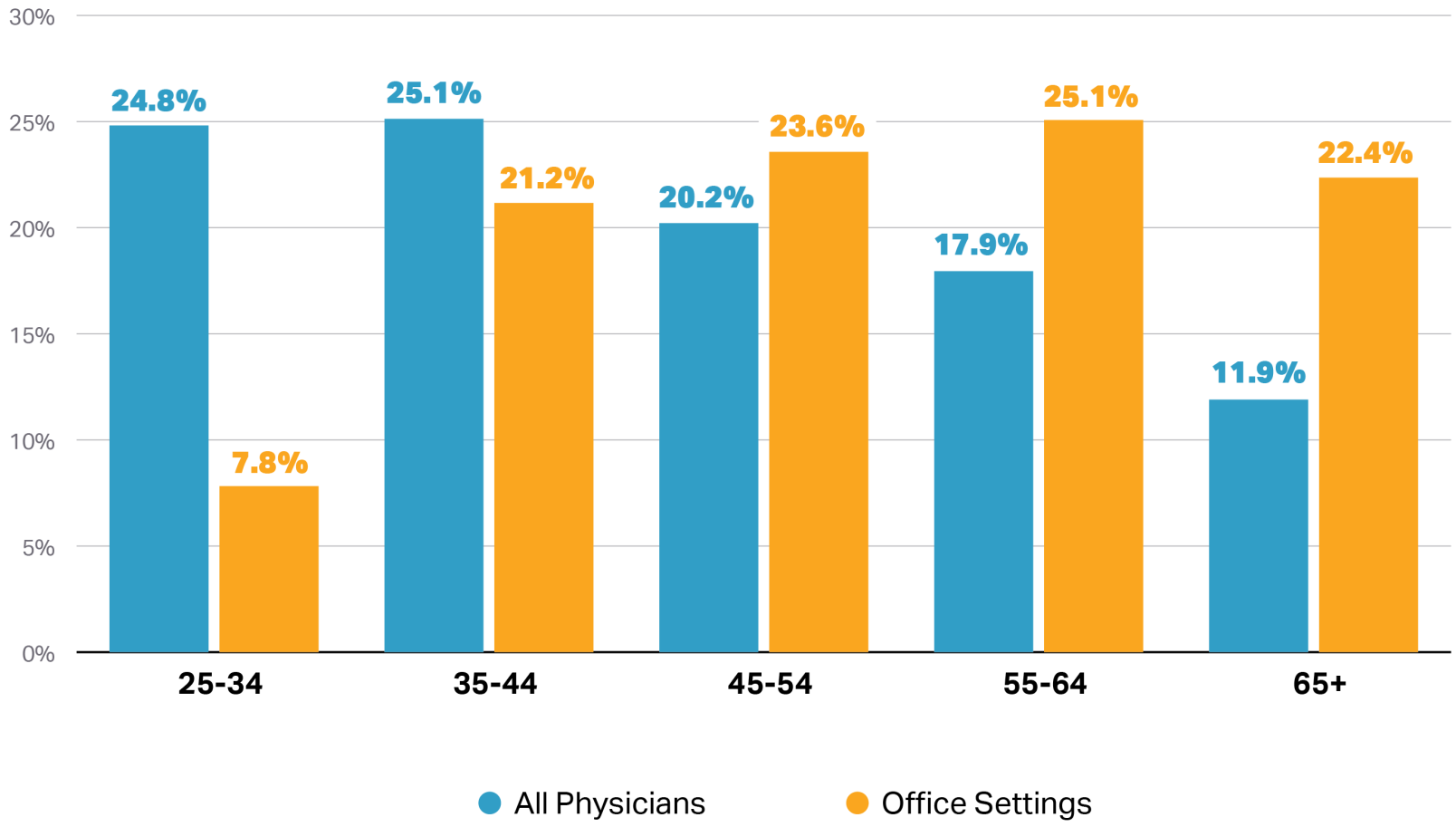
Sources: NRMP Residency Match Results and Data Books, 2019 – 2024

1 Paralkar N, LaVine N, Ryan S, Conigliaro R, Ehrlich K, Khan A, Block L. Career Plans of Internal Medicine Residents From 2019 to 2021. JAMA Internal Medicine. 2023:18(10)

2 Residency and Fellowship Programs. Residentswap.org

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



- The share of physicians aged 40 and older in all care settings grew by 0.4% from 2018 to 2021, but fell by 5.5% in office settings,[1] suggesting that the overall share of physicians in office settings is decreasing as more experienced physicians exit and are not replaced by younger entrants.

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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Challenges to Primary Care Access

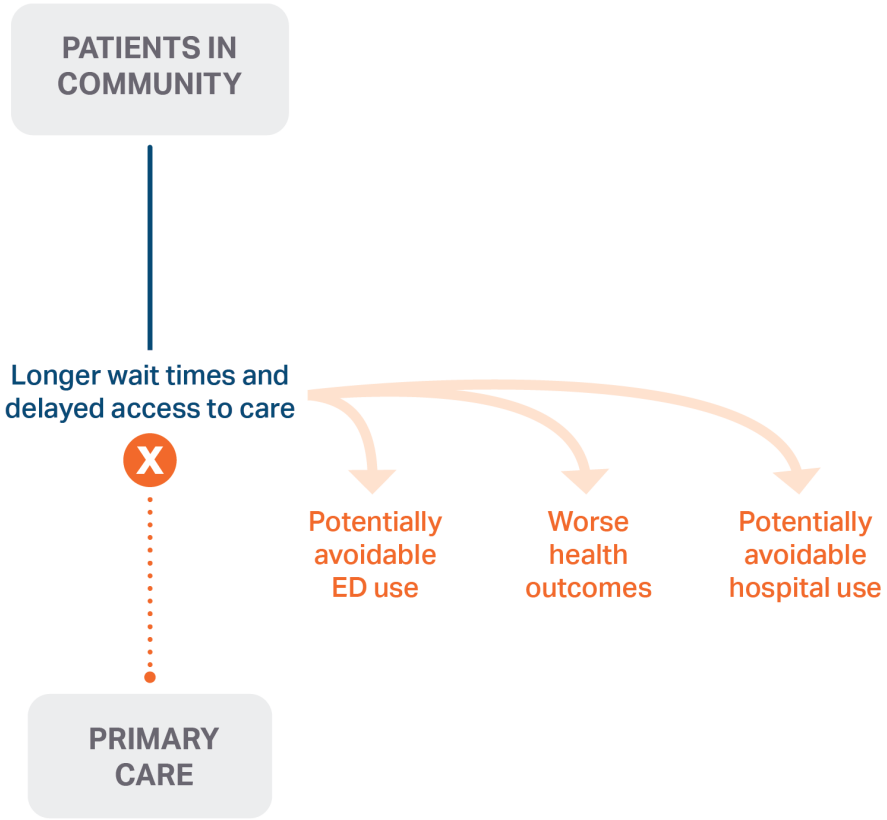
- Although Massachusetts has a relatively high number of primary care physicians per capita, patient access issues persist, suggesting challenges beyond the sheer number of providers.
- A study of primary care appointment availability in four states found that **wait times for new patients were more than twice as long in Massachusetts than in other states**.[1]
- A separate survey found that Massachusetts patients reported **worsening access to primary care each year from 2019 to 2023**.[2]
- Access may be **even worse in lower-income communities**, where more than one in four Massachusetts residents had no primary care spending in 2022.[3]

1 Kyle MA, Tipirneni R, Thakore N, Dave S, Ganguli I. Primary Care Access During the COVID-19 Pandemic: a Simulated Patient Study. Journal of General Internal Medicine. 2021; 35(21):3766-3771. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8075018/ Median wait time for a new-patient primary care appointment in MA was 24 days.

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

3 HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2022, 2022.

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

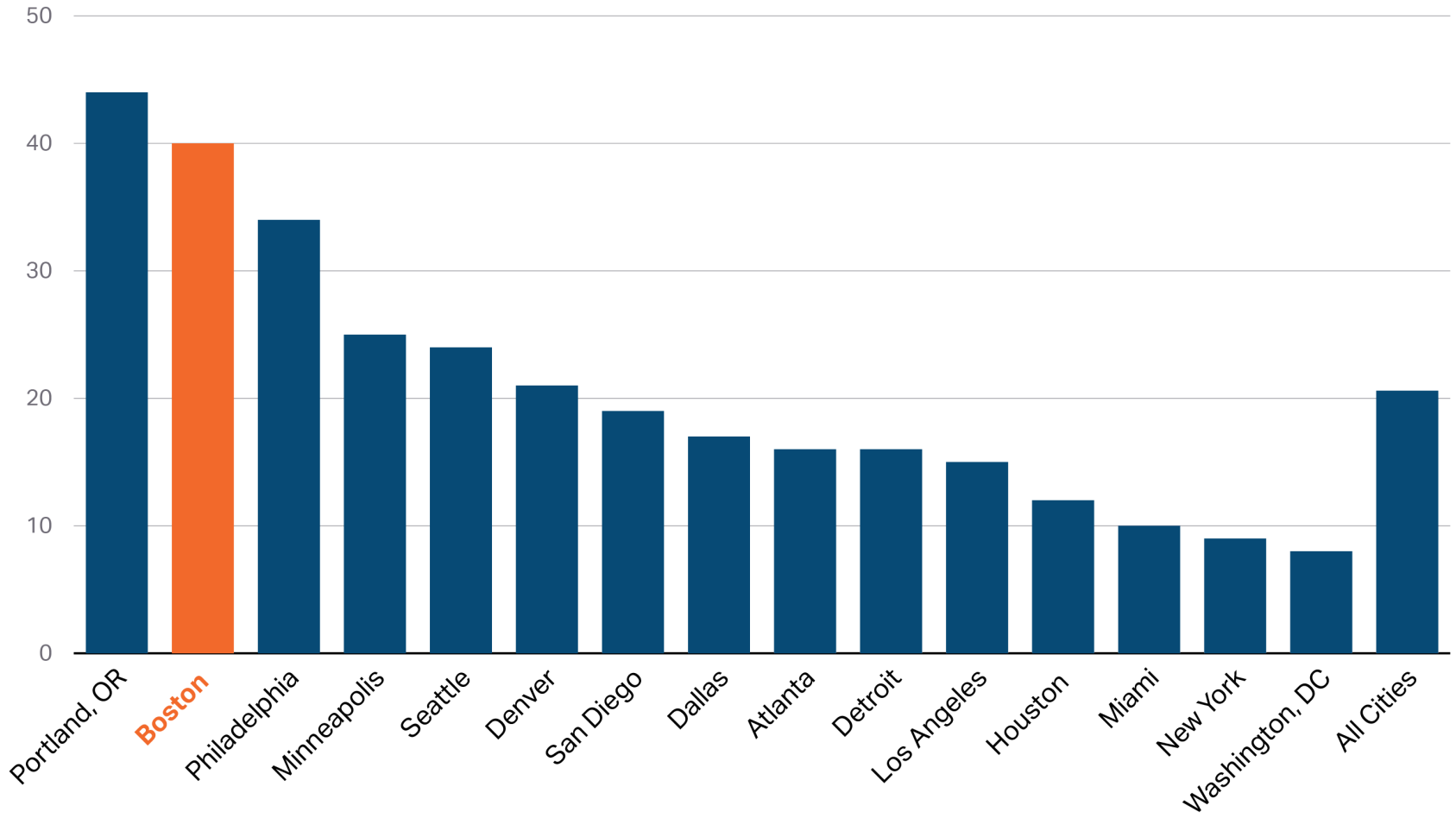
4 Jennifer Villani and Karoline Mortensen. Nonemergent Emergency Department Use Among Patients With a Usual Source of Care. The Journal of the American Board of Family Medicine November 2013, 26 (6) 680-691;

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.

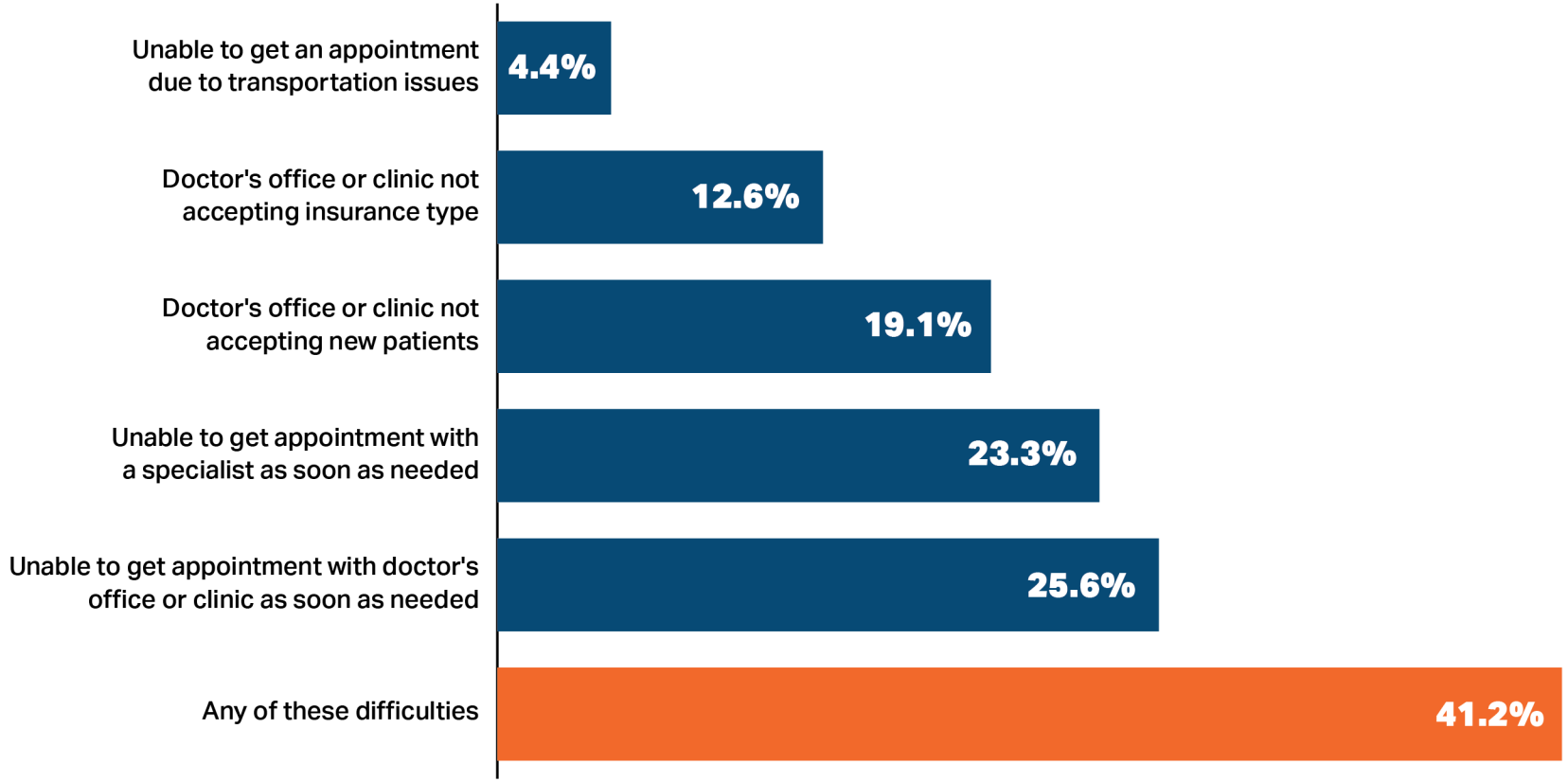
Average wait time in days for a new patient appointment for a physical by metropolitan area, 2022



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

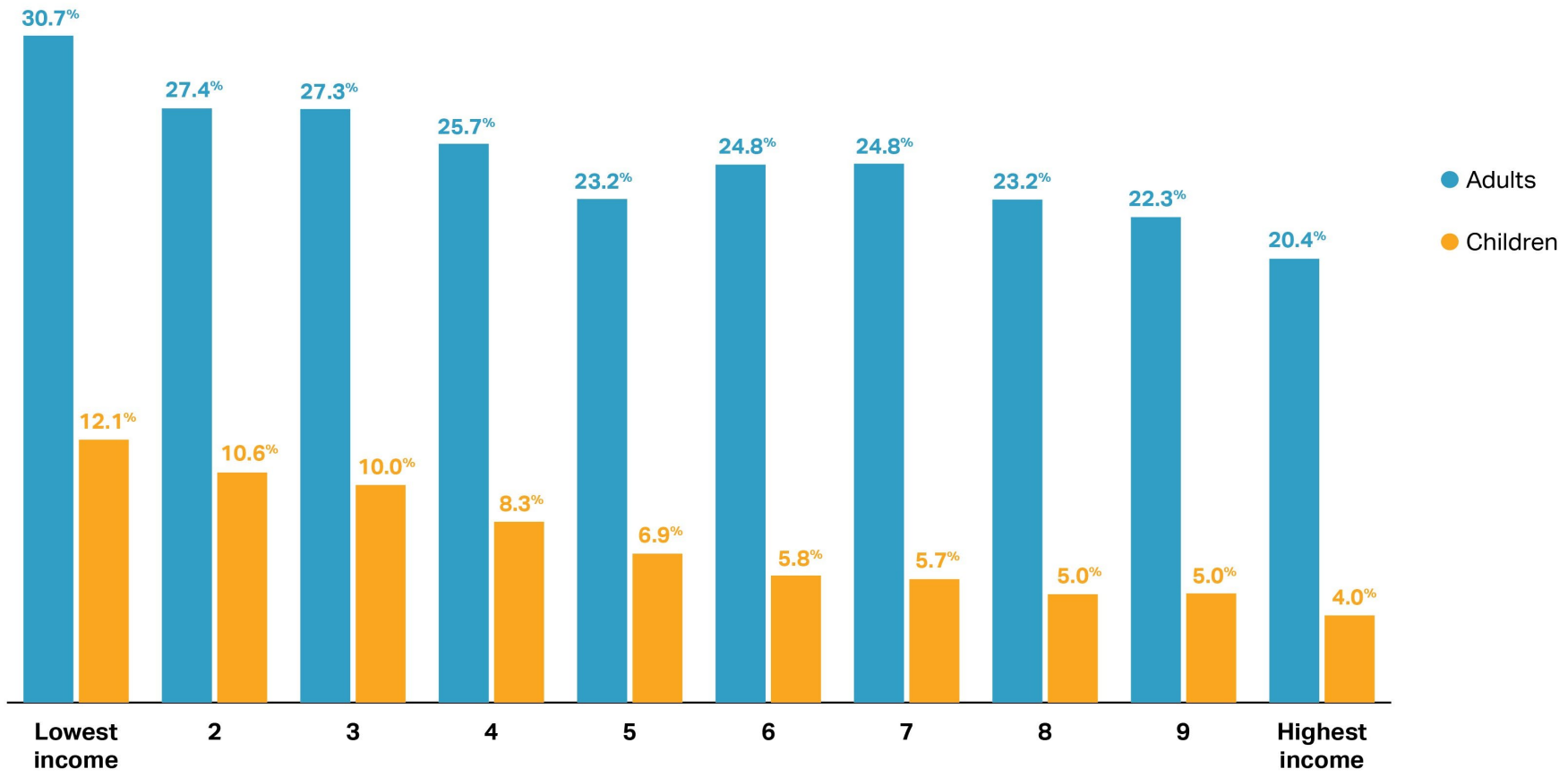


- As of 2021, 34% of Massachusetts residents reported any of these difficulties accessing care.[1]
- A separate, multi-year survey of Massachusetts patients found that access to primary care became more difficult every year from 2019 to 2023 for both adults and children.[2]

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.

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



- Massachusetts residents in communities with **lower median incomes were more likely to have no primary care visits, and more likely to have no care utilization at all**, than residents in higher-income areas.
- **Individuals and families with lower incomes may face barriers to care** including challenges with transportation, time off from work, continuous insurance coverage, affordability (particularly for those with commercial insurance), proximity to appropriate providers, and health literacy or experience navigating the health care system.[1,2]

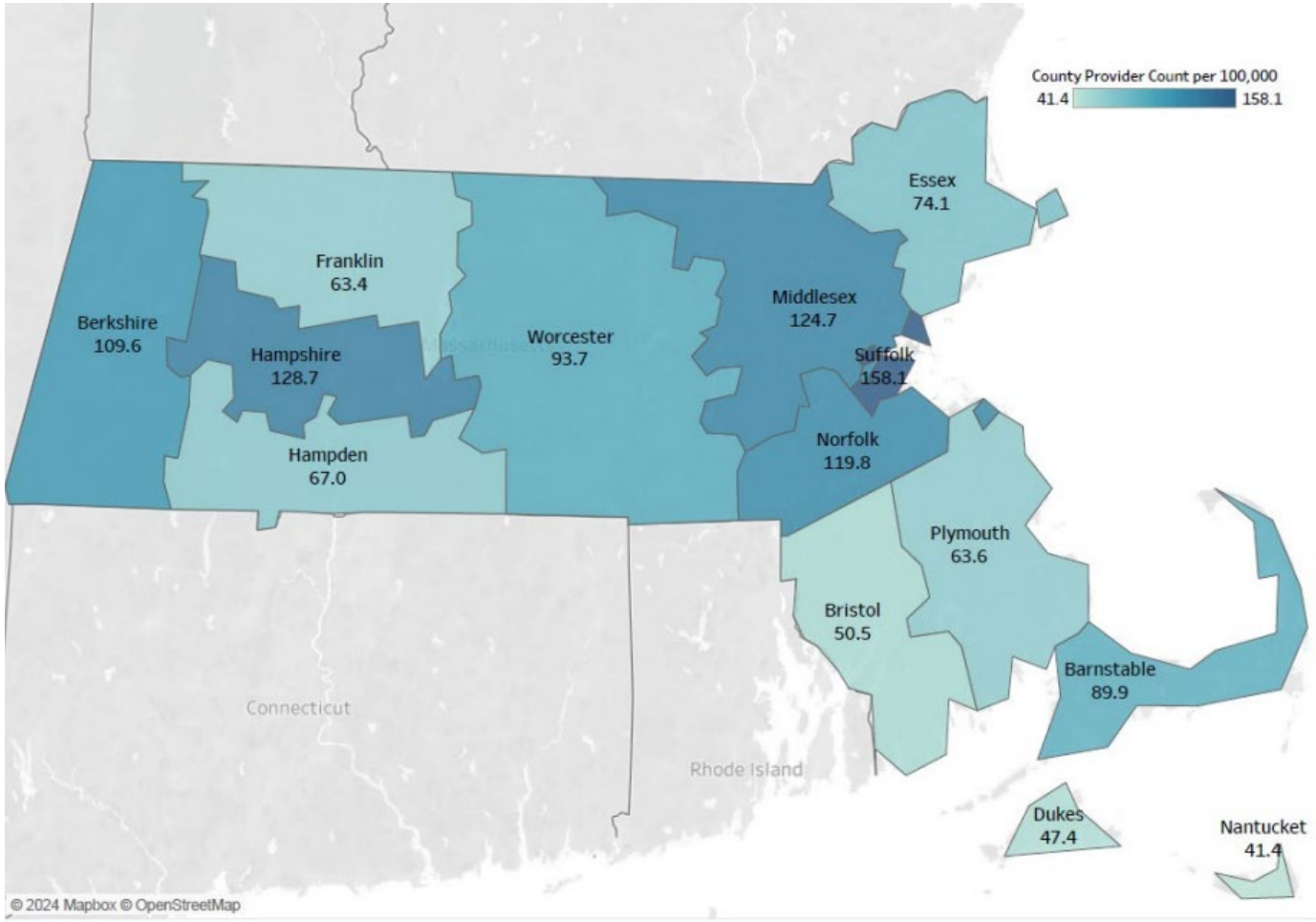
Notes: Analysis restricted to members under 65 with full year medical and prescription drug coverage. Children are defined as those under 18 years old. Adults are those aged 18 to 64. Income groupings represent population-weighted deciles based on median income of zip code sourced from U.S. Census Bureau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

1 Lazar M, Davenport L. Barriers to Health Care Access for Low Income Families. Journal of Community Health Nursing. 2018. 35(1):28-37. https://www.jstor.org/stable/48537679

2 Lewis C, Abrams MK. Listening to Low-Income Patients: Obstacles to the Care We Need, When We Need It. Commonwealth Fund. December 1, 2017. https://www.commonwealthfund.org/blog/2017/listening-low-income-patients-obstacles-care-we-need-when-we-need-it

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

Primary care physicians per 100,000 Massachusetts residents

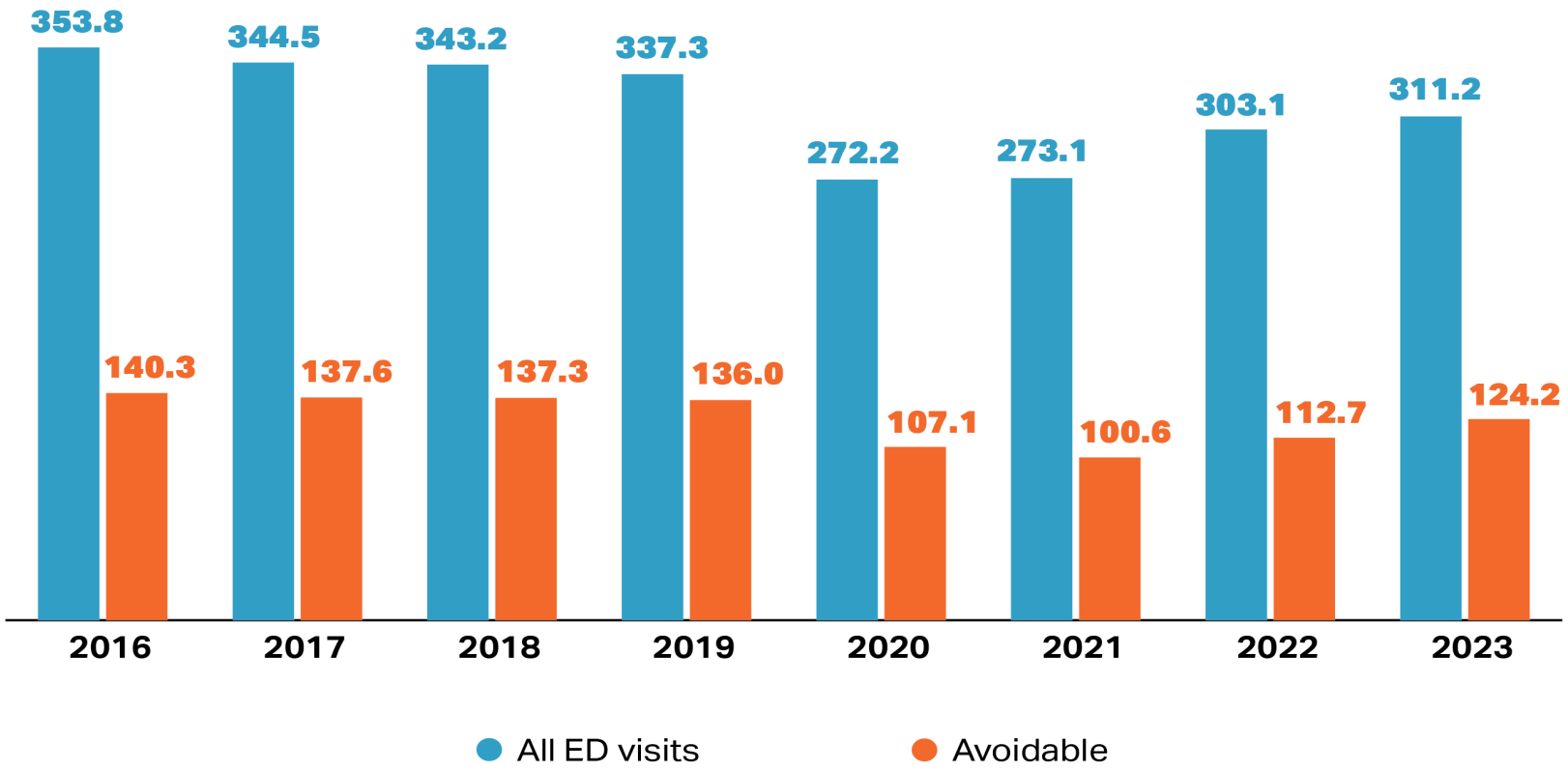


- The number of primary care physicians providing direct patient care in Massachusetts ranges from 41 per 100,000 residents in Nantucket to 158 per 100,000 in Suffolk County.
- The density of providers varies in a way that is only somewhat related to median income in different parts of the Commonwealth.[1]
- The supply of primary care providers is one of many factors in access to care.

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
1 U.S. Department of Health & Human Services. National Institutes of Health. National Institute on Minority Health and Health Disparities. Massachusetts Income: Median household income, 2018-2022.

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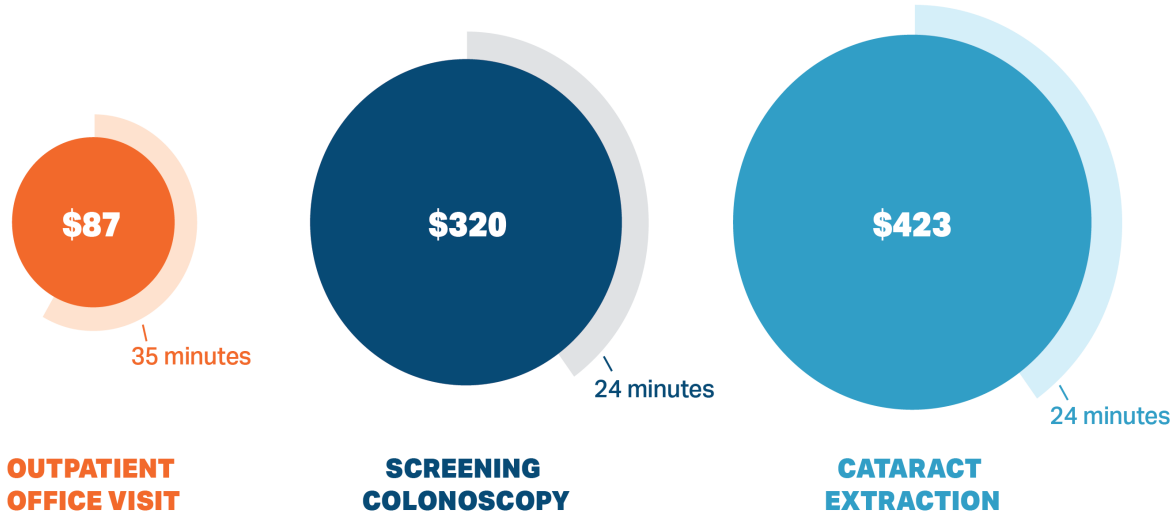
Key factors driving the current challenges in primary care include reimbursement models and administrative burden.

- **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
- **Impacts of administrative burden**:
  - Can make the work of primary care less rewarding and more frustrating, leading to burnout
  - Can contribute 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

Exhibit notes: Outpatient office visit is for Current Procedural Terminology code 99214.

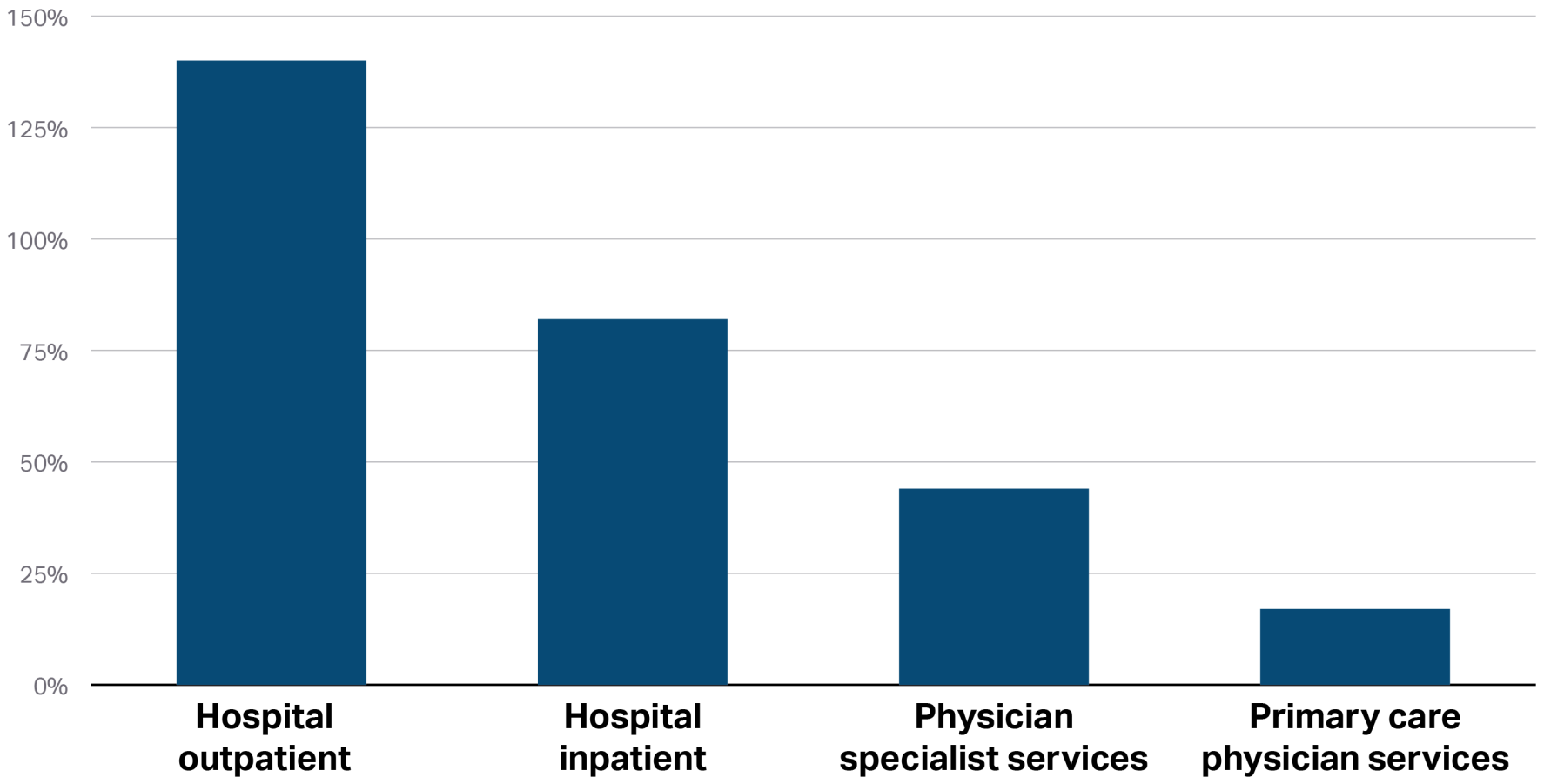
Sources: Exhibit and 3: Sinsky CA, Dugdale DC. Medicare payment for cognitive vs procedural care: minding the gap. JAMA Internal Medicine. 2013;173(18):1733-1737. https://pubmed.ncbi.nlm.nih.gov/23939411/ 1 MedPAC Report to the Congress: Medicare and the Health Care Delivery System | June 2018

2 Calsyn M, Twomey M. Rethinking the RUC: Reforming How Medicare Pays for Doctors' Services. Center for American Progress. July 13, 2018. https://www.americanprogress.org/article/rethinking-the-ruc/

- **Medicare payment rates arguably overvalue procedures and undervalue the cognitive services at the core of primary care**, including careful history taking, clinical assessment, care coordination, and management of multiple chronic conditions.[1]
  - Experts widely criticize Medicare's reliance on the Relative Value Scale Update Committee (RUC) to set rates, highlighting the conflict of interest inherent in a physician panel with a financial stake in the rates it sets and the influence of dominant specialist representation.[2]
- **Medicare reimburses physicians 3 to 5 times more for common procedures than for cognitive care.**[3]
  - Common specialty procedures can generate more revenue in one or two hours than a primary care physician receives for a whole day of patient care.[3]
- The **overvaluing of procedures relative to cognitive services may be increasing.** While technical innovations and other productivity improvements have reduced physician time and work involved in many procedures, cognitive services such as care coordination for high-risk patients have become increasingly complex.

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



- Commercial payer reimbursement for primary care is close to the Medicare payment level while commercial reimbursement for specialist and hospital services is far higher.
- Payment rates impact patients' access to care. For example, increases in Medicaid payment rates for primary care have been found to increase the likelihood that physicians accept Medicaid patients, and **reduce disparities in access to care** between commercially insured patients and Medicaid patients.[1]

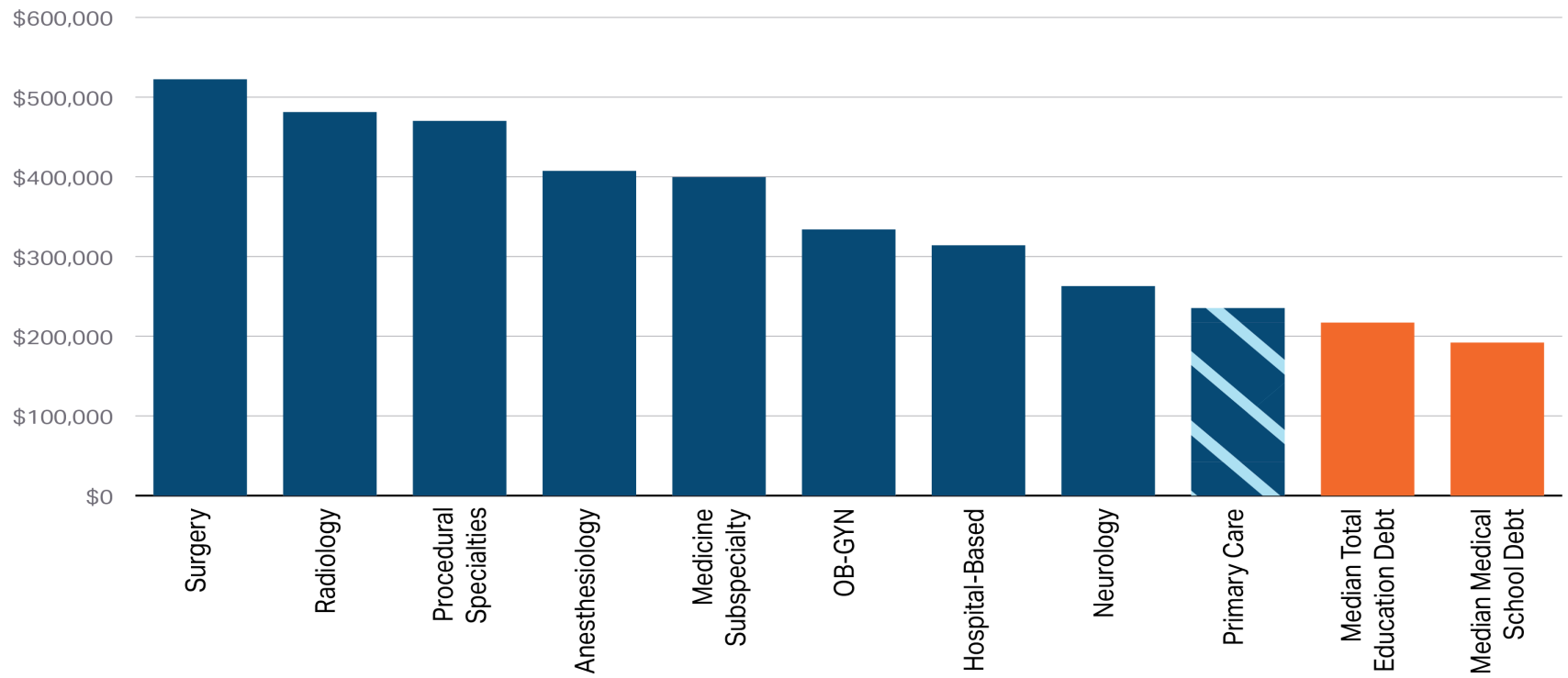
Notes: Data in the above figure represent an aggregate of research studies mostly performed over the 2010s.

Sources: Congressional Budget Office. The prices that commercial health insurers and Medicare pay for hospitals' and physician's services. Jan, 2022.

1 Alexander D & Schnell M. The impacts of physician payments on patient access, use, and health. National Bureau of Economic Research. NBER Working Paper 26095. July 2019.

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



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.

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.

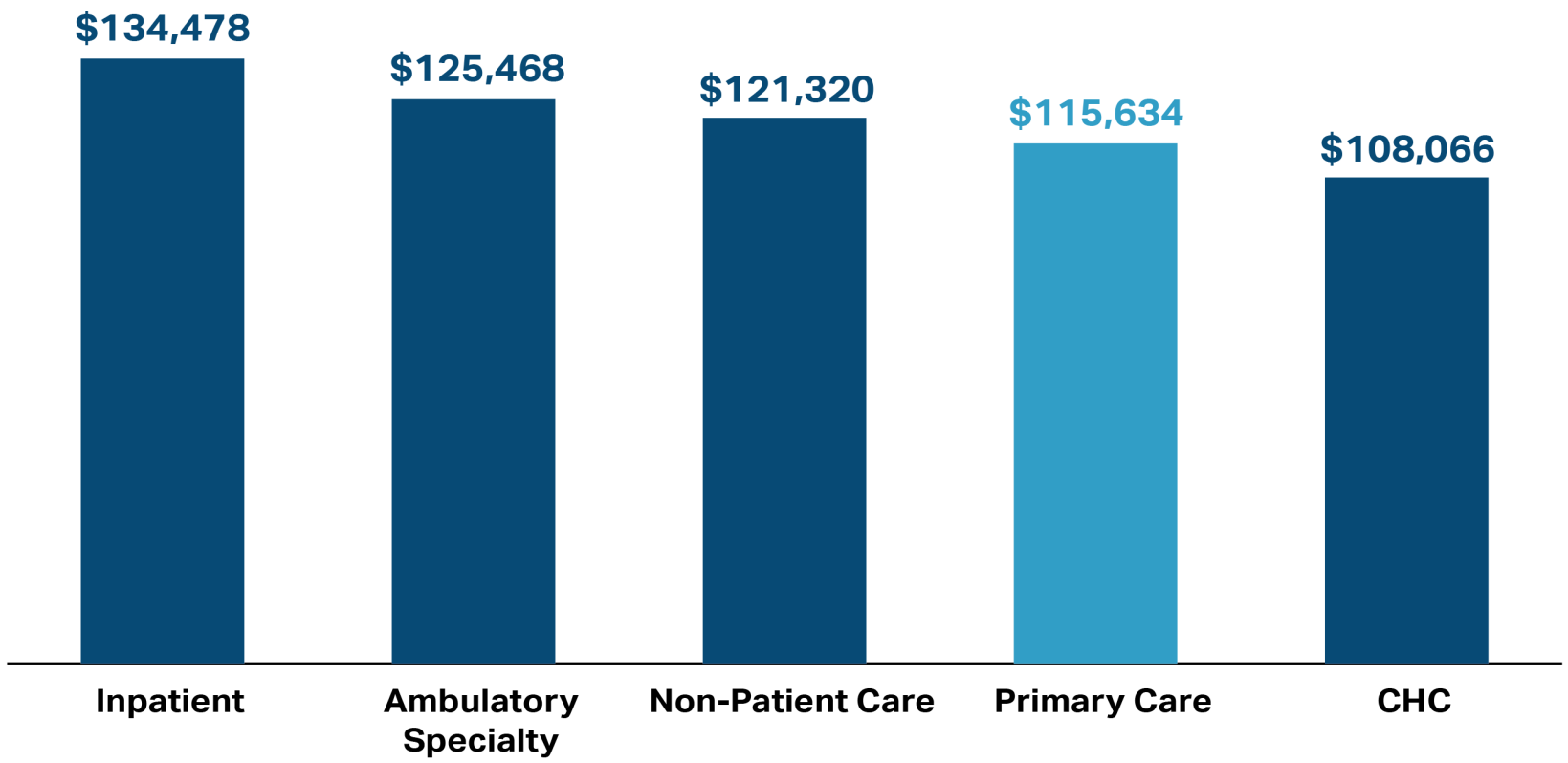
1 Association of American Medical Colleges. Medical School Graduation Questionnaire, 2021 All Schools Summary Report. 2021.

2 Goodson JD. Unintended Consequences of Resource-Based Relative Value Scale Reimbursement. *JAMA*. 2007;298(19):2308–2310.

- About 70% of medical graduates had medical education debt in 2021, with a median debt amount of $200,000 per graduate with debt.[1]
- Salary differentials can impact medical students' residency choices.[2] **About one-fifth (21.4%) of medical graduates surveyed reported that their level of education debt had moderate or strong influence in their choice of specialty.**[1]
- Financial considerations may be a key factor for medical graduates in Massachusetts, which has among the highest costs of living in the U.S.

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

Average annual earnings for Massachusetts nurse practitioners by setting, 2022



- 69% of APRNs nationwide had education debt in 2017, with a median debt amount of $55,000.[1]
- PAs also earn higher wages in hospital settings compared to physician offices and have significant education debt. As of 2017, 84% of PAs nationwide had education debt, with a median debt amount of $100,000. [2,3]

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 American Association of Colleges of Nursing, The Numbers Behind the Degree: Financing Graduate Nursing Education, 2017.

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

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

In addition to lower pay, primary care providers face high administrative burden.

- 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]
  - In a 2022 survey of Massachusetts physicians, 24% responded that they had reduced their clinical care hours, while another 24% were "definitely" or "likely" reducing their clinical care hours in the coming year.[2]
- Administrative burden is a key job sustainability challenge in primary care, including high-touch asynchronous messaging (such as patient portal emails), EHRs, quality measure reporting, prior authorization, and billing and coding documentation, all of which require substantial work outside of regular working hours.[2,3,4,5,6]
- One study found that physicians participating in value-based contracts report an **average of 57 distinct quality measures**, including multiple measures for the same condition.[7]
- Other studies, using various measurement approaches, have found that **primary care physicians spend anywhere from equal to double the amount of time on administrative work as spent in direct patient care** – with their administrative time spent mostly on EHR-related tasks, including patient correspondence – and that primary care physicians are able to spend less time on direct patient care without also multitasking on EHR-related tasks than specialists.[8,9,10]
- 81% of Massachusetts physicians surveyed cited **increased documentation requirements that were not always related to clinical care** as an aspect of job quality in need of improvement.[2]

(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) Massachusetts Medical Society. Supporting MMS Physicians' Well-Being Report: Recommendations to Address the On-Going Crisis. March 2023. (3) Stillman M., Death by Patient Portal. JAMA. June 30, 2023. doi:10.1001/jama.2023.11629 (4) 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. (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. Pajama Time: Working After Work in the Electronic Health Record. Journal of General Internal Medicine. 2019. 34:1695–1696. https://doi.org/10.1007/s11606-019-05055-x (7) Boone C, Zink A, Wright BJ. Value-Based Contracting in Clinicial Care. JAMA Health Forum. 2024; 5(8).https://jamanetwork.com/journals/jama-health-forum/fullarticle/2822685 (8) Sinsky C, Colligan L, Li L, et al. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. Annals of Internal Medicine. 2016;165:753-760. doi:10.7326/M16-0961 (9) Tai-Seale M, Olson CW, Li J, Chan AS, Morikawa C, Durbin M, Wang W, Luft HS. Electronic Health Record Logs Indicate That Physicians Split Time Evenly Between Seeing Patients And Desktop Medicine. Health Affairs. 2017. 36(4):655-662. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0811 (10) Toscano F, O'Donnell E, Broderick JE, May M, Tucker P, Unruh MA, Messina G, Casalino LP. How Physicians Spend Their Work TIme: an Ecological Momentary Assessment. Journal of General Internal Medicine. 2020. 35(11):3166-3172. doi: 10.1007/s11606-020-06087-4

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

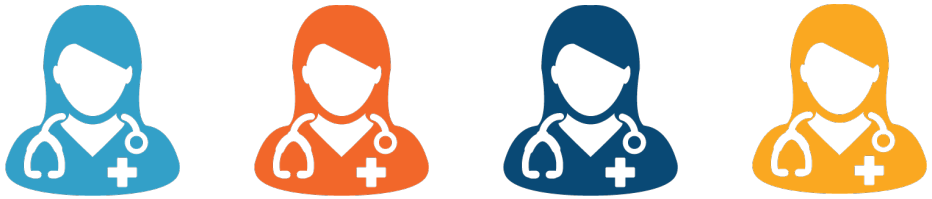
High levels of burnout fuel workforce sustainability challenges.

- In a June 2022 survey, Massachusetts physicians of all types reported **concerning levels of burnout and intent to leave clinical practice.** 55% of physicians surveyed experienced symptoms of burnout. Self-reported burnout and wellbeing were worst among female physicians and physicians of color.[1]
  - More than half of respondents already had reduced their clinical hours or planned to in the next 12 months, while about one-quarter planned to leave medicine altogether in the next two years.[1]
- Burnout and job exit fuels **a cycle of workforce sustainability challenges**:
  - Fewer PCPs mean larger patient panels for those remaining, further exacerbating both patient access and job feasibility issues.
  - Team-based care, where primary care patients are treated by multiple types of providers including physicians, APRNs, PAs, RNs, medical assistants, CNAs, and mental and behavioral health providers, is beneficial for both patients and providers – but can be costly to set up and difficult to maintain when there is high turnover or inconsistent staffing, especially in lower-paid roles such as medical assistants and CNAs.
  - **Workforce challenges can also become affordability challenges**: high turnover and retention difficulties can drive up costs for practices via salary increases, retention incentives such as loan repayment, and the cost of training new providers.[2]

1 Massachusetts Medical Society. Supporting MMS Physicians' Well-Being Report: Recommendations to Address the On-Going Crisis. March 2023.
2 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 also face disincentives to go into primary care, as well as job sustainability challenges.

- APRNs and PAs often carry substantial amounts of student debt,[1] which may incentivize going into higher-paid fields. NPs and PAs in primary care receive lower pay than those in specialty practice.[2]
- Advanced-practice providers can experience the same kind of burnout as their physician colleagues.[3]
  - NPs cite both pay and benefits and stressful work environments among their top reasons for leaving or considering leaving their jobs.[4]
- While PAs usually receive primary care training, the share working in primary care in Massachusetts fell from 18% in 2018 to 16% in 2022.[5] Similarly, the share of NPs working in office-based settings (a proxy for primary care) fell from 26% to 21% during that same period.[6]
- **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 Shields RK, Suneja M, Shields E, Tofte JN, Dudley-Javoroski S. Healthcare educational debt in the united states: unequal economic impact within interprofessional team members. BMC Medical Education. 2023. 23. https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-023-04634-1#Tab1

2 Andrews M. The Lure of Specialty Medicine Pulls Nurse Practitioners From Primary Care. KFF Health News. May 17, 2024. https://kffhealthnews.org/news/article/nurse-practitioners-trend-primary-care-specialties/

3 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

4 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

5 HPC analysis of National Commission on Certification of Physician Assistants State Profiles, 2018-2022

6 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.

Barriers to increased clinician workforce diversity exist in both the training pipeline and in employment and retention.

TRAINING PIPELINE

- The diversity of the clinical education pipeline varies by profession – for example, Black students are underrepresented in U.S. M.D. programs but not in APRN programs – but overall has **less racial and ethnic diversity than the U.S. population** as a whole.[1]
- Lack of diversity among medical, nursing, and PA students and faculty as well as **lack of academic and social supports (including mentorship) during training** can impede increasing clinician diversity.[2,3,4]
- For prospective physicians with disabilities**, medical training is often inaccessible**, including the lengthy hours required of medical residents.

EMPLOYMENT AND RETENTION

- Job sustainability challenges do not affect all groups equally, and can be related to bias and discrimination.**A 2022 Massachusetts survey found that self-reported burnout was worst among female physicians, younger physicians, and physicians of color**, with 36% of female physicians reporting sexism and 86% of Black physicians reporting racism as top workplace stressors.[5]
- Likewise, **care settings with inaccessible equipment** such as scales and exam tables can limit disabled physicians' ability to practice.

1 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.

2 McDonald TC, Drake LC, Replogle WH, Graves ML, Brooks JT. Barriers to Increasing Diversity in Orthopaedics: The Residency Program Perspective. JB JS Open Access. 2020 May 11;5(2):e0007.

3 Cuenca, John Patrick MBA, MPAS, PA-C; Ganser, Katie MS, MPAS, PA-C; Luck, Morgan EdD, PA-C; Smith, Noël E. MA; McCall, Timothy C. PhD. Diversity in the Physician Assistant Pipeline: Experiences and Barriers in Admissions and PA School. The Journal of Physician Assistant Education 33(3):p 171-178, September 2022.

4 Yuen, Cynthia X. MA. Strength in Differences? The Importance of Diversity to Students When Choosing a Physician Assistant Program. The Journal of Physician Assistant Education 30(3):p 143-148, September 2019

5 Massachusetts Medical Society. Supporting MMS Physicians' Well-Being Report: Recommendations to Address the On-Going Crisis. 2023

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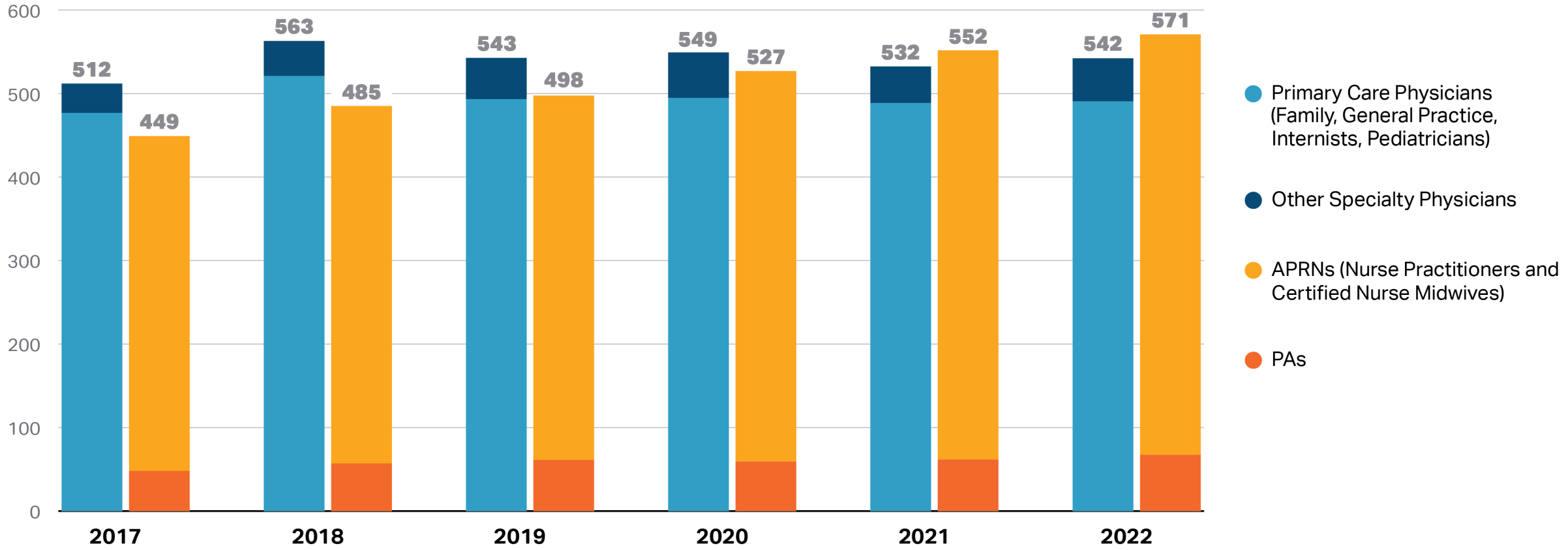
Community health centers are experiencing an exacerbated version of the trends and challenges facing primary care delivery across the Commonwealth.

- Community health centers (CHCs) are an **essential source of primary, mental, behavioral, and dental care for patients who are medically underserved** or may otherwise lack a regular source of care.[1]
- CHCs provide primary and preventive care services to an estimated 30 million people in the U.S., and care for over 800,000 Massachusetts residents.[2,3]
- CHCs are **more likely to treat patients with chronic conditions** (and those with multiple chronic conditions) than providers in private practices.[4]
- CHCs in Massachusetts are experiencing the same staffing patterns as in primary care generally, but **financial and job sustainability challenges for providers are likely greater**.
- CHCs also have **unique opportunities**, in the form of loan repayment and other retention programs.

1 National Association of Community Health Centers. Closing the Primary Care Gap: How Community Health Centers Can Address the Nations Primary Care Crisis. 2023
J Ambul Care Manage. 2020 Apr/Jun;43(2):136-147.
2 National Association of Community Health Centers. Health Center Service Expansion. 2023. https://www.nachc.org/wp-content/uploads/2023/07/Service-Expansion-Issue-Brief_2023_print-ready_final.pdf
3 National Association of Community Health Centers. Massachusetts Health Center Fact Sheet. February 2024. https://www.nachc.org/wp-content/uploads/2024/02/StateFactSheet_MA_2022UDS_Feb2024.pdf
4 Corallo B, Proser M, Nocon R. Comparing Rates of Multiple Chronic Conditions at Primary Care and Mental Health Visits to Community Health Centers Versus Private Practice Providers.

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

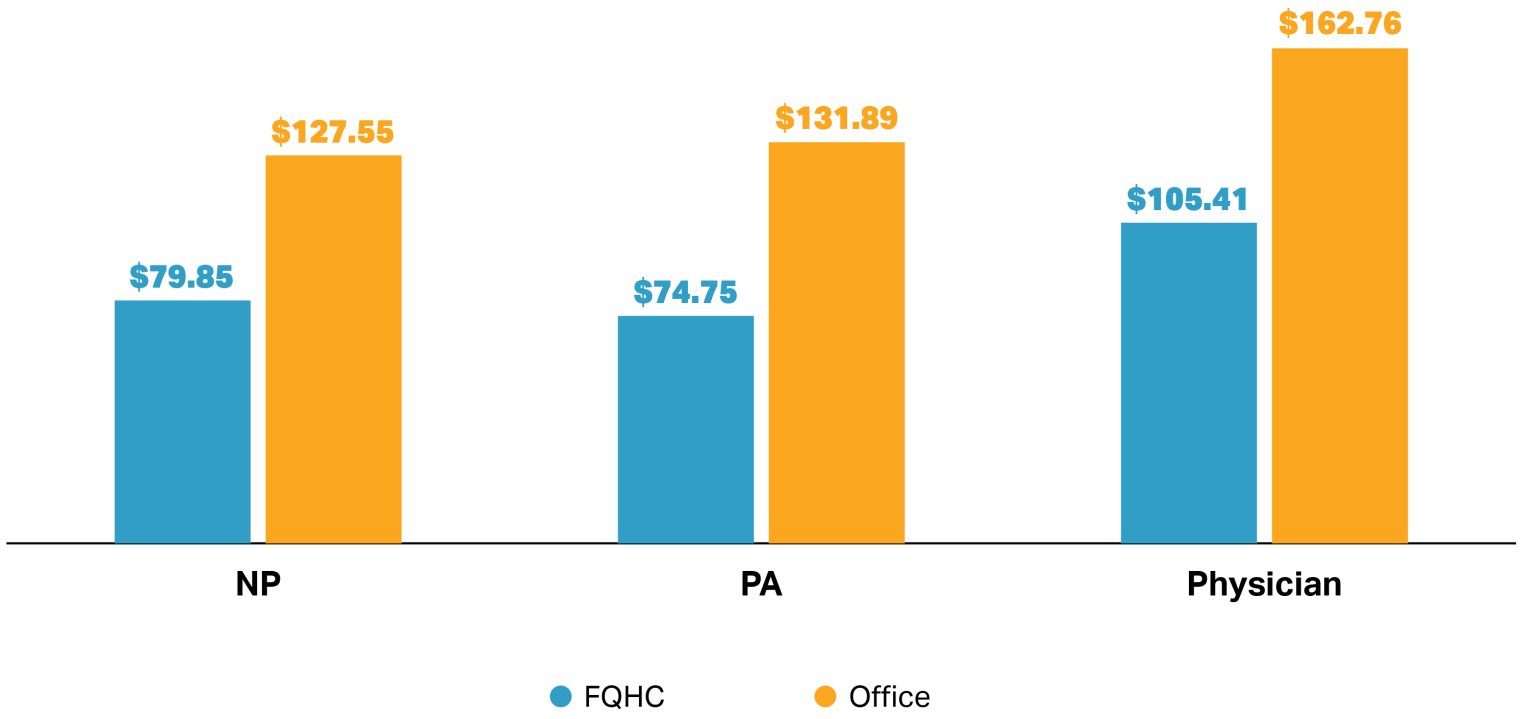


Notes: Data labels are totals for each bar.

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

Federally-qualified health centers (FQHCs), a subset of community health centers, are particularly challenged by lower commercial payment rates than in 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

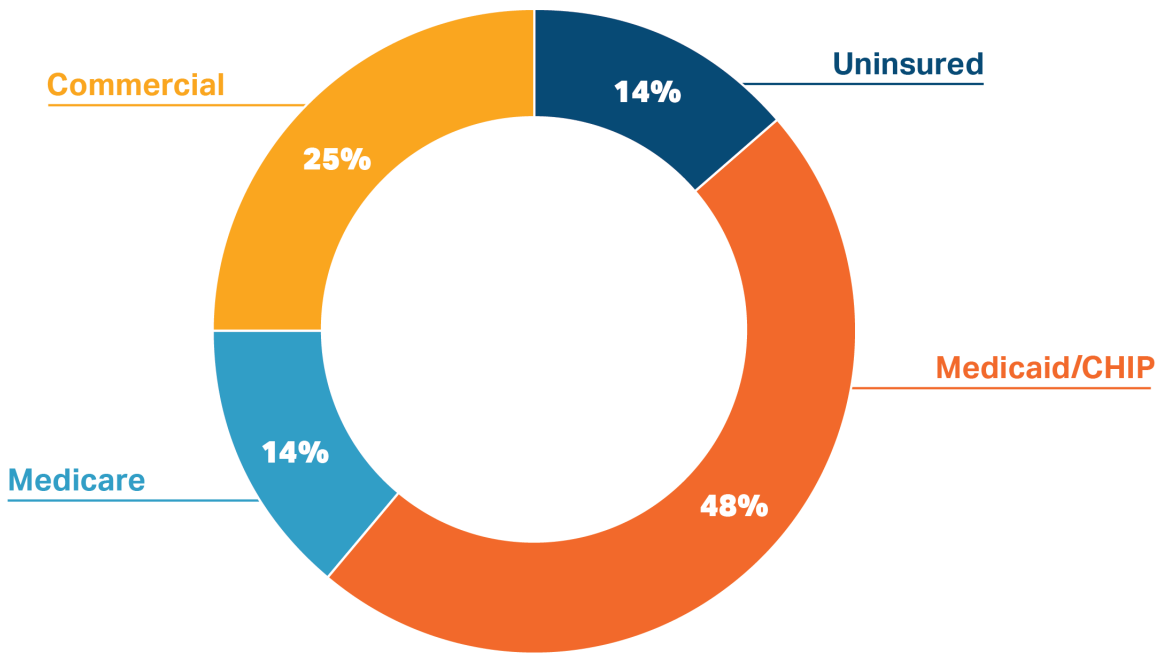
1 Centers for Medicare & Medicaid Services. FQHC PPS Overview. 2024. https://www.cms.gov/medicare/payment/prospective-payment-systems/fqhc_pps

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), which come with federally designated requirements and unique public funding.
- Medicare services at FQHCs are covered via prospective payment that includes enhanced rates for preventive physicals and annual wellness visits. As of 2022, MassHealth also provides per-visit prospective payment for services at CHCs in MA.[1,2]
- Additionally, primary care services for MassHealth ACO members at all Massachusetts CHCs are covered via primary care sub-capitation, which reimburses on a per-member-per-month capitated basis.[2]

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

Patients at CHCs by payer, 2022



- As organizations designed to provide primary and behavioral health care to a largely publicly insured or uninsured patient population (see graph of CHC payer mix), **CHCs receive relatively low reimbursement without the ability to cross-subsidize from more lucrative services 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.
- According to the Massachusetts League of Community Health Centers, MassHealth pays higher rates than commercial payers.
- **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.[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.
- As of 2023, Massachusetts CHCs reported 16-17% vacancy rates among physicians, PAs, and nurses.[2]

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

Less competitive wages can lead community health center staff to seek financial opportunities at other organizations.

- The most commonly-reported retention challenges for U.S. CHCs in 2022 included staff seeking financial opportunities at larger organizations, ongoing pandemic stress impacting staff wellbeing, staff seeking professional growth, and difficulty securing childcare and other personal caregiving challenges.[1]
- In Massachusetts, **advanced practice providers (APPs) report being motivated to work at CHCs by the mission of caring for underserved patients, but that they may need to seek higher salaries elsewhere.**[2]
- Of APPs surveyed at Massachusetts CHCs, 42% report being somewhat or very dissatisfied with their rate of pay, and of those who reported being unlikely to continue working at a CHC, increasing their salary and work-life balance were key reasons. Nearly **one-quarter of APPs reported working at another organization in addition to their CHC, largely for the additional income**.

1 National Association of Community Health Centers. Current State of the Health Center Workforce: Pandemic Challenges and Policy Solutions to Strengthen the Workforce of the Future. Available at NACHC-2022-Workforce-Survey-Full-Report-1.pdf
2 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.

Loan repayment programs have been a successful retention strategy at CHCs.

- **64% of Massachusetts CHC APPs surveyed have participated in a CHC loan repayment program**, and nearly one-third of those surveyed report loan repayment participation as a key motivator for working in a CHC.[1]
- Some Massachusetts loan repayment programs have ended, while others continue or have been reinitiated with different funding sources.
- Other programs designed to support the retention of providers in CHCs are no longer active, such as funding and protected time to work on special projects, as well as certain residency training programs.[2,3,4]

1 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.

2 The Massachusetts League of Community Health Centers. Workforce Program Descriptions. 2023.

3 Community Health Institute Literature Review, Provider Retention in High Need Areas; Negrusa et al. Prepared by the Lewin Group for the HHS Assistant Secretary for Planning and Evaluation, 2014.

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.

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The challenges facing primary care in the traditional medical system have created an opening for ownership changes and new models of care delivery.

- 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 features such as 24/7 access to clinicians or virtual-first care.
- In addition to the increasing **consolidation** of primary care practices into large 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**, nontraditional primary care providers could capture around **30% of the U.S. market**.[1]

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/

Emerging primary care models reflect a variety of care delivery approaches and patient payment models.

Examples of care delivery and payment approaches among emerging primary care models as of fall 2024

EXAMPLE	CARE DELIVERY	ENROLLMENT/PAYMENT	CONTRACTS WITH EMPLOYERS?
Health system-affiliated concierge care	Concierge; in-person	Accepts insurance; requires membership	No
One Medical (Amazon)	Concierge; virtual and in-person	Accepts insurance; requires membership	Yes
Amazon One Medical Pay-Per-Visit (formerly Amazon Clinic)	Virtual	Cash only	No
Firefly Health	Virtual	Accepts insurance	Yes
Sesame	Virtual and in-person	Cash only; membership option for lower prices	No
Carbon Health	Virtual and in-person	Accepts insurance	Yes*

Notes: Diagram includes examples, not a comprehensive or exhaustive list. Firefly provides health insurance and a network of virtual providers. In addition to membership, Sesame is available at even lower cost to Costco members, who pay cash for appointments. As of summer 2024, Amazon Clinic is One Medical's pay-per-visit telehealth provider. *Carbon health works with employers on occupational health.

Sources:
Whitehead DC, Mehrotra A. The Growing Phenomenon of "Virtual-First" Primary Care. JAMA. 2021;326(23):2365-2366.Shah 2023 https://www.nejm.org/doi/full/10.1056/NEJMp2212841
Schwartz, N. Costco bets big on healthcare - what it means for hospitals. September 25, 2023. https://www.beckershospitalreview.com/disruptors/costco-bets-big-on-healthcare-what-it-means-for-hospitals.html
Bruce, G. Walmart Health's advantages over health systems, per its CMIO. September 19, 2023. https://www.beckershospitalreview.com/disruptors/walmart-healths-advantages-over-health-systems-per-its-cmio.html
https://www.walmarthealth.com/
Rosenfield L. Sesame Announces New Partnership with Costco. September 25, 2023. https://sesamecare.com/blog/sesame-costco-partnership
https://carbonhealth.com/insurance-pricing
https://www.fireflyhealth.com/employers
Amazon Clinic is now Amazon One Medical's Pay-per-visit telehealth service—here's what it means for our customers. Amazon Staff. June 27, 2024. https://www.aboutamazon.com/news/retail/introducing-amazon-one-medical

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/

Concierge primary care practices increasingly exist in both the traditional medical system and among newer entrants to primary care.

Examples

MASSACHUSETTS HEALTH SYSTEM-AFFILIATED CONCIERGE PRIMARY CARE

- Annual membership fee covers an annual physical. Accepts insurance for all other visits, including Medicare. Annual fee may be paid privately, or via an employer-based Health Savings Account.[1]
- Features in-depth in-person physician visits, including multi-hour annual physicals with extensive labs, same-or-next-day appointments, 24/7 physician access by pager, and coordination of prescriptions and specialty care.
- Small patient panels for physicians, and dedicated support staff for the concierge program.

ONE MEDICAL

- Annual membership fee of $199, and accepts insurance for visits. Amazon Prime members receive discounted membership pricing.[2]
- "Digital front door" of virtual services that may address needs not requiring in-person care or triage whether to visit the ED, plus in-person office locations. Physicians provide all services at in-person office visits, including collecting vitals.
- Longer patient visits than in the traditional medical system.
- Clinicians are paid on a salary basis to avoid tying financial incentives to volume. Investment in support team of non-clinical staff and virtual clinical staff helps minimize administrative burden for "in-clinic" primary care providers; for example, the support team addresses prior authorization requirements and manages lab and imaging results.

1 e.g., Tufts Medicine. Concierge Primary Care. 2024. https://www.tuftsmedicine.org/services-treatments/concierge-primary-care#overview

2 Source: HPC interview with OneMedical representatives and other stakeholders. Membership rate as of 2/29/2024.

Ownership changes and consolidation in primary care are becoming more prevalent.

- There are shifting patterns of ownership in primary care.[1] This trend is in part due to the **financial sustainability challenges facing many primary care practices.**
  - The share of U.S. physicians in private practice fell by from 60.1% to 46.7% from 2012-2022, while the share in practices at least partly owned by a hospital or health system increased by almost 8%.[2] Likewise, private equity and other investor acquisition of primary care physician practices has become increasingly common.[3]
  - A 2020 survey found that about **one-quarter of Massachusetts primary care practices were considering selling** to private equity, provider groups, or larger health systems.[4] Nationally, consolidation of primary care physicians into the largest health systems increased by 14% from 2018-2021.[5]
- Ownership by private equity or large retailers can provide an **infusion of needed financial resources** into primary care, support adoption of care delivery innovations, and offer fewer administrative requirements and a more attractive work-life balance for clinicians.[4] However, it can also involve **pressure for physicians to upcode** to maximize patients' risk scores (and practice revenue) while reducing clinical autonomy.[1]

1 Shah S, Rooke-Ley H, Brown ECF. Corporate Investors in Primary Care - Profits, Progress, and Pitfalls. The New England Journal of Medicine. 2023;388(2):99-101. https://www.nejm.org/doi/full/10.1056/NEJMp2212841

2 Vogel S. Share of physicians working in private practice continues to dip. Healthcare Dive. July 13, 2023.

3 Ikram U, Aung K, Song Z. Private Equity and Primary Care: Lessons from the Field. NJEM Catalyst. 2021. https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0276

4 Song Z, Giuriato M, Lillehaugen T, Altman W, Horn DM, Phillips RS, Barnett KG, Auerbach D. Economic and Clinical Impact of COVID-19 on Provider Practices in Massachusetts. NJEM Catalyst. 2020. https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0441

5 Contreary K, Cathrath S, Jones DJ, Cohen G, Miller D, Rich E. Consolidation and Mergers Among Health Systems in 2021: New Data from the AHRQ Compendium. Health Affairs Forefront. 2021. https://www.healthaffairs.org/content/forefront/consolidation-and-mergers-among-health-systems-2021-new-data-ahrq-compendium

Many new entrants to primary care rely on virtual care. Some use the traditional long-term provider-patient relationship model, while others do not.

VIRTUAL MODELS

- Some new entrants offer virtual-first comprehensive primary care practices, in which a patient is matched with a virtual PCP who replaces an in-person PCP, while other models offer "one-off" virtual provider visits. Most offer 24/7 virtual urgent care visits.

Examples

FIREFLY

- Comprehensive virtual-first primary care
- Patient is assigned to dedicated care team and virtual PCP (similar to traditional in-person model)
- If virtual PCP determines patient needs in-person care, the patient visits an urgent care center or lab test site
- Patient uses insurance for visits
- Firefly contracts with employers and health plans (e.g. BCBSMA)

SESAME

- "One-off" virtual provider visits for common conditions, including mental health and prescriptions
- Cash payment per visit. and visit prices are lower if patient purchases a membership (e.g., with a membership starting at $84, primary care visits may be $29, mental health visits may be $79); insurance is not accepted
- Partnership with Costco gives discount pricing for Costco members
- Sesame negotiates cash price rates with in-person doctors and imaging services in select cities

New models of care delivery raise questions and concerns, but may offer lessons for needed reforms to enhance the sustainability of traditional primary care practices.

- **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, and with enhanced access for patients who receive care as part of these newer models. Likewise, in recent years many adults report not having a designated primary care clinician, and models providing "one-off" visits may support access for these patients.[1]
- **However, new care models may not be accessible to all patients.** Virtual models require internet access and technology fluency, while concierge models require subscriptions that are unaffordable for many. Likewise, care models relying on "one-off" provider visits raise questions about care coordination and continuity.
- **Ownership changes may affect spending**. Private equity acquisition of primary care practices is associated with physician price increases.[2] Additionally, the difficulty of generating profits in primary care has led some newer entrants to shut down operations, potentially leaving patients without care and providers without employment.[3,4,5] For example, Walgreens announced plans to open VillageMD primary care clinics in Massachusetts in 2022 but closed them all in 2024 after significant operating losses.[6,7]
- **Promising aspects of new care models could likely be replicated in traditional practices with greater use of capitated funding** so practices can invest in support staff and clinician activities that are not reimbursable under fee-for-service payment, and to improve job sustainability, reduce clinician burnout, and improve patient access.

1 KFF. One-Fourth Of Adults And Nearly Half of Adults Under 30 Don't Have A Primary Care Doctor. Feb 8, 2019. https://www.kff.org/other/slide/one-fourth-of-adults-and-nearly-half-of-adults-under-30-dont-have-a-primary-care-doctor/

2 Scheffler RM, Alexander L, Fulton BD, Arnold DR. Abdelhadi OA. Monetizing Medicine: Private Equity and Competition in Physician Practice Markets. American Antitrust Institute, Petris Center UC Berkeley, and Washington Center for Equitable Growth. 2023.

3 Grumbach, K, Cohen DJ, Jabbarpour Y. The Failing Experiment of Primary Care as a For-Profit Enterprise. Health Affairs Forefront. 2024. https://www.healthaffairs.org/content/forefront/failing-experiment-primary-care-profit-enterprise

4 Adams K. Healthcare Is a Frontier Not Even Walmart Could Conquer — And It's Not Looking Great For Others Either. MedCity News. May 1, 2024. https://medcitynews.com/2024/05/walmart-healthcare-telehealth-retail/

5 Pifer R. Amazon Care to shut down by year's end as corporate customers don't see value. Healthcare Dive. August 25, 2022. https://www.healthcaredive.com/news/amazon-care-shut-down-2022-one-medical/630468/

6 Wallgreens and VillageMD Expand to Massachusetts with Goal of Opening More than 10 New Full-Service, Primary Care Practices by Early 2023. VillageMD. April 28, 2022. https://www.villagemd.com/press-releases/walgreens-and-villagemd-expand-to-massachusetts-with-goal-of-opening-more-than-10-new-full-service-primary-care-practices-by-early-2023

7 Landi H. Walgreens narrows profit outlook for 2024, takes $6B hit in Q2 from VillageMD investment. Fierce Healthcare. March 28, 2024. https://www.fiercehealthcare.com/retail/walgreens-takes-6b-hit-q2-villagemd-investment

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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 to avoid 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]

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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%.
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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.

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- 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
- What Is the Role of New Primary Care Business Models In Workforce and Access Challenges?
- Where Do We Go From Here?
- **DATA SOURCES AND ACKNOWLEDGEMENTS**

Data Sources

- Association of American Medical Colleges. State Physician Workforce Data Report, 2017-2021
- Center for Health Information and Analysis Emergency Department Database, CY2016 – 2022
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- U.S. Bureau of Labor Statistics Occupational Employment and Wage Statistics
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- U.S. Census American Community Survey 5-Year Estimate, 2018 and 2022
- U.S. Health Resources & Services Administration (HRSA) Health Center Program Uniform Data System, 2017-2022

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The Massachusetts Health Policy Commission (HPC), established in 2012, is an independent state agency working to improve the affordability of health in the Commonwealth. Through data-driven analysis, actionable policy insights, public accountability, and innovative investments, the HPC seeks to improve health care delivery, lower costs, and reduce health disparities.

The HPC is committed to better health and better care – at a lower cost – for all residents of the Commonwealth.

For more information, visit https://masshpc.gov.

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