

NATIONAL CONFERENCE
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Primary Care Workforce

Health Care Safety-Net Toolkit for Legislators



Introduction

The primary care workforce delivers essential primary and preventive health care to a population that is increasingly demanding these services. Access to appropriate primary care services is important to maintaining and improving health. Those who obtain regular primary care receive more preventive services, are more likely to comply with their prescribed treatments, and have lower rates of illness and premature death, according to research.¹ Effective primary care is comprehensive, coordinated, timely, and patient-centered and can result in better health for the patient, fewer avoidable hospitalizations and emergency room visits and lower costs.

Despite the benefits of a high-quality primary care system, the reality is that today's primary care workforce is struggling to meet current demand for services—and the unmet needs are expected to intensify as a result of demographic changes, coverage expansions due to the Affordable Care Act (ACA), and a decline in the primary care physician workforce. At the same time, reforms and quality improvements, such as health information tech-

nology adaptation, provide new challenges for the existing workforce.

This primer provides an overview of the issues and challenges facing the primary care workforce. It also contains policy options and actions that states have adopted to address gaps and strengthen the primary care workforce's capacity to meet the growing demand for services.

“Primary care is a foundational element of the U.S. health care system and is required to meet our Nation's triple aims of improving quality, containing costs, and improving patient and family experience.”

—Agency for Healthcare Research and Quality

At a Glance: What Legislators Need to Know

What is primary care and why is it important?

The Institute of Medicine defines primary care as “The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”²

As a first contact with patients, primary care refers to the long-term, comprehensive, coordinated and patient-centered care delivered by a primary healthcare provider. Access to primary care “is associated with more timely care, better preventive care, avoiding unnecessary care, improved costs, and lower mortality.”³

Who provides primary care services?

Primary care providers (PCPs) include physicians, Advance Practice Registered Nurses (APRNs) such as nurse practitioners, and physician assistants in family medicine, general internal medicine and general pediatrics. Other health care professionals—such as pharmacists, dentists, dietitians/nutritionists, certified nurse midwives, and social workers—deliver or help to deliver primary care services.

How and why do state legislators address primary care workforce policy?

State legislators address the primary care workforce in various ways that are discussed in greater detail in this primer. Examples include regulating and licensing health professions, analyzing and requiring data collection on workforce supply and distribution, identifying shortage areas and resource gaps, establishing loan repayment programs and other incentives to encourage practice in underserved areas, defining the services a provider can

deliver, and establishing reimbursement policies (e.g., enhanced Medicaid reimbursement for primary care services).

Legislators adopt workforce policies and engage in workforce planning to ensure an adequate supply and geographic distribution of primary care providers in their state so that their constituents have access to high-quality primary care services, regardless of where they live. A competent and sufficient primary care workforce offers important public health benefits and cost savings.

What is a shortage area, why is it important, and how is it determined?

Research and policy discussions about the primary care workforce frequently cite the challenge of workforce shortages and poor distribution throughout the country—and specifically the mismatch between the need for primary care workers to provide adequate access to essential health care services and the availability of staff to meet those needs. The U.S. Health Resources and Services Administration (HRSA) develops shortage designation criteria to determine if a geographic area, population or facility is a Health Professional Shortage Area (HPSA) or Medically Underserved Area or Population (MUA/MUP).⁴

HPSA designation is used to determine eligibility for certain federal workforce programs and policies, such as National Health Service Corps, the J-1 Visa Program and the Medicare Physician Bonus program. While the programs vary in terms of eligible providers, they share in common a focus on attracting primary care physicians to or retaining them in underserved areas.



Primary Care Workforce Issues and Challenges

The demand for primary care services is rapidly outpacing the supply of providers able to deliver these services. More than 64 million Americans currently live in areas designated by the Health Resources and Services Administration as having shortages of primary care professionals.⁵

Estimates of the scope of the provider shortage vary, but it is generally agreed upon that thousands of additional primary care providers are needed to meet the current demand. During the coming decade, tens of thousands of additional primary care providers will be needed to meet increasing demands. Rural and underserved communities are especially hard-hit by the shortage of primary care physicians. Only 11 percent of the nation's physicians work in rural areas, although nearly 19 percent of Americans live there.⁶

With passage of the Affordable Care Act, the Congressional Budget Office estimated in 2012 that between 30 and 33 million additional Americans could have access to insurance coverage in 2016 and subsequent years.⁷ Starting in 2014, millions of the newly insured will be more able to seek medical care in a primary care setting, placing an even greater strain on the primary care workforce. Increased federal investments in community health centers and patient-centered medical homes will offer enhanced access to primary care services. At the same time, however, these new primary care settings will require more primary care providers to deliver and coordinate care.

Despite the growing needs, there are not enough primary care physicians and other primary care providers to fill the gaps. Primary care physicians in particular are aging—one-quarter are nearing

retirement age—and not enough medical students and new physicians exist to replace them, let alone meet the increasing demand for additional providers. Although the number of medical students choosing primary care rather than a specialty has increased in the past four years, it is not enough to meet the current and future demand for primary care. In addition, existing primary care physicians are retiring or leaving for opportunities in other fields. According to a March 2013 article in the journal *Family Medicine*, “Accessible, high-quality, cost-effective health care systems are anchored in primary care, yet decreasing production of graduate medical education (GME) jeopardizes the primary care workforce and the nation's health.”⁸ A number of factors contribute to the selection of primary care training by medical students, including the perceptions that those in practice have heavy workloads, poor quality of work life, and lower comparative income relative to specialty care.

Solutions: Federal and State Policies and Actions

To reverse these trends, federal and state policymakers have adopted policies and programs—including payment reforms, expanded use of non-physician providers, and expanded training opportunities—to increase the numbers and practice locations of primary care providers to respond to changing population needs. In addition to bolstering the workforce, systemic changes—such as strengthening community health centers and other models that focus on primary care—emphasize the importance of primary care in the overall health care system. This section summarizes some key federal and state resources and actions that can help to meet the needs for more primary care services.

Federal Resources

Federal workforce funds provide a wide range of support and assistance to develop the primary care workforce and ensure that people have access to primary care professionals. In addition to scholarships and loan repayment programs for providers who practice in underserved areas, federal initiatives support primary care infrastructure and delivery in many ways—from funding streamlined pathways to becoming a primary care doctor to diversity programs to enhancing national and state-level workforce data and analysis capabilities (see Appendix: Federal Primary Care Workforce Resources and Programs).

Affordable Care Act Investments

The ACA requires the federal government to invest resources in strengthening the primary care workforce and its capacity to provide essential services. Primary care funding from the American Recovery and Reinvestment Act of 2009 and other federal programs and initiatives support primary care workforce developments that expand primary care education and training programs, provide financial incentives for primary care training and practice, and invest in delivery models (e.g., Medicaid “health homes”) that emphasize the importance of primary care and prevention of chronic diseases.

In 2010, the U.S. Department of Health and Human Services (HHS) announced the availability of \$320 million in grants aimed at improving and expanding the primary care workforce and providing education, training and support for low-income people who want to pursue a career in health professions.⁹

Combined with earlier funding through the American Recovery and Reinvestment Act, the ACA will support the training and placement of

more than 16,000 new primary care providers over five years.¹⁰

The act re-authorizes existing workforce training programs and invests in public health infrastructure, programs and state-level workforce analysis and planning. The Prevention and Public Health Fund expands the supply of primary care providers through additional primary care residency slots, and increases the number of training opportunities for physician assistants and nurse practitioners. In addition, the fund supports state workforce analysis and strategic planning to help states expand their primary care workforce by 10 percent to 25 percent over 10 years.

The Affordable Care Act also established the Center for Medicare and Medicaid Innovation (CMMI), to promote and test “innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care” provided to Medicare, Medicaid or Children’s Health Insurance Program (CHIP) beneficiaries.¹¹

Among CMMI’s priorities are projects that promote new models of workforce development and deployment.

- CMMI’s Health Care Innovation Awards fund up to \$1 billion to organizations that are implementing innovative ideas to deliver better health, improve care and lower costs for Medicare, Medicaid or CHIP enrollees. Funding supports models that emphasize the development or deployment of health care workers in innovative ways.
- Another CMMI initiative, the State Innovation Models Initiative, provides up to \$300 million to support state-based models for

multi-payer payment and delivery system transformation. Many of the state-based innovations seek to expand the supply and improve the distribution of primary care physicians and other professionals.

The ACA supports systemic reforms that emphasize and fund models of primary care delivery,

including primary care delivery and coordination through medical homes and community health centers. The law increases funding for health centers and supports the development of Accountable Care Organizations (ACOs), groups of physicians, hospitals and other health care providers who work together to provide high-quality, coordinated care.

Case Study: Community Health Centers Reduce Disparities, Improve Health Outcomes

Community health centers provided preventive and primary care services to more than 21 million patients in 2012, particularly those in “safety-net” populations.¹² Health center patients are more likely to be poor, uninsured or publicly insured, and a member of a racial or ethnic minority group.¹³ Compared with those seeking care in other health care settings, health center patients are more likely to suffer common chronic conditions, such as depression, diabetes, asthma and hypertension, and the percentage of chronically ill patients is growing rapidly. Between 2000 and 2010, the percentage of health center patients with diabetes and hypertension increased by 154 percent and 147 percent, respectively.¹⁴

Despite the challenges of providing care to a population that is both sicker and poorer than the overall population, health centers offer improved access to high-quality primary care, successfully reduce health disparities and achieve improved health outcomes for their patients.^{15,16} The community health center model offers a consistent source of health care to patients, as well as access to recommended preventive and primary care education and services. Compared to the uninsured who do not use a health center, health center uninsured patients are twice as likely to receive the care they need instead of delaying care because of cost or other reasons—which can mean less impact from severe illness and less costly care in the long run.¹⁷ Health centers provide more preventive care services—e.g., asthma education and immunizations for adults over age 65—for their patients than primary care providers in other settings. They also have reduced disparities in access to mammograms, pap tests and colorectal cancer screening.¹⁸ Health centers reduced disparities in access to colorectal cancer screening for Medicaid enrollees and the uninsured by 14 percent, for example, which both improves patient lives and reduces costs.¹⁹

State Policies and Actions

State policymakers seek to strengthen the primary care workforce through a wide range of strategies, including targeted recruitment and retention strategies (e.g., payment incentives for practice in underserved areas), enhanced workforce data and analysis to support effective policies, and a redefinition of the scope and standards of practice for non-physician practitioners.

Recruitment and Retention of Primary Care Providers

States offer financial incentives to encourage health professions students to pursue a career in primary care and remain in that discipline after their training to practice medicine. These strategies often are intended to help offset the significant salary differential for providers who work in primary care instead of in specialty areas. Financial incentives include scholarships, tuition assistance, loan repayment and other incentives (e.g., tax credits) for providers who agree to practice in medically underserved areas. Some examples of state recruitment strategies follow.

- **Alaska's** Supporting Health Care Access through Loan Repayment Program (SHARP), created in 2010, repays educational loans for practitioners who agree to work in designated Health Professional Shortage Areas. The program is funded by a federal HRSA grant, a 50 percent match from the Alaska Mental Health Trust Authority and three community health centers.
- **California** recruits providers to community health centers through the Student/Resident Experiences and Rotations in Community Health (SEARCH) program, which allows health centers to serve as teaching and training centers for medical students and residents.

- The **Mississippi** Rural Physicians Scholarship Program, created by the Legislature in 2007, provides financial support and mentoring opportunities for rural students who wish to practice medicine in their home areas.

Several states support workforce initiatives aimed at exposing middle and high school students to primary care careers. For example, Colorado's Recruiting and Retaining Youth of Color task force provides technical assistance to programs and organizations that assist youth of color who are interested in health professions. Other strategies for expanding the primary care workforce pipeline include providing training and career pathways for allied health professionals and supporting initiatives that use alternative health care providers—including community health workers—to provide outreach and guidance and link patients to primary care providers and services.

Payment Reform

States are implementing federal and state payment policies that increase reimbursement for primary care providers and care coordination services. As an incentive to support primary care providers who accept Medicaid enrollees, the ACA provides increased payments for certain Medicaid primary care services provided by qualified primary care providers. The increase is fully funded by the federal government for two years—in 2013 and 2014—and is 90 percent funded thereafter.²⁰ States are responsible for implementing this pay increase, which has been challenging, leading to delays.

Other state strategies encourage high-value care through coordinated care models, such as patient-centered medical homes (also sometimes called health homes). The medical home model provides comprehensive, patient-centered preventive and

primary care through a team of providers and across health care settings. Among other benefits, the medical home helps smooth the transition between health care settings (such as hospital to home) and reduce hospital readmissions. By coordinating care and services among a patient's care team, health homes not only offer an important tool for improving care and results, but also reduce costs related to poor coordination and lack of communication among disparate providers. As of April 2013, policies in 43 states promote the medical home model for certain Medicaid or Children's Health Insurance Program beneficiaries.²¹

States also are adopting payment policies that offer incentives for quality and efficiency and/or disincentives for ineffective care or uncontrolled costs. Rather than paying providers for individual services or procedures, bundled payments provide a single payment for all services—e.g., tests, office visits and hospitalizations—associated with an episode of care. By bundling payments into one episode-based payment, providers have incentives to provide efficient and appropriate services, coordinate care among all health care providers, and achieve positive health outcomes. The Arkansas Medicaid Payment Improvement Initiative, for example, offers episode-based payments for certain medical conditions, such as upper respiratory infections, perinatal care and congestive heart failure.

Workforce Analysis and Planning

States invest in workforce data collection, analysis and strategic planning to support effective workforce initiatives and policies. Systematic planning and analysis helps state officials and policymakers measure and analyze the current and projected supply of health professionals across the state and identify current and future shortage areas. In

2010, for example, the Virginia legislature established the Virginia Health Workforce Development Authority to collaborate with the Department of Health Professions Healthcare Workforce Data Center and other state workforce initiatives to “facilitate the development of a statewide health professions pipeline that identifies, educates, recruits and retains a diverse, geographically distributed and culturally competent quality workforce for all Virginians.”²² The authority provides a clearinghouse of information about health professions education and training, workforce data, grants and scholarships.

The ACA supports state workforce analysis and strategic planning through State Health Workforce Development Grants, which help states gather and analyze workforce data, examine current resources and practices, identify approaches for removing state and local barriers to primary care and develop and implement plans for addressing workforce needs.

- **Maryland's** 2011 report, “Preparing Maryland's Workforce for Health Reform: Health Care 2020” identifies short- and long-term strategies for developing the state's workforce capacity to meet the increasing demand for primary care. The plan recommends support for non-traditional pathways to primary care, as well as other methods for supporting the pipeline of primary care providers (e.g., using graduate medical education payments for community-based primary care training).
- To meet the demand for primary care services, **Ohio's** Primary Care Workforce Plan recommends development of a statewide primary care workforce data system and widespread adoption of patient-centered medical homes, among other strategies.

- *Colorado's* strategic plan recommends, among other things, creating a clinical placement clearinghouse to support its recruitment objectives.

Scope of Practice

One approach to meeting the increased demand for primary care under consideration in many state legislatures is a redefinition, and often expansion, of the scope and standards of practice for non-physician practitioners. A recent survey found that 41 percent of rural Medicare beneficiaries saw a physician assistant or nurse practitioner for all (17 percent) or some (24 percent) of their primary care in 2012.²³

Many states have taken steps to increase the procedures, treatments, actions, processes and authority that are permitted by law, regulation and licensure for non-physician primary care providers. Some examples follow.

- Physician assistants may prescribe medication in all 50 states, and according to the National Association of Boards of Pharmacy, 40 states have given physician assistants varying degrees of authority to dispense patient medications.
- All 50 states pay for medical services provided by physician assistants under the supervision of a physician through Medicaid fee-for-service or Medicaid managed care programs.²⁴
- Fifteen states allow nurse practitioners to diagnose, treat and prescribe medications without physician supervision. Another eight states allow nurse practitioners to independently diagnose and treat patients, but not to prescribe medications. The remaining 27 states require either direct or indirect physician supervision of nurse practitioners to diagnose, treat and prescribe.

What Is Scope of Practice?

Scope of practice is a term used to describe the procedures, treatments, actions, processes and authority that are permitted by law, regulation and licensure for a health professional. A professional's scope of practice is limited to that which law or regulation allows and is often based on the education, training and experience typical for that profession. Scope of practice regulations vary by state.

It can be challenging to find an appropriate balance between expanding scopes of practice for non-physician practitioners while ensuring patient safety, quality of care and provider accountability.

Investing in Residency and Training Programs

Federal Medicare payments to hospitals provide the great majority of the funding for graduate medical education or residency programs. Despite the growing need to expand residency slots, Medicare funding has been capped as a result of the Balanced Budget Act of 1997, which limited the number of available national residency slots to 1996 levels. Other funding sources for graduate medical education include Medicaid, hospital revenues and state appropriations.

The ACA requires the Centers for Medicare and Medicaid Services to redistribute certain residency slots that were not used during a three-year period into primary care and general surgery positions. The federal law also established a new five-year program, administered by HRSA, that provides \$230 million to reimburse qualified teaching health centers—community-based, ambulatory patient care centers that operate a primary care residency program, such as community health centers, rural health clinics, community mental health centers and health centers operated by the Indian Health Service—for direct and indirect costs of training residents.²⁵

Many states have developed successful community-based opportunities that promote primary care education and training. Research shows that residents trained in community-based settings are more likely to practice in underserved communities.²⁶ Some examples follow.

- **North Carolina's** Area Health Education Centers (AHECs) have focused on providing more community-based training opportunities through expanded primary care residency programs. Historically, these programs have had very high rates of retention of trainees (53 percent) for practice within the state after graduation.²⁷
- The **California** Office of Statewide Health Planning and Development awarded more than \$300,000 to University of California Davis training programs, which include funding for the Family and Community Medicine Residency Program and the Family Nurse Practitioner and Physician Assistant Program.
- In 2013, **Wisconsin** Governor Scott Walker announced \$1.75 million in state funding for additional family medicine residency slots, as well as \$7.4 million in general purpose revenue bonding to support a Community

Medical Education Program Initiative that includes two new campuses. In addition, state funds support the Wisconsin Academy for Rural Medicine and Training in Urban Medicine and Public Health programs that seek to increase the number of students who want to practice in underserved rural and urban areas, respectively. In addition, \$1 million in state funds will support grants to hospitals to help offset the costs of medical residencies in family medicine, internal medicine and other key areas.²⁸

- Created through an executive order in 1987 and re-authorized in 2007, the **New York** State Council on Graduate Medical Education provides advice to the governor and commissioner of health on state medical education and training policies. The council addresses several issues, including the composition, supply and distribution of residency programs and fellowship training, as well as state efforts to increase under-represented minorities in medicine and to increase and improve physician training for those who will serve as residents and practitioners in underserved areas.

Conclusion

Despite the daunting challenge of developing the primary care workforce, federal and state initiatives have demonstrated that a multi-faceted approach can address the various dimensions of the primary care workforce problem. These include enhanced payment and other financial incentives, increased training opportunities, expanded primary care infrastructure and scope of practice changes to increase efficiencies within the current workforce.

Anticipating a nationwide primary care workforce shortage, the ACA included many provisions

intended to strengthen the current primary workforce and to build the future workforce. Many provisions will be implemented by stakeholders within the states, and policymakers will play a key role in securing the future health workforce for their state. Many provisions in the act are aimed at health care centers and academic institutions. By leveraging federal resources with state resources for more effective projects, convening stakeholders, and working with their medical schools, legislators can play an important role in developing a high quality, adequate primary care workforce.

For More Information: Primary Care Workforce Resources

NCSL, Primary Care Workforce resources

<http://www.ncsl.org/issues-research/health/primary-care-workforce.aspx>

NCSL Rural Health Issues and Research, <http://www.ncsl.org/issues-research/health/closing-the-gaps-in-the-rural-primary-care-workfor.aspx>

Agency for Healthcare Research and Quality (AHRQ), Primary Care Workforce resources, <http://www.ahrq.gov/research/findings/factsheets/primary/pcworkforce/index.html>

AHRQ, Distribution of Primary Care Workforce, <http://www.ahrq.gov/research/findings/factsheets/primary/pcwork3/pcwork3.pdf>

HRSA, Health Center Program, <http://bphc.hrsa.gov/>

HRSA, Bureau of Health Professions, <http://bhpr.hrsa.gov/>

HRSA, Health Data Warehouse, <http://datawarehouse.hrsa.gov/bhpr.aspx>

HRSA, National Center for Health Workforce Analysis, <http://bhpr.hrsa.gov/healthworkforce/index.html>

National Health Policy Forum, “Health Care Shortage Designations,” June 2010, http://www.nhpf.org/library/background-papers/bp75_hpsa-mua_06-04-2010.pdf



Appendix. Federal Primary Care Workforce Resources and Programs

Resource or Program	Description
Community Health Centers	The Health Resources and Services Administration’s (HRSA) Bureau of Primary Health Care’s Health Center Program provides grants to support more than 1,100 community health centers operating in over 8,500 service delivery sites throughout the country. Health centers were the primary care medical home for more than 20 million people nationwide in 2011. Health centers employ a multi-disciplinary workforce, including more than 9,900 physicians, 6,900 nurse practitioners, physician assistants and certified nurse midwives. ²⁹
National Health Service Corps	The National Health Service Corps (NHSC), administered by HRSA’s Bureau of Clinician Recruitment and Service, offers loan repayment and scholarships to eligible primary care providers and students that agree to practice a minimum of two years at an approved NHSC site in a health professional shortage area. Over 40,000 primary care medical, dental, and mental and behavioral health providers have practiced in underserved areas since the program’s inception in 1972.
Primary Care and Rural Health Offices	HRSA’s Office of Rural Health Policy funds state-based primary care offices to perform various primary care functions, including workforce assessments and designations, developing NHSC sites and placing NHSC clinicians, providing technical assistance and managing state workforce programs, such as the J-1 Visa Waiver Program for Physicians. ³⁰ State offices of rural health represent a federal-state partnership to support a wide range of rural health activities.
State Loan Repayment Programs	The State Loan Repayment Program is a grant program that helps states recruit and retain primary care providers in federally designated shortage areas. HRSA’s state loan repayment program offers cost-sharing grants to more than 30 states to operate their own loan repayment programs. ³¹ The program requires matching funds from non-federal sources, which can include state funding or donations from public or private entities and administration by a state agency. Not every state administers a state loan repayment program.*
Other Pipeline Programs	<p>HRSA’s Bureau of Health Professions (BHP) administers multiple programs aimed at collecting and analyzing workforce data, providing financial assistance, supporting primary care training programs, and expanding the primary care pipeline. Some examples of BHP resources include:</p> <ul style="list-style-type: none"> • The National Center for Health Workforce Analysis gathers and analyzes national and state-level data, develops tools for projecting workforce supply and demand, and evaluates workforce programs and policies. • Established in the Affordable Care Act, the Teaching Health Center Graduate Medical Education Program is a five-year, \$230 million initiative to expand the number of primary care residents and dentists trained in community-based, ambulatory care settings. Grants to eligible programs support direct and indirect expenses associated with training residents. • The Area Health Education Centers program makes grants to schools of medicine or schools of nursing to: provide education and training in underserved areas; provide continuing education; and expose youth from medically underserved areas and under-represented racial and ethnic groups to health care professions. • Financial assistance programs include scholarships and low-interest loans for disadvantaged students to pursue degrees in certain high-need health professions. • Diversity and pipeline programs aim to increase exposure to careers in the health professions, and academic and stipend support for under-represented students. The Centers of Excellence program provides grants to health professions schools to increase opportunities for minority students to enter and complete a health professions program.
CMS Innovation Grants	The Centers for Medicare and Medicaid Services’ Innovation Center develops payment and service delivery models, including primary care transformation demonstration projects and state multi-payer payment and delivery innovation models.
*To see if your state administers an SLRP, visit http://nhsc.hrsa.gov/loanrepayment/stateloanrepaymentprogram/index.html .	

Notes

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This brief was written by .

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