Primary Care Development Corporation

State Trends

Primary Care Investment

Update

A LOOK BACK AT 2024

Investing in Primary Care – A Critical Policy for Every State

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. Regular access to primary care is consistently associated with positive health outcomes, including fewer hospitalizations, emergency department visits, severe chronic conditions, and surgeries.[1] Investing in primary care is one of the most effective ways to save lives, improve individual and community health, and advance health equity. Investment in primary care can support a stronger health system infrastructure, a more robust, diverse, and sustainable health care workforce, and more comprehensive care.

While the United States spends more than other high-income countries on health care in general,[2] very few of those dollars go to primary care.[3] For decades, experts have noted that this inversion of priorities—using our health care resources to pay for tertiary care for serious or emergency situations that arise largely due to lack of prevention and early care—is hurting Americans and costing our health system far more than it would if we simply spent more on primary care up front.[4]

At the same time, the U.S. health system continues to burden primary care providers with more tasks and complex requirements, leading to extreme burnout and a growing primary care workforce shortage.[5] Research has shown that primary care appointments are often more complicated than other types of medical appointments, both in terms of the number of conditions and medications to address and the number of codes to bill as a result.[6] Further, recent research indicates that primary care providers who participate in value-based payment systems are responsible for meeting an average of 57 quality measures, an intense burden on already overwhelmed practices.[7] Experienced professionals are leaving the field, while fewer medical students are entering primary care, given lower salaries and higher administrative burden than other specialties. These administrative burdens are especially prevalent in FQHCs where only 42% of physicians report having a manageable workload, and 55% of physicians report burnout.[8] With the national primary care provider supply projected to fall short of demand, possibly by as many as 40,400 providers by 2036, increasing reimbursement to providers is crucial to addressing this workforce crisis.[9]

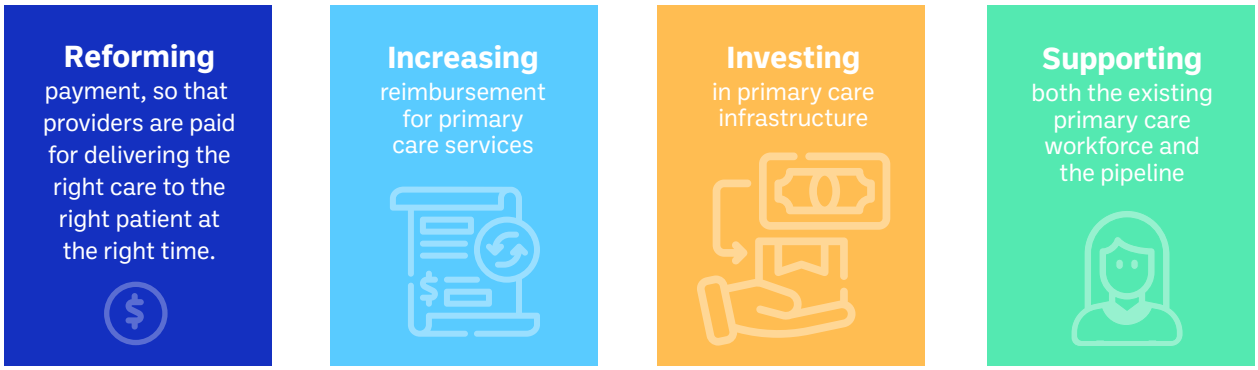
In the United States, primary care accounts for approximately 35% of all health care visits each year.[10] However, according to the Commonwealth Fund, in 2021, "[t]he U.S. spent 4.7 percent of its total health care spending on primary care… compared to an average of 14 percent in other high-income countries." [11]

The lack of adequate funding for primary care impacts both patients and providers, and leads to insufficient access, low-quality care, poor health outcomes, and an overburdened and burnt-out workforce that routinely loses experienced health care professionals and has trouble attracting new ones.[12] The effects 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.

The COVID-19 pandemic demonstrated what happens when there is insufficient primary care access. PCDC has published research showing that: (1) the impact of COVID-19 hit hardest in New York City communities that lacked access to primary care before the pandemic;[13] (2) delays in accessing primary care were associated with worse COVID-19 outcomes across the state; and, in contrast, (3) communities in New York with more federally qualified health centers (FQHCs) - clinics that provide primary care and other services to all, regardless of ability to pay or insurance coverage – had lower COVID-19 mortality rates.[14] This research drives home that without primary care access, communities have inferior health outcomes, and with access to high-quality primary care, communities are better protected from both chronic and infectious diseases.

To address these issues, PCDC recommends investing in the following areas:

1. Reforming payment, so that providers are paid for delivering the right care to the right patient at the right time;
2. increasing reimbursement for primary care services;
3. investing in primary care infrastructure; and
4. supporting both the existing primary care workforce and the pipeline.[15]



A recent article by experts from the federal Agency for Healthcare Research and Quality stated that: “In a primary care–centered health system, all individuals would receive comprehensive, [continuous] and coordinated care anchored in primary care.” [16]

The components of such a system should include:

- Clinicians with a holistic perspective and long-term relationship with their patients;
- Integrated care, including sexual and reproductive health care and behavioral health care;
- Coordinated care, including specialty care, home care, acute care, and post-acute care;
- A medical home where patients can seek care from trusted clinicians and have their voices respected and heard;
- Ongoing communication supported by a comprehensive primary care team.

Achieving that vision will require policy change starting with an increased investment in primary care. This report specifically looks back at state policies introduced or moved forward in 2024 intended to increase investment in primary care, to provide some models for policymakers and other stakeholders to consider in the coming years.

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II. State Policy Trends in Primary Care Spending

Although the United States has a long record of underfunding primary care, policymakers at the state and federal levels have begun to recognize the critical role of primary care in improving health outcomes and ultimately lowering health care costs.[17] At the state level, between 2009 and 2023, at least 15 states enacted policies designed to measure, report on, and in some cases increase spending on primary care, with most policy change occurring in the last few years.[18] Seven of those states have set primary care spending targets.[19] Many of these targets have been set recently, so most have not been fully implemented and there are few outcomes to assess at this point.

An early model from Rhode Island (RI) is instructive: In 2009, Rhode Island became the first state to mandate increased health care spending on primary care, requiring commercial insurers to increase spending on primary care by 1% per year for the next five years. Early findings from RI's investment efforts point to largely positive outcomes, including that while primary care spending in RI grew by 37% from 2008 to 2012, total medical spending fell 14% during the same period.[20] Moreover, following the 2009 regulation, RI was the only state in New England to increase its supply of primary care providers per capita between 2009 and 2014.[21] In addition, the Center for Evidence-Based Policy recently noted that increasing spending on primary care, specifically by setting a primary care spending target, often goes hand-in-hand with policies aimed at reducing the growth of health care costs, because policymakers have concluded that, "Investments in primary care lead to improved patient health, reduced emergency department visits, fewer hospitalizations, and long-term cost savings" and that "benchmarking allows state officials to compare primary care spending with total system spending and use this information to improve funding allocation for preventive care." [22]

At the federal level, in 2023, the Centers for Medicare and Medicaid Innovation (CMMI) put forth two new payment models, Making Care Primary and States Advancing All-Payer Health Equity Approaches and Development (AHEAD), that include increasing primary care investment across all types of payers as a core goal.[23]

AHEAD is a new 11-year long model being rolled out in eight states beginning in 2025.[24] It is based in part on the idea that investing more in primary care will ultimately help control "overall growth in health care expenditures" and "improv[e] population health."[25] One of the core requirements for AHEAD-participating states is to set an all-payer, statewide primary care spending target, so over the next several years, primary care spending targets will be set in at least these states: Connecticut (which already has a spending target); Hawaii (which has a spending target for Medicaid); Maryland; New York; Rhode Island (which has a spending target for commercial plans); and Vermont.[26]

III. 2024 State Policy

Measuring and increasing investment in primary care

In 2024, several state legislatures considered legislation that proposed studying or increasing spending on primary care. California imposed new requirements for increasing primary care spending through executive action, while legislation was introduced in New York to do the same. In several other states, legislation was considered or enacted that would focus more attention on primary care funding and access.

Primary care investment

While not set through formal legislation, the California Department of Health Care Access and Information (HCAI) announced that the state's Health Care Affordability Board approved benchmarks for increasing primary care spending: [27]

- An annual improvement benchmark for all health plans, calling for a 0.5 to 1.0 percentage point per year increase in primary care spending as a percentage of total health care spending until 2033.
- A statewide primary care investment benchmark, calling for all payers to be spending 15% of total health care spending on primary care by 2034.

Stakeholders and advocates in California primary care are now exploring the best pathway to assure accountability for authentically achieving the ambitious targets set by the OHCA Board. In New York, the Primary Care Investment Act (A8592/S1197B) was introduced, and would have required plans and payers that spend less than 12.5% of their total health care spending on primary care to increase their primary care spending by 1% each year until they reach 12.5%.

In Connecticut, which enacted a law in 2022 to control overall health cost growth in part by establishing 10% target for primary care spending across payers, lawmakers introduced SB210, which would have added hospitals to those required to meet the 10% primary care spending target set.

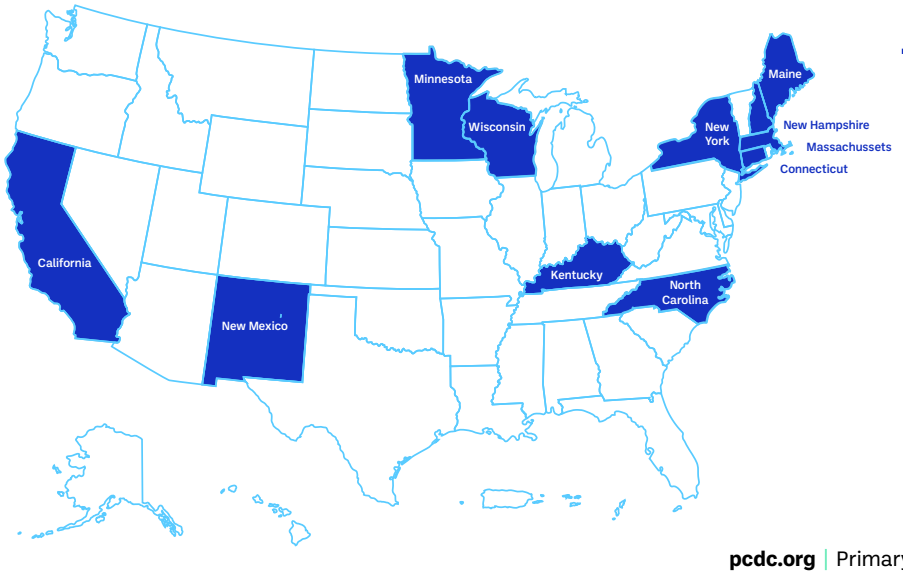
Studying and expanding access to primary care

New Mexico (SB0014), New Hampshire (HB1609), and Louisiana (HCR87) all enacted laws to continue to fund existing task forces on primary care and rural health that had been authorized in previous legislative sessions. In Massachusetts, in the last days of 2024, the legislature and governor collaborated to introduce House Bill 5159, which, among other purposes, sets up a task force to study primary care access and funding and make recommendations to strengthen the primary care workforce and increase investment in and access to primary care. Massachusetts House Bill 5159 then became law in early 2025.

Legislation was introduced in Kentucky (SCR187/SB367), Maine (LD1792), Minnesota (HF4046), and North Carolina (NCSB595) that would have established similar task forces to address health care disparities, including access to primary care.

Other notable proposed legislation related to measuring and increasing investment in primary care included:

- Wisconsin legislators introduced SB905/AB953, which would allow direct primary care (DPC) to be provided in the state for the first time. Direct primary care plans are a practice and payment model where patients pay their physician or practice directly in the form of periodic payments for a defined set of primary care services. [28]
- Lawmakers in New Mexico introduced legislation (SB210) that included funding to support the state's Primary Care Capital Funding Act. New Mexico's Primary Care Capital Fund was established in 1994 with the purpose of making loans to nonprofit primary care clinics in rural and medically underserved areas. [29]
- Kentucky lawmakers introduced SB367, which would have established an all-payer claims database.



States studying and expanding access to primary care

Expanding access to Medicaid through increased reimbursement

In many states, Medicaid pays significantly less than Medicare for the same set of services, often resulting in fewer providers accepting Medicaid patients. Advocates and stakeholders have long urged "Medicaid parity," or paying the same amount for services under both types of plans. As of 2019, Medicaid parity status varied drastically across the country. 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.[30] In 2022, two states passed laws to move towards Medicaid parity, and in 2023, three states increased their Medicaid rates, including Hawaii, which appropriated at least $30,000,000 to bring Medicaid reimbursement rates up to parity with Medicare rates in their annual budget.

In 2024, Louisiana was the only state to pass legislation to increase Medicaid rates to that of Medicare rates. This bill, SB190, prioritizes primary care as one of the services that should benefit most from the increased reimbursement rates. In Texas, while no parity legislation was introduced, the legislature did include in their 2024-2025 budget a 6% increase for certain Medicaid primary pediatric care and care for pregnant women, following the enactment of legislation in 2023.

In addition, legislation was introduced in New Jersey (A1860/S2250) to increase Medicaid rates to full Medicare parity. This bill followed the publication of a state-legislature-funded report by the New Jersey Health Quality Institute, *Primary Care in New Jersey: Findings and Recommendations to Support Advanced Primary Care*,[31] which included Medicaid parity as one of its many recommendations to increase access to and investment in primary care in the state. Advocates in New Jersey expect they will continue to urge passage of this bill and others that aim to improve primary care access in the next few years.

California lawmakers considered legislation (AB1549) that would have increased per-visit rates at FQHCs or Rural Health Clinics (RHCs). Similarly, a bill introduced in the New York legislature (A7560/S6959) proposed to close the gap between FQHC Medicaid payment rates and the costs of delivering services by implementing a new payment rate to account for increases in operational costs and the new, expanded model of health and social care that is the hallmark of FQHCs and RHCs.[32]

Workforce Changes

In 2022, PCDC found that more than a dozen states had adopted policies to address the primary care workforce crisis. The following year at least eight states continued the trend by passing legislation aimed at stabilizing their primary care workforce by supporting recruitment and retention policies.

While not nearly as many states passed new legislation to tackle the workforce crisis in 2024 as in previous years, many introduced and some enacted legislation related to loan forgiveness programs for the primary care workforce. New Mexico enacted HB288, adding "osteopathic primary care physicians" to the state's Health Professional Loan Repayment Program. Oklahoma passed HB1696, which updated its medical loan repayment program. While primary care physicians already qualified for this program, this legislation allows nurse practitioners and physician assistants, who provide a significant amount of primary care in many communities, to qualify as well.

Finally, Rhode Island (S3165) and South Dakota (SCR602) both enacted legislation requiring an investigation and report on the health care workforce and retention efforts within their states.

Legislation was introduced in many other states that related directly to efforts to increase the number of primary care providers as well as other types of providers in those states, including:

- Legislation in Oklahoma (SB1613), which proposed an increase in the number of graduate physicians in rural or medically underserved areas.
- HB1175, introduced in Indiana, would have established the medical school loan forgiveness fund for the purpose of attracting physicians to practice medicine in the state.
- Legislation introduced in Massachusetts (S781/H1245) would have established a primary care workforce development and loan forgiveness grant program at community health centers to enhance recruitment and retention of primary care physicians.
- Legislation introduced in New Jersey (A2801/S780) would have extended eligibility for the state's existing Primary Care Practitioner Loan Redemption Program.
- Legislation in Rhode Island (HB7903) would have established the Medical Primary Care Scholarship Program, which would have awarded a maximum award of $70,000 scholarships each year for four years to medical students and $47,000 scholarships each year for two years to nurse practitioners and physician assistant students who agreed to provide at least eight years of primary care in the state after graduation.
- Legislation introduced in South Carolina (S847) would have included primary care providers who work in a Medically Underserved Area as part of their Healthcare Professional Loan Forgiveness program.
- Legislation introduced in Maine (LD1797) included provisions to expand their state's health care workforce that support rural primary care clinical rotations.
- Legislation introduced in Massachusetts (S750), titled Primary Care 4 You, would have established a state-managed primary care trust that would have fundamentally changed the payment structure for commercially-insured primary care in the state for participating providers, shifting from fee-for-service to prospective monthly payments, doubling investment to 15% of total health care spending, and removing cost-sharing for patients.

Other notable proposed legislation related to tackling the primary care workforce crisis included:

- Legislation introduced in Rhode Island (SB2716/HB7902) to establish a program within the Department of Health focused on primary care training for health care workers.
- Legislation introduced in Illinois (SB3486) requiring the Department of Healthcare and Family Services to enter into managed care contracts with safety net providers to expand access to health care services.
- Legislation introduced in Massachusetts (S798/H1170) to increase reimbursement rates to acute care hospitals for graduate medical education training in primary care, among other specialties.
- Legislation introduced in New Mexico (SB47) to create a health care recruitment and retention fund in the state treasury to provide for programs that recruit and retain health care personnel, including primary care providers, in rural communities and other underserved areas.
- Legislation introduced in West Virginia (HB4768) to increase the number of out-of-state medical students receiving in-state tuition rates who agree to practice for a specific time in a medically underserved area and in a primary care or specialty practice or field in which there is a shortage of physicians.
- Legislation introduced in New Jersey (A2992) to encourage medical students to enter primary care by allowing income tax deductions totaling $300,000 over five years for certain primary care physicians.

Grants & Tax Credits

Various states worked to expand primary care access through grant programs. These programs included support for telehealth services and renovations of FQHCs. Mississippi (HB760) passed legislation extending a grant program for health centers that increases access to services for the uninsured and provides a salary supplement to primary care physicians. Texas (SB2193) passed legislation creating a grant program for FQHCs to provide greater access to primary care services.

Finally, legislation was introduced in California (AB2726) to expand telehealth services by establishing a grant program to build out technology infrastructure and provide technical assistance to support primary care coordination.

IV. Conclusion

State and federal policymakers have begun to recognize that without access to high-quality primary care, communities are less healthy, health care is less equitable, and health care costs will continue to rise. As more states enact policies shifting resources towards primary care, including those aimed at recruiting primary care providers into the field and retaining those who are already in it, PCDC anticipates that health outcomes will improve and become more equitable across communities. With better access to primary care and improved health outcome across communities, ultimately, health care costs—particularly for preventable emergency department visits and hospitalizations—will be reduced. PCDC encourages state lawmakers to consider the policies included in this report as potential options for improving access to primary care in their own states.

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