



Primary Care
Development
Corporation

Primary Care Legislative Trends

2022

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Introduction

Primary care is a cornerstone of vibrant, thriving communities and helps keep families healthy, children ready to learn, and adults able to pursue education and participate in the workforce.¹ Primary care is also the only part of the health system that has been proven to lengthen lives and reduce inequities at the population level while reducing overall health care costs.² Regular access to primary care is consistently associated with positive health outcomes, including reduced severe chronic conditions, fewer hospitalizations, fewer emergency department visits, and fewer surgeries.³

Despite primary care's proven role in improving population health, increasing health equity, and reducing costs, primary care is underfunded and undervalued across the country. The complex nature of the United States health system often obscures the value of primary care, making it harder for policymakers and stakeholders to find policy options to create a strong, primary care-centric health system that could address many of our nation's most difficult health care crises.

The impact of inadequate investment in primary care became even more visible during the COVID-19 pandemic, when communities that lacked adequate access to primary care before the pandemic suffered higher rates of COVID infections and COVID-related mortality and morbidity.⁴

Regular access to primary care is consistently associated with positive health outcomes, including reduced severe chronic conditions, fewer hospital visits, fewer emergency department visits, and fewer surgeries.

The first and most critical step towards establishing a stronger health system built on a foundation of primary care is to rebalance health care spending towards primary care. Spending on primary care should be sustainable and support comprehensive, team-based care, meaning providers must be paid prospectively, rather than continuing the traditional "fee for service" payment structure based on paying for individual patient encounters.⁵ There are also many specific policy actions that would improve access, quality, and cost that can be taken by state policymakers.

This report reviewed policy proposals in four major primary care areas:

- 1** Investing in primary care infrastructure and services
- 2** Expanding access to primary care, including through increased insurance coverage and expanding access to telehealth
- 3** Facilitating the availability of comprehensive, integrated primary care through advanced payment models, incentives, and training
- 4** Supporting and growing a responsive, culturally competent primary care workforce

This report, PCDC’s first on state legislative trends in primary care, focuses on the role of state legislators and governors in strengthening and supporting quality primary care through legislation, and provides a snapshot of some of the major primary care policy trends considered in state legislatures in 2022. PCDC reviewed state legislative efforts on primary care to see what progress is being made at the state level.⁶ Our research demonstrates that state lawmakers across the country are beginning to understand the value of primary care and are putting forward policy solutions to achieve better access to high-quality primary care for their communities.

Specifically, this report provides an overview of general trends in primary care policy that were considered or moved in 2022,¹ highlighting one or two specific bills on each topic, and should not be viewed as an endorsement of any particular policies. PCDC encourages state lawmakers and advocates to review these 2022 legislative trends and consider which policies might be most effective in addressing their states’ needs.

I. Paying for the Care Communities Need

Deliberately investing in primary care is one of the most effective ways to save lives, improve individual and community health, and move toward health equity. In the United States, primary care accounts for approximately 35% of all health care visits each year – yet only about five to seven percent of all health care expenditures are for primary care services, even though primary care is critical to keeping people healthy and preventing them from needing more expensive and acute care.⁷

In contrast, other similarly situated countries spend as much as 12-14% on primary care as a proportion of

Addressing underinvestment in primary care requires systemic change, including:

Improved ways to pay for care delivery

Higher reimbursement for primary care

Investing in primary care infrastructure

Investing in the workforce and pipeline

¹ Note that this report is not an exhaustive list of every primary-care related piece of legislation proposed or moved in 2022. Many other individual pieces of legislation touched on or would have impacted primary care in some way, but were not included due to the scope of this report.

their total health care spending.⁸ The lack of adequate funding for primary care impacts both patients and providers, and leads to inadequate access, low-quality care, poor health outcomes, and an overburdened and burnt-out workforce that loses experienced professionals and has trouble attracting new ones.⁹ The harms of underinvestment in primary care are not felt equally across populations but instead hit hardest in communities already suffering from other health and social inequities.

This section focuses on two specific ways state lawmakers considered addressing these connected problems of underinvestment and inequity in 2022: Investing in primary care as a whole and increasing Medicaid reimbursement rates by bringing them up to Medicare levels.

Directly Increasing Investment in Primary Care

Existing Policies

The lack of investment in primary care is one of the core problems affecting access to quality primary care in the United States¹⁰ – and for more than a decade, state policymakers have been trying different strategies to increase investment in a meaningful and sustainable way. By January 2022, at least 10 states had already initiated efforts to begin measuring and reporting their primary care spending with the goal of increasing the proportion of that spending over time.¹¹ Several states acted through state agency regulation to establish studies or otherwise require increased investment in primary care, as in Rhode Island¹² and Utah,¹³ while Oregon, Delaware, Colorado, Maine, Vermont, and West Virginia¹⁴ began their efforts to drive more investment in primary care with legislation, and Washington State did so through a budget item. In Connecticut and Pennsylvania, two of the most recent states to initiate efforts, the governors issued executive orders to require the development of primary care spending targets.¹⁵

Some states started with a study, task force, or commission to measure spending and make recommendations, whereas other states simply mandated increased spending by insurers.

2022 Trend: Primary Care Investment

In 2022, eight additional states considered primary care investment legislation, often looking to the examples set by the states that have already started down this road.

At least five states fully enacted primary care investment legislation:

- Nebraska Legislative Bill 863 created a Council with gubernatorial appointees to assess primary care spending in the state and make recommendations to the legislature and governor regarding increasing access to and spending on primary care.
- In Connecticut (House Bill 5506), Maryland (Senate Bill 734), Utah (House Bill 210), and Washington State (Senate Bill 5589), an already established governmental entity (a

“ Senate Bill 734 . . . requires the establishment of a multi-stakeholder workgroup to analyze primary care investments Recommendations from this workgroup will identify the funding needed to make whole-person, team-based primary care a reality across the state. ”

Committee, Commission, or Office) was newly tasked with studying primary care or setting up a new workgroup to explore primary care spending.

- Vermont enacted legislation, Senate Bill 285, which directs several state-level Commissions to work with the Centers for Medicare and Medicaid Services (CMS) to adopt new multi-payer alternative payment methodologies across the health system and includes a requirement that the Director of Health Care Reform must consider “strategies and investments to strengthen access to ... primary care.”

In addition, several states considered but have not yet fully enacted similar legislation.

- Both houses of the New York legislature passed Assembly Bill 7230B/Senate Bill 6534C, which would have established a stakeholder-government primary care commission to assess primary care spending and make recommendations to increase investment, but New York Governor Kathy Hochul vetoed the legislation.

“

It is critical that we properly invest in primary care, not only because it is our first line of defense when it comes to health but also because it can significantly improve health outcomes and indicators, which our state desperately needs.

”

New York State Senate Health Committee Chair Gustavo Rivera

- Massachusetts Senate Bill 2774, entitled “An Act Investing in the Future of Our Health,” was put forward by Governor Charlie Baker. Proposed first in 2019 and revised in 2022, incorporating experiences during the COVID-19 pandemic, the legislation envisions a wholesale approach to increasing investment in and access to quality primary care, with specific spending targets and ongoing data collection and research.

“

Governor Baker said the current health care system “rewards those providers that invest in technology and transactional specialty services at the expense of those who choose to invest in primary care, geriatrics, addiction services and behavioral health” and that he is proposing reforms “designed to address the underlying changes the system faces.”

”

- In Vermont, Senate Bill 244, introduced but not moved, would have addressed multiple issues, including requiring most health insurers to increase their primary care spending at least one percent per year until it reaches 12% of total spending, asking the federal government to increase reimbursement for primary care in Medicare, and requiring the state to reimburse Medicaid at the same level as Medicare.

Increasing Access to Medicaid Through Increased Reimbursement

Existing Policies

Medicaid and the Children’s Health Insurance Program (CHIP) are joint federal-state programs, regulated at both the federal and state levels, that offer health insurance coverage for lower-income Americans. Almost 90 million Americans, about 20% of the population, are covered through Medicaid and the CHIP.¹⁶ In 2010, the Affordable Care Act (ACA) allowed states to expand Medicaid coverage to a larger percentage of the population, leading to increased access in 38 states and the District of Columbia.¹⁷ Twelve years later, research shows that expanding Medicaid coverage has led to “better access to health care[;] better health outcomes, including fewer premature deaths[; and] more financial security and opportunities for economic mobility.”¹⁸

However, Medicaid-insured individuals often struggle to find providers who will take their insurance, leading to delayed care and other adverse health outcomes.¹⁹ A critical factor in providers’ unwillingness to accept Medicaid is that Medicaid reimburses providers at far lower rates than other insurance programs, including both private plans and Medicare plans.²⁰ To improve access for Medicaid patients, state legislatures have looked specifically at how to ensure that providers are compensated similarly for caring for Medicaid patients as other patients.

To address the lack of Medicaid providers and the challenges in providing care without sufficient reimbursement, the ACA contained a temporary provision that mandated parity between Medicaid and Medicare reimbursement specifically for primary care providers, but only for 2013 and 2014.²¹ Following the expiration of this mandate in 2014, a few states implemented policies to continue Medicaid parity within their jurisdictions. As of 2019, Medicaid parity status across the country varied drastically by state.

Only five states had achieved close to full parity; 16 states reimbursed Medicaid services at rates somewhere between 75-99% of Medicare rates; 22 states reimbursed between 50-74%; and six states reimbursed Medicaid at less than 50% of Medicare.²²

2022 Trends: Medicaid Parity

In 2022, at least two states enacted laws to increase Medicaid funding closer to Medicare parity:

- Vermont enacted a new Medicaid parity law, Senate Bill 285, which expresses legislative intent to reimburse Medicaid participating providers at 100% of the Medicare reimbursement rate, prioritizing primary care providers in the first year. The bill requires the Department of Vermont Health Access to either provide Medicaid parity for primary care services in its FY2024 budget or to inform the legislature what level of additional appropriation would be required to achieve full reimbursement parity for primary care services.
- In Virginia, the state budget included an increase for both Medicaid and CHIP to 80% of Medicare reimbursement, specifically for physician primary care services.

Several other states considered but did not pass legislation to establish Medicaid parity:

- In New Jersey, a bill was introduced that would have established Medicaid parity for both primary care and mental health services (Senate Bill 2792).

- In Rhode Island, lawmakers considered Senate Bill 2073, which would have required Rhode Island Medicaid and any contracted managed care organizations (MCOs) to ensure that primary care reimbursement rates were not lower than 100% of the federal Medicare reimbursement rates.

II. Creating Comprehensive Primary Care Through Integration

High-quality, comprehensive primary care includes the full suite of physical and behavioral health services people need to live healthy, productive lives.²³

However, physical and behavioral health services are regulated, insured, and reimbursed in different ways, making it challenging for providers to give their patients integrated access to the full range of services at one site at one time and to coordinate their patients' needs. Lack of coordination and integration contribute to health inequity and poor health outcomes.²⁴ Integrated care models, especially those that pay for holistic care and integrated care teams, are essential to ensuring access to health care services that treat the whole person.²⁵

This section focuses on three ways in which state lawmakers this year encouraged high-quality primary care integration: Facilitating the integration of behavioral health care into primary care, expanding access to postpartum care, and ensuring that all types of providers are equipped with the knowledge and skills necessary to treat diverse patient populations.

Integrating Behavioral Health and Primary Care

Existing Policies

In 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) - Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions released a continuum of five potential policy approaches to implement and achieve behavioral and physical health integration.²⁶ Many states have adopted one or more of the policies recommended by SAMHSA-HRSA. First, many states have required some form of universal screening for behavioral health issues as a part of primary care visits.²⁷ Second, some states implemented policies to facilitate a warm handoff between physical and behavioral health care providers by reimbursing the work of navigators, including Social Workers, RNs, and peer specialists.²⁸ Third, states have attempted to make it easier for individuals to access behavioral health through policies encouraging the co-location of and collaboration between physical and behavioral practices.²⁹ Finally, states have used Health Homes as a means of ensuring that Medicaid Beneficiaries receive coordinated and comprehensive care that includes both physical and behavioral health services.³⁰

2022 Trends: Behavioral Health Integration Grants

In 2022, at least two states passed legislation to design grant programs to fund integration initiatives statewide.

- Colorado enacted House Bill 1302, establishing the Primary Care and Behavioral Health Statewide Integration grant program, which will provide primary care clinics with grants to implement a wide range of integration initiatives with behavioral health specialists focusing on adult and pediatric populations.

- In Washington State, the FY23 Enacted Budget, Senate Bill 5693, appropriated \$2,000,000 of the general fund for the creation of one-time grants for eligible primary care clinics to establish behavioral health integration for children and adolescents through team-based care, universal screenings, and collaborating with community partners.

2022 Trends: Enhanced Care Coordination and Referral Services

“ Sen. Derek Slap, a West Hartford Democrat, referring to this and two other bills that passed as a package:

Our children have been suffering for a long, long time, and we’ve been failing. ... I think [these bills are] going to shine some light on our children ... give them some hope. It’s the most important thing we’re going to do this legislative session.

”

State policymakers also considered ways to create enhanced care coordination processes and referral services.

- Connecticut enacted House Bill 5001 that establishes a new regional mental and behavioral health consultation and care coordination program for PCPs who have pediatric patients. The program will provide PCPs with timely access to a consultation team (including a child psychiatrist, social worker, and care coordinator), patient care coordination, transitional services for mental or behavioral health care, and further training and education for providers.
- Multiple bills were introduced, though not passed, in Minnesota (House File 4579 and Senate File 4355), which focused on multidisciplinary care teams and enhanced referral services for substance abuse disorder (SUD) patients and pediatric mental health patients.

Expanding Access to Postpartum Coverage and Services

Existing Policies

For many years, the United States has had by far the highest rates of maternal mortality compared to other developed nations, with over 23 deaths per 100,000 live births in 2020.³¹ Recent research confirmed what primary care providers have long understood -- that more than 80% of those deaths are preventable if only the pregnant individuals had received appropriate health care.³²

As with many health care outcomes, Black women and other women of color are more likely to suffer, with Black women three times more likely to die from a pregnancy-related cause than White women,³³ and 93% of maternal deaths among American Indian and Alaska Native women found to be preventable.³⁴ It is clear that this disparity stems largely from a lack of access to high-quality preventative and prenatal care, including high-quality primary care, for many women, especially those in low-income, underserved, and disinvested communities, as well as communities of color.³⁵

In recent years, lawmakers in many states have acknowledged the severity of this problem and considered the best way to address it, often creating Maternal Mortality Task Forces or Commissions as a first step toward understanding the problem and identifying potential solutions.³⁶ In states that have attempted to take further steps, the focus has largely been on the post-partum period. Inconsistent health coverage or inaccessible providers can leave postpartum women unable to access the full range of necessary postpartum services in the critical year after birth.³⁷ Although primary care is rarely named in public conversations about maternal mortality, virtually all post-partum care after six or 12 weeks is part of primary care.³⁸ In fact, over the last several years, the American College of Obstetrics and Gynecology has adopted an approach to postpartum care that emphasizes transitioning a post-partum patient to primary care as part of the 12-week post-partum OBGYN visit.

Because Medicaid finances an estimated 42% of annual U.S. births, many of the policies addressing maternal health have focused on either extending Medicaid coverage for a longer duration of time postpartum or expanding Medicaid benefits to cover maternal health services that are not traditionally covered or not currently federally required. Both of these strategies intend to ensure that expectant and new mothers stay insured and have access to high-quality health services during the postpartum period. Federal law already requires state Medicaid policy to keep postpartum women enrolled in Medicaid for at least 60 days postpartum, but a number of states have expanded that requirement (through both legislation and Medicaid 1115 waivers) to anywhere between 6 and 12 months postpartum. Further, states have added new covered services, including free-standing birth clinics, SUD services, mental health services, and home visiting services.

2022 Trends: Extending Medicaid Postpartum Coverage

At least five states enacted legislation or adopted budget language that extends Medicaid postpartum coverage beyond the federal 60-day requirement.

- Kansas (Senate Bill 267), New York (Senate Bill 8006C/Assembly Bill 9006), New Mexico (House Bill 2), and Utah (House Bill 3) included an extension of Medicaid postpartum coverage to 12 months in their respective state budgets.



Governor Kelly called the postpartum coverage “a huge victory for Kansas families.”



- Maine enacted Legislative Document 1781, which extends postpartum MaineCare coverage to 12 months post-birth as long as permitted under federal law.
- Oregon enacted House Bill 5202, which appropriates sufficient resources to provide postpartum coverage through Medicaid for 12 months.
- Georgia enacted Senate Bill 338, which requires the Department of Community Health to submit a Medicaid State Plan Amendment or 1115 waiver to CMS to extend Medicaid postpartum coverage for a full year after the birth.

Similar legislation was considered, although did not pass, in Arizona (Senate Bill 1272), Hawaii (Senate Bill 2634), Kentucky (House Bill 174), and New Hampshire (Senate Bill 407).

2022 Trends: Expanding Postpartum Medicaid Benefits

Many states considered legislation to expand postpartum Medicaid benefits to cover services that were not previously covered and not federally required.

- Oregon enacted Senate Bill 1555, which establishes a voluntary statewide newborn nurse home visiting program to support healthy child development and strengthen families in the postpartum period.
- An almost identical bill, Assembly Bill 9140, was introduced in New York but did not pass.

Other policies focused on including services that address maternal mental health and/or substance use disorders (SUD).

- Louisiana enacted HB784, providing resources to build awareness and expand screening and treatment for mental health and SUD for pregnant and postpartum patients.
- Ambitious bills regarding postpartum mental health and SUD services were also introduced in several states, including Rhode Island (House Bill 7341), New York (Senate Bill 8233), and Massachusetts (House Bill 4741), but did not pass this session.

Training PCPs to Better Serve Vulnerable Communities

Existing Policies

Training primary care providers to be culturally competent and thus better serve their patient population is critical to achieving health equity. Since the early 2000s, states have enacted a wide variety of requirements – for example, New Jersey requires a clearly defined course of cultural competency training as a condition of licensure and re-licensure for many health professionals,³⁹ while many other states simply encourage training. There is strong federal support for these types of state policies, with the federal Office of Minority Health offering cultural competence training resources and publishing national standards that can be implemented at the state level in a variety of ways.⁴⁰

2022 Trend: Training and Continued Education

Several states considered legislation intended to equip practitioners with the information and skills needed to better serve vulnerable patients.

- Colorado enacted House Bill 1267, which created the Culturally Relevant and Affirming Health Care Training Grant program to provide funds for nonprofit entities and statewide associations of health care providers to develop new cultural competency training programs that will benefit priority populations.
- California enacted Senate Bill 923, which mandates annual cultural competency training specifically regarding gender inclusivity for most health insurance plan staff, requires tracking and reporting of complaints related to trans-inclusive health care, and encourages inclusive

care from providers by mandating the creation of continuing medical education curriculum focusing on gender inclusivity.

- Louisiana enacted House Concurrent Resolution 44, establishing the Health Disparities in Rural Areas Taskforce, which will identify key drivers of rural health disparities, study practical solutions for reducing health care provider shortages in rural communities, and develop proposals for health care workforce training initiatives that promote diversity in the profession.

Similar legislation was introduced but not passed in Nebraska, where Legislative Bill 885 would have mandated annual training on implicit biases for a wide range of credentialed health care professionals.

III. Telehealth as a Tool to Expand Access to Primary Care

Telehealth, or telemedicine, includes real-time communication between health care practitioners and patients via video teleconference, telephone, or a home health monitoring device, allowing providers to provide remote care to patients that is comparable to care provided in person.⁴¹ Before the COVID-19 pandemic, telehealth utilization had been steadily growing, with many providers recognizing its value in increasing access and visit efficiency.⁴² The pandemic expanded the use of telemedicine for primary care delivery dramatically, with a 95% growth in primary care physicians across the United States reporting use of telehealth at least occasionally.⁴³

Telehealth has a particularly significant role in addressing access gaps in rural areas. While almost 20% of Americans reside in rural areas, less than 10% of physicians practiced in rural communities in 2022.⁴⁴ The prolonged disproportionate access to care in rural areas has contributed to the fact that those living in rural areas are more likely than urban residents to die prematurely from the five leading causes of death in the U.S.⁴⁵ The pandemic only exacerbated these existing health disparities and barriers to care, increasing the health burden in rural areas.

This section highlights how state legislators have addressed increased reliance on telemedicine in response to the pandemic and its potential to serve the needs of rural populations by improving access to telehealth, reducing restrictions, and reimbursing providers for providing telehealth services.

Lifting Restrictions and Allowing Reimbursement to Increase Access to Telehealth Services

Existing Policies

In the years approaching the COVID-19 pandemic, as telehealth emerged as an effective alternative to in-person consultations, many states enacted telehealth laws, largely governing the permissible uses of telehealth within their states. Even before the start of the pandemic in 2020, at least 43 states and the District of Columbia mandated insurance coverage for telehealth, requiring insurers that provided coverage for in-person services to also provide telehealth coverage for many of the same services.⁴⁶ However, utilization was low and very few states required payment parity, which would mean reimbursing providers for telehealth visits at the same rates as in-person visits.⁴⁷ Some states also had fairly restrictive telehealth regulations, governing when and how telehealth could be practiced within the state and often limiting its use to specialists or for patients in rural areas.⁴⁸

Since 2020, much of the enacted legislation at the state level expanded the definitions of telemedicine under the COVID-19 state of emergency or in response to the Coronavirus Aid, Relief, and Economic Security (CARES) Act.⁴⁹ Some of these expansions included cross-state licensing, preventing the denial of coverage for services provided through telemedicine, removing geographic restrictions based on rural designations or mileage requirements, and removing the requirement for a first in-person visit, and allowing a patient's home to be the originating site.³⁸

Additionally, at least 37 states enacted legislation to make at least some of their COVID-19 related changes permanent, and at least three states (including California, Idaho, and Ohio) took non-legislative action to do the same.⁵⁰ These non-legislative measures expanded telehealth capabilities through Governor executive orders, state Medicaid agencies, and licensing boards.

2022 Trends: Reducing Barriers to Telehealth

Lawmakers in many states considered legislation to revise and broaden their telehealth laws.

- Virginia included in its budget both funding for a broad Primary Care Task Force, which has existed for several years without state funding, and a request that the Task Force prioritize policies that would promote telehealth innovations across the state. It also enacted House Bill 81, requiring the State Board of Health to regularly update the existing Statewide Telehealth Plan to reflect changing technologies and medical standards.

Other states considered but did not pass legislation:

- A bill was introduced in Alaska to allow licensed out-of-state providers to provide telemedicine services in the state (Senate Bill 175/House Bill 265).
- A telehealth expansion bill, Senate Bill 1135, was introduced in Michigan which would have increased the types of allowable locations for patients and providers during a telehealth visit as well as required insurance coverage for these visits under the state's Healthy Michigan program.
- In Vermont, Senate Bill 244 was introduced and would have required insurers to reimburse primary care providers for telehealth visits at the same rate as in-person visits.

At least two states focused their telehealth expansion efforts on rural health, aiming to address health inequities for historically underserved rural populations.

- Hawaii enacted Senate Bill 2624, establishing funding for rural health care programs that leverage telemedicine for service delivery. To be eligible for funding, these programs must provide support for medical residents at project sites in medically underserved areas, including rural areas, use telehealth as a primary means of health care delivery, and include at least one FQHC or rural health clinic at each project site.
- Louisiana enacted House CR 44, establishing a Health Disparities in Rural Areas Task Force, to promote greater access to care for rural residents through telemedicine service delivery.

IV. Strengthening the Primary Care Workforce

If primary care is to fulfill its role as the foundation of an equitable health system, primary care providers and their teams must be supported, the pipeline into primary care must be robust, and experienced primary care health care professionals must be encouraged to stay in the field and train those coming into it.

Unfortunately, rather than growing to meet the expanding need for care, the primary care workforce is currently unable to even meet current demand for care, largely due to physician shortages in the field. This shortage is expected to grow worse in future years – the American Association of Medical Colleges has estimated that by 2033, there will be a primary care workforce shortage ranging from 21,400 to 55,200 providers.⁵¹ This shortage of PCPs will have a devastating impact on rural and underserved communities.

The lack of a sufficient primary care workforce has many causes, including lower salary ranges for primary care physicians than specialists, high medical school debt, burnout, and the mis-match between where primary care providers are currently located and where the need is greatest.⁵² This section focuses on ways in which state lawmakers have attempted to strengthen the primary care workforce, through efforts to recruit medical students into primary care and to retain the primary care physicians already practicing in the field.

Recruitment of Medical Students into Primary Care

Existing Policies

Following the passage of the ACA, many states focused on incentivizing and expanding primary care through workforce strategies. A number of states created state-level loan repayment programs for a variety of primary-care professionals, education initiatives aimed at exposing public school students to primary care careers, and policies to increase the number of primary care residency slots.⁵³

According to the American Association of Medical Colleges, there are 37 state-specific programs aimed at reducing the debt-to-income ratio for medical professionals.⁵⁴

These programs vary by dollars awarded and service commitments. For example, in New York, the Doctors Across New York (DANY) program offers loan repayment assistance of up to \$120,000 for physicians who serve for at least three years in underserved areas in specialties including primary care.⁵⁵ In Georgia, through the Physicians for Rural Areas Assistance Program under the Physicians, Dentists, Physician Assistants, and Advanced Practice Registered Nurses for Rural Areas, licensed physicians can be awarded a maximum of \$100,000 in student loan repayment in exchange for providing direct patient care in underserved, rural counties.⁵⁶

Similarly, some states have also focused efforts on expanding the number of family medicine residency programs. In Wisconsin, for nearly a decade, the state has directed millions of dollars in general revenue toward increasing family medicine residency slots.⁵⁷

Although some of these state-level recruitment and incentive programs have ended, a number of loan repayment, forgiveness, and scholarship programs still exist.

2022 Trends: Loan and Scholarship Repayment Programs

At least 11 states considered legislation to create or expand a loan or scholarship repayment program for medical professionals.

States approached these programs differently, with some aiming to recruit professionals to work in certain geographic areas and others attempting to recruit professionals to work with vulnerable patients or to work specifically in primary care.

- Hawaii enacted Senate Bill 2597, which appropriates \$500,000 toward the Hawaii State Loan Repayment Program for health care professionals that agree to work in a federally designated health professional shortage area.



This bill...supports recruitment and retention of a health care workforce that better reflects, represents, and understands the patients that they are serving and community-based providers that serve a high proportion of Medicaid and uninsured patients.



Senator Mattie Hunter (D-Chicago)

- Illinois enacted House Bill 4645, establishing the Equity and Representation in Health Care Workforce Repayment and Scholarship program, which will offer loan repayment and scholarship funds to eligible professionals (including, but not limited to, physicians, nurses, and PAs) who agree to see and treat all patients at a medical facility regardless of the patient's ability to pay for services. This program will also emphasize workforce diversity, prioritizing applicants from a race, ethnicity, gender, sexual orientation, gender identity, or disability status underrepresented in the health care sector.
- New York created a new loan repayment program specifically for nurses working in medically underserved areas for at least three years, including those working in primary care, adopted as part of the annual budget, Assembly Bill 9007/Senate Bill 8007.

A number of states considered but did not pass loan repayment or scholarship for medical professional legislation.

- The Washington DC City Council considered Bill 943, which would have established the High-Need Healthcare Career Scholarship and Supports Program to help cover costs associated with education, training, and examinations for students who commit to serving in a high-need area of health care, such as primary care or mental health, in Washington, DC for at least two years following their licensure, certification, or registration as a health care worker.
- Other states considered similar legislation, including Connecticut (Senate Bill 449), Indiana (House Bill 1088), Maryland (Senate Bill 716), Minnesota (Senate File 4014), Missouri (House Bill 2881), New Mexico (Senate Bill 23), North Carolina (House Bill 1090) and Vermont (House Bill 703).

2022 Trends: Education/Mentorship Programs

Several states considered legislation aimed at recruiting medical students and advanced nursing students into primary care by providing tax incentives to encourage practicing PCPs to act as preceptors for primary care-focused clinical rotations.

- Colorado passed House Bill 1005, which will more than double the number of preceptors eligible to take advantage of the state's Rural and Frontier Healthcare Preceptors Tax Credit Program. This program offers tax credits to practitioners who offer at least four weeks of mentorship, instruction, training, and supervision to health care professional students who are seeking a degree or certification in a primary health care-related field.
- Similar legislation was proposed but not enacted in other states. The Kentucky legislature considered, but did not pass, House Bill 718, which would have established a tax credit system for primary care preceptors who supervised primary care students in a health professional shortage area.

Other states considered but did not pass different approaches to provider recruitment. For example, in Louisiana, the proposed House Bill 226 would have created a program with education institutions to increase the number of students receiving high-quality education for primary care delivery.

Retention of Current Primary Care Providers

Existing Policies

Many states have adopted policies that establish financial incentives to keep experienced physicians in the primary care field, particularly in rural and other primary care shortage areas. States have pursued this goal in a variety of different ways, such as offering loan repayment or forgiveness to PCPs who commit to practicing in a rural or shortage area, state tax credits, or other financial incentives through community matching programs. Most recently, due to the high strain put on primary care providers during the COVID-19 pandemic, many states passed legislation intended to provide financial relief to health care professionals both to compensate for the hardship of the pandemic as well as to incentivize staying in the field. Federally, the CARES Act included the Provider Relief Fund, which provided funds to providers who enrolled in Medicare, Medicaid, and CHIP to recover lost revenue and unreimbursed costs due to the pandemic.⁵⁸ In response to this federal legislation, most states have adopted related policies to support providers, particularly those that care for a disproportionate share of Medicaid patients, largely through non-legislative Medicaid policies such as Disaster-Relief State Plan Amendments, Home & Community Based Services waivers, and Medicaid 1115 waivers.⁵⁹

2022 Trends: Provider Tax Deductions

A few states considered legislation that would establish tax credit programs for practicing PCPs in primary care workforce shortage areas.

- Georgia enacted House Bill 1039, which establishes tax credits for physicians, NPs, PAs, and dentists who provide care to rural communities – counties with 65 or fewer people per square mile – for family practice, obstetrics and gynecology, pediatrics, internal medicine, or general surgery. Eligible health care professionals can earn up to \$5,000 per year in tax credits for a maximum of five years.

At least three other states considered but did not pass similar legislation.

- In Missouri, House Bill 2133 would have established a tax credit of \$15,000 per year for PCPs and dentists practicing in rural Missouri counties of less than 25,000 inhabitants.
- In New Jersey, Assembly Bill 3910 would have established gross income tax deductions (totaling \$300,000 over five taxable years) for eligible physicians who work in family medicine, general internal medicine, general pediatrics or general obstetrics and gynecology.
- Similar legislation in New Mexico, Senate Bill 115, would have established a tax credit specifically for providers practicing in rural underserved areas.

Conclusion

In 2022, many state legislatures considered and enacted proposals to address the core challenges facing primary care by investing more in primary care, expanding access, facilitating care integration, and shoring up the shrinking and insufficient primary care workforce.

The growing list of states focused on investing more in primary care shows that state-level health policy can be ambitious and focused on systemic change. At the same time, the incremental changes proposed in states on integrated care, telehealth and workforce could all contribute to a more primary care-centric health system – as long as the system is funded to provide the foundational primary care every person needs.

In 2023, PCDC strongly encourages state lawmakers across the country to continue to adopt and strengthen policies to ensure that primary care can fulfill its potential to support healthy, thriving, equitable communities now, in the next health crisis, and into the future.

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