

Addressing Persistent Workforce Shortages in Massachusetts Community Health Centers: Recruitment, Retention, and Statewide Investment

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Executive Summary

Across the Commonwealth of Massachusetts, community health centers (CHCs) play a crucial role in delivering equitable and high-quality healthcare to diverse populations of state residents. Though CHCs serve patients of all backgrounds, they fill a particularly vital niche in rural communities and Massachusetts' gateway cities, both of which often face a compounding dearth of adequate healthcare providers and an outsized burden of disease. Despite their necessity, Massachusetts CHCs are the most likely of all evaluated healthcare provider types statewide to be short-staffed, lacking adequate supplies of physicians, nurses, physician assistants, and other allied health professionals.

Massachusetts CHC staffing challenges are driven by difficulties with both workforce recruitment and workforce retention. In many cases, the final practice locations chosen by healthcare workers are heavily affected by the environments in which they were trained, which, given the lack of available training opportunities at CHCs and in rural communities and Gateway Cities more broadly, means that relatively fewer practitioners choose to practice at CHCs and in otherwise medically underserved areas. Additionally, the financial challenges that CHCs face, which are driven by both their significant reliance on Medicaid for reimbursement and high proportion of uninsured patients, mean that CHCs struggle to provide their staff with competitive salaries and benefits, particularly in locations with high costs of living, inhibiting their capacity to recruit and retain sufficient workforce. Finally, due to their relatively ill patient population, high patient-to-staff ratios, and significant administrative burden, many CHCs fail to retain healthcare practitioners.

Although both the Commonwealth of Massachusetts and various state-wide CHCs have begun implementing a range of approaches to address their workforce shortages, further policy development is necessary. The Massachusetts legislature must lead efforts to address CHC workforce shortages, amending and enacting a range of previously introduced bills to drive further investment in CHC workforce retention and recruitment, while developing novel statutory approaches to support CHCs, including through novel practitioner tax credits and a pathway to associate physician licensure. In tandem, a range of other state executive agencies, led primarily by the Executive Office of Health and Human Services, should utilize their regulatory authority to improve, reinstate, and expand programs benefiting CHCs. Finally, the Massachusetts League of Community Health Centers must further strengthen its relationship with the state, leveraging existing programs to support the growth and improvement of individual CHCs statewide. Together, this multi-pronged policy approach represents a promising step in advancing long-term sustainable staffing at CHCs across Massachusetts, a key aspect of advancing the objectives of equitable health access and outcomes for residents.

Background Information

Community Health Centers

Since their formation and development in the 1960s, community health centers (CHCs) have provided equitable and high-quality primary care to residents of their local communities nationwide, regardless of socioeconomic and insurance statuses. In the state of Massachusetts, there are currently 52 CHCs providing essential health services to more than one million residents of the state.[1] During the COVID-19 pandemic, one of the most devastating health crises in recent history, Massachusetts' CHCs were crucial in the state's recovery, distributing more than one million COVID tests and 737,000 kits and administering over one million vaccine doses for vulnerable populations across the state.[2]

Financial Challenges of Community Health Centers

Many CHCs face unique challenges in funding their operations, centered on two characteristics of the patient populations they serve: first, many of the patients CHCs treat are medically uninsured, meaning that the care delivered to these patients often goes uncompensated, and second, many of the insured patients are insured via Medicaid, which has relatively low per-procedure reimbursement rates.[3] The distribution of payer sources at CHCs stands in stark contrast to that of private hospitals, which receive 37% of their compensation from private insurance, 19% from Medicaid, and 25% from Medicare.[4]

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[1] Shelto, Audrey, "There are 52 community health centers in Mass.; What you should know about these 'unsung heroes,'" *MassLive*, July 21, 2023, https://www.masslive.com/opinion/2023/07/there-are-52-community-health-centers-in-mass-what-you-should-know-about-these-unsung-heroes.html.

[2] Shelto, "There are 52 community health centers in Mass.; What you should know about these 'unsung heroes.'"

[3] Federman, Sara, Alexandra Bryan, Celli Horstman, and Corinne Lewis, "Community Health Centers Are Serving More Patients Than Ever, but Financial Challenges Loom Large," *Commonwealth Fund*, November 13, 2024, https://doi.org/10.26099/TQ9Q-1N30.

[4] "Key Facts About Hospitals: National Hospital Spending – Spending by Payer," KFF, accessed June 24, 2025, https://www.kff.org/key-facts-about-hospitals/?entry=national-hospital-spending-spending-by-payer.

To fill expense gaps left by reduced rates of reimbursement and per-procedure reimbursement rates, Massachusetts CHCs are eligible for Federal Health Resources and Services Administration Section 330 grants that allow sliding-scale fees, care coordination, and other services. However, despite federal support, Massachusetts CHCs continue to find themselves increasingly financially strained.[5]

Workforce Shortages at Community Health Centers

As healthcare workforce shortages negatively affect outcomes in health care settings across the country, Massachusetts' CHCs are at the frontline of this crisis.[6] In 2024, over 70% of CHCs nationwide faced shortages of primary care physicians, nurses, or mental health professionals.[7] Quality of patient care has suffered as a result of this. Among 10 surveyed healthcare settings, including public and private hospitals, CHCs were most likely to report increased wait times, with 72% of them reporting an increased waiting period in the past 12 months. In 2023, CHCs identified low pay and burnout as top staffing challenges. Over 80% had to ask staff to work extra hours, fueling a cycle of overwork, burnout, and turnover; such a practice of constant hiring and retraining disrupts team-based care. Physician, physician assistant (PA), and nurse vacancy rates at CHCs are 16–17%, and for the first time, nurse practitioners

[5] Federman, Sara, Alexandra Bryan, Celli Horstman, and Corinne Lewis. 2024. "Community Health Centers Are Serving More Patients than Ever, but Financial Challenges Loom Large." Commonwealthfund.org, November. https://doi.org/10.26099/TQ9Q-1N30.

[6] "A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action," Massachusetts Health Policy Comission, January, 2025, https://masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and.

[7] "NEW SURVEY: Over 70 Percent of Community Health Centers Face Critical Staff Shortages amid Rising Demand for Care and Limited Resources," Commonwealth Fund, August 8, 2024, https://www.commonwealthfund.org/press-release/2024/new-survey-over-70- percent-community-health-centers-face-critical-staff.

and PAs now outnumber physicians as CHC employees.[8] Additionally, 26% of CHCs reported limiting new intakes as a result of staffing shortages.[9]

In CHC settings, it remains extremely difficult to remedy this issue; the Massachusetts Health Care and Human Services Workforce Survey found that nearly 70% of CHCs reported shortages of eligible applicants as a challenge to the recruitment of RNs, and 38% cited their inability to provide a competitive salary as an additional barrier.[10] Further, 40% of Massachusetts CHC respondents said that burnout posed a challenge to the retention of RNs, and another 60% said the same of non-competitive salary/benefits.[11]

The hiring challenges faced by CHCs are a consequence of broader challenges in primary care funding. Massachusetts' health care system, which emphasizes specialty care, has a low relative share of physicians working in primary care (1 in 7). This crisis of primary care leads 41% ofMassachusettsresidents to report that they had difficulty accessing care, with the most cited reason being an inability to get an appointment. This lack of accessibility also contributes to 1 in 4Massachusettsresidents living in low-income communities having spent no money on primary care in the last year.[12] As fewer people receive preventative care, more patients require emergency care. In 2023, 36.2% ofMassachusettsresidents who visited an ER in the past year said their diagnosis could have been treated by a general practitioner had one been available.[13]

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[8] "A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action." A Special Report on Primary Care Workforce, Access, and Spending Trends, Massachusetts Health Policy Commission, January 2025. https://masshpc.gov/sites/default/files/HPC%20Chartpack_A%20Dire%20Diagnosis%20-%20The%20Declining%20Health%20of%20Primary%20Care%20in%20MA_0.pdf.

[9] Commonwealth Fund, "NEW SURVEY: Over 70 Percent of Community Health Centers Face Critical Staff Shortages amid Rising Demand for Care and Limited Resources."

[10] Commission on Status of Persons With Disabilities, 2025, "Massachusetts Health Care and Human Services Workforce Survey," Center for Health Information and Analysis, February 13, 2025, https://www.mass.gov/doc/ma-health-care-and-human-services-workforce- survey-presentation-from-the-center-of-health-information-and-analysis-chia-0/download.

[11] Commission on Status of Persons With Disabilities, "Massachusetts Health Care and Human Services Workforce Survey"

[12] "A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action." Massachusetts Health Policy Commission.

[13] "A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action." Massachusetts Health Policy Commission.

This challenge persists because it remains hard to recruit and retain healthcare professionals in both primary care and CHC settings. Both fields face a high administrative burden that leads 81% ofMassachusetts physicians to state that increasing documentation requirements decreased the quality of their job. Additionally, CHCs are uniquely burdened by a relatively low reimbursement rate because they are primarily funded through Medicaid, which has lower reimbursements than private insurance or Medicare.[14] CHCs are therefore less able to provide competitive salaries to healthcare workers, making it harder to recruit and retain professionals. Unsurprisingly, healthcare providers in CHC settings report higher rates of burnout and lower job satisfaction. Massachusetts has already implemented multiple strategies to address workplace shortages in rural CHCs. Among these are the National Recruitment and Retention Network (3RNet) which recruits physicians and healthcare professionals to serve rural communities placing particular emphasis on community based recruitment initiatives, the Massachusetts Loan Repayment program which provides loan repayment as an incentive to work in rural areas in MA, and the J-1 Visa waiver program that approves requests for visiting physicians by centers that have a "history of serving the state's medically underserved populations."[15]

Wait Times at Community Health Centers

Across the state, due to these financial challenges, CHC patient care has suffered, with the Massachusetts League of Community Health Centers (MLCHC) finding that new patients are waiting an average of nearly 80 days to see primary care providers, while existing patients wait

[14] Commonwealth Fund, "NEW SURVEY: Over 70 Percent of Community Health Centers Face Critical Staff Shortages amid Rising Demand for Care and Limited Resources."

[15] "Rural Healthcare Workforce Programs," 2025, Mass.gov, 2025, https://www.mass.gov/info -details/rural-healthcare-workforce-programs.

an average of 44 days for routine exams.[16] In addition, 74% ofMassachusettsCHCs have a waitlist for primary care services, 84% ofMassachusettsCHCs have a waitlist for behavioral health services, and 82% ofMassachusettsCHCs that have a dental program have a waitlist for new dental patients.[17]

Existing Healthcare Challenges in Massachusetts

Medical Deserts: In-State and Nationwide

Western Massachusetts is disproportionately rural, disproportionately aging, and disproportionately affected by the shortage of workers. Unfortunately, the problem with understaffing in rural communities is not isolated to this state; it is nationwide. While 20 percent of the U.S. population lives in rural areas, only 10 percent of physicians practice in these communities.[18] Workforce maldistribution creates medical deserts, where access to emergency services, primary physicians, and healthcare resources is limited, and at times, unavailable. On average, rural residents must travel 17 minutes longer than urban residents to reach the nearest hospital offering definitive care, which translates to increased mortality rates. There were 23,664 Federally-identified health professional shortage areas (HPSAs) in September 2023, of which 56.67% were in rural areas and 3.83% in partially rural areas.[19] Healthcare shortages disproportionately affect rural communities, particularly when HPSAs are classified into primary

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[16] Mohammed, Zeina. "Community Health Centers Push for State Support amid Workforce Shortages." The Boston Globe, June 20, 2023. https://www.bostonglobe.com/2023/06/20/metro/community-health-centers-push-state-support-amid-workforce-shortages/.

[17] Competenow. 2024. "Survey of Community Health Centers Reveals Alarming Wait Times for Vulnerable Patients to Access Primary Care, Calls for Urgent $180 Million Funding - Massachusetts League of Community Health Centers." Massachusetts League of Community Health Centers. June 23, 2024. https://www.massleague.org/news/survey-of-community-health-centers-reveals-alarming-wait-times-for-vulnerable-patients-to-access-primary-care-calls-for-urgent-180-million-funding/.

[18] Health Resources and Services Administration. "Health Professional Shortage Areas Dashboard." Updated September 2023. Accessed July 8, 2025. https://data.hrsa.gov/topics/health-workforce/shortage-areas.

[19] "Health Professional Shortage Areas Dashboard." Health Resources and Services Administration.

care, dental, and mental health categories (the percentages constituted by rural communities were 66.32, 66.75, and 61.87, respectively).[20]

Even in the absence of disproportionate workplace shortages, the social environment and economic infrastructure are also worse in rural communities, aggravating determinants of disease and worsening public health. Economic barriers in rural areas create a positive feedback loop where poor access and economic instability reinforce each other. For example, rural workers often struggle with affordable housing, an issue aggravated by the supply shortage and aging infrastructure in these communities.[21] Nearly 1 in 5 rural renters spend more than 50 percent of their income on housing, and 20 percent of rural health care workers cited affordable housing as a significant barrier to retention.[22] To improve worker retention, we may need to resolve larger socioeconomic determinants of health that ensure the stability and quality of life in rural communities.

The limitations in staffing disrupt the productivity and accuracy of medical professionals, which is particularly disturbing in an industry where error or miscalculation carries great risk. Researchers surveyed 422 family physicians and general internists who worked in 119 ambulatory care clinics and surveyed 1,795 patients from these clinics and reviewed their medical records for information on care quality and medical errors.[23] From their examinations, they reported that a majority of physicians experienced time pressures when conducting physical examinations, and nearly a third were unsatisfied with their inability to provide enough time,

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[20] U.S. Census Bureau. New Census Data Show Differences Between Urban and Rural Populations. December 2022. Accessed July 8, 2025. https://www.census.gov/newsroom/press-releases/2022/population-changes.html.

[21] Bryan Weichelt, Kasey Delynn Shakespear, and Tianna Fallgatter, "Rural Workforce Recruitment and Retention Factors," 2025, https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/nrha-policy-brief-workforce-retention-factors-final-3-7-25.pdf.

[22] U.S. Census Bureau. 2022 American Community Survey 5-Year Estimates. Washington, DC: Census Bureau; 2022. Accessed July 8, 2025. https://www.census.gov/programs-surveys/acs/data.html.

[23] Agency for Healthcare Research and Quality, "Physician Burnout," Ahrq.gov, July 2017, https://www.ahrq.gov/prevention/clinician/ahrq-works/burnout/index.html.

suggesting that at least 50% more time ought to be allotted for patient care. Further, nearly a quarter said they needed at least 50% more time for follow-up appointments. Overall, physicians are unsatisfied with the care they are able to provide in times of staff shortage and acknowledge the compromises to patient health that result.

Disparities in Access to Healthcare in Massachusetts

The shortage of healthcare workers in rural and gateway cities in the Massachusetts community health centers has led to disparities in health outcomes. During the COVID-19 pandemic, "COVID-19 testing deserts" emerged in rural and gateway cities, as well as low-income communities of color. These "testing deserts" were classified as areas with low income and low access (at least 1 mile away for an urban region and at least 10 miles for a rural region) to a testing site.[24] The percentage of Massachusetts patients testing positive for COVID-19 was 17.2% for Hispanic patients and 11.9% for Black patients, but at a significantly smaller percentage of 5.6% for white patients.[25] The number of "testing deserts" for COVID-19 was abundant in regions of segregation: 35.3% of the "testing deserts" were regions with segregated Hispanics, and 51.3% in areas with segregated Blacks.[26] Similarly, communities of color in rural areas encountered greater rates of delayed healthcare and mental health disorders during the pandemic.[27] The limited healthcare infrastructure in place in these rural and gateway cities to combat the COVID-19 pandemic fostered a culture of burnout. In a survey of Massachusetts nurses, 33% of respondents expressed that they plan to leave the nursing profession sooner than

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[24] Caitlin E. Radford et al., "Availability versus Accessibility: Identifying COVID-19 Testing Deserts across Massachusetts," *Health Affairs* 42, no. 5 (May 1, 2023): 712–20, https://doi.org/10.1377/hlthaff.2022.00683.
[25] Radford et al., "Availability versus Accessibility," 712.
[26] Radford et al., "Availability versus Accessibility," 716.
[27] "CCIS Spotlight: Rural Communities," Mass.gov, 2025, https://www.mass.gov/info-details/ccis-spotlight-rural-communities.

expected due to pandemic-related burnout and stress. This placed greater pressure on the scarce number of healthcare workers available during the pandemic, and "testing deserts" grew in scope.

The preexisting shortage of healthcare workers decreases the pool of providers who are bilingual and able to connect to the diverse cultural perspectives of patients. Healthcare worker shortages in rural and gateway cities can persist if these providers lack linguistic and cultural competence. Since rural and gateway cities disproportionately house low-income communities of color, the divide in healthcare access is exacerbated by the various cultural, linguistic, and socioeconomic barriers in rural and gateway cities. In fact, certain racial and ethnic groups endure a lower quality of healthcare and more emergency room visits than whites.[28] The non-White population in Massachusetts has grown considerably, with the emergence of several cultural and ethnic minority groups.

Communication is critical to delivering tailored healthcare services; thus, language barriers can deter residents in underserved areas, including rural and gateway cities, from accessing the healthcare they need. Recruiting medical interpreters for in-person and telehealth services is challenging and demands additional funding.[29] For the few interpreters available, there can be long wait times and scheduling difficulties.[30]

Likewise, cultural barriers can create barriers between healthcare providers and patients. Cultural beliefs can influence healthcare trust, and ethnic groups in rural Massachusetts with these cultural beliefs may be hesitant to utilize community health centers. African Americans and

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[28] Olveen Carrasquillo and Joseph Betancourt, "Massachusetts Health Disparities: Key Lessons for the Nation," *Journal of General Internal Medicine* 25, no. 12 (October 19, 2010): 1266–67, https://doi.org/10.1007/s11606-010-1535-2.
[29] Quynh Tu, "Language Barriers and Healthcare Access," Eatrightma.org, 2024, https://blog.eatrightma.org/2022/05/31/language-barriers-and-healthcare-access/.
[30] Tu, "Language Barriers and Healthcare Access."

other ethnic groups tend to have less autonomy in healthcare decisions and lower satisfaction with the healthcare received.[31] African Americans, Asian Americans, and Latin Americans were more likely than Whites to believe they would have received better healthcare if they were of another ethnicity.[32] Healthcare providers who have their own cultural biases can have a direct impact on the quality of healthcare. Minority groups are often compared against white standards and pressured to conform to racial stereotypes. Ethnic minority groups are more likely to be uninsured and have less influence over where they choose to receive healthcare.[33] Rural communities utilize preventive health services and have lower rates of private health insurance.[34]

Socioeconomic barriers can further create health disparities, as rural communities tend to have lower incomes and experience higher instances of poverty than urban communities.[35] Poor infrastructure and environmental health can increase the likelihood of chronic disease onset.

These barriers to healthcare access brought on by worker shortages have led to a 20% higher death rate in rural regions than in urban areas.[36] Rural communities have lower life expectancies, as well as a higher likelihood of participating in poor lifestyle behaviors (e.g., Smoking and drinking).[37] From 2014 to 2016, youth living in rural areas were 50% more likely to smoke cigarettes than urban youth.[38]

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[31] Health Policy Institute, "Cultural Competence in Health Care: Is It Important for People with Chronic Conditions?," Health Policy Institute (GeorgeTown University, 2022), https://hpi.georgetown.edu/cultural/.
[32] Health Policy Institute, "Cultural Competence in Health Care."
[33] Jean Lau Chin, "Cultural Competence and Health Care in Massachusetts: Where Are We? Where Should We Be?," *ResearchGate*, no. 5 (August 1999): 1–20, https://www.researchgate.net/publication/10741477_Cultural_competence_and_health_care_in_Massachusetts_where_are_we_Where_should_we_be.
[34] Rural Health Information Hub, "Rural Health Disparities Introduction - Rural Health Information Hub," Ruralhealthinfo.org, November 28, 2022, https://www.ruralhealthinfo.org/topics/rural-health-disparities.
[35] Rural Health Information Hub, "Rural Health Disparities Introduction."
[36] Rural Health Information Hub, "Rural Health Disparities Introduction."
[37] Sally Curtin and Merianne Spencer, "Key Findings Data from the National Vital Statistics System," September 2021, https://www.cdc.gov/nchs/data/databriefs/db417.pdf.
[38] Curtin and Spencer, "Key Findings Data."

During a wave of healthcare reform, Federally Qualified Community Health Centers in Massachusetts received reimbursements for medical services provided at a faster rate. On the other hand, entities such as Boston Medical Center and Cambridge Health Alliance faced decreased funding, resulting in reduced Medicaid payments and a disproportionate share of hospital payments (DSH).[39] Reform is needed across the board to reduce the number of low-income, underrepresented communities in rural areas who are uninsured. The shortage of healthcare workers in Community Health Centers has resulted in disparities in the services provided to patients in Massachusetts' rural and gateway cities. There is not only a shortage of healthcare workers, but also a shortage of those who are culturally and linguistically competent.

The Fiscal Solvency of Massachusetts CHCs

The Fiscal Status Quo of Massachusetts CHCs

According to the National Association of Community Health Centers, over 48% of patients at Massachusetts CHCs utilize Medicaid, compared to a state-wide average of 24%.[40] This reliance, double that of the state average, creates challenges in funding CHC programs as costs have risen faster than revenue, squeezing the budgets across the state. Even though Medicare reliance is a smaller proportion of the clientele, at 12% compared to a state average of 14%, the thousands of seniors and adults still strain CHC operations. Under this financial situation, CHCs have little room to invest in improving services or recruiting staff, leading to burnout of current workers.

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[39] Catherine Myong et al., "The Impact of Funding for Federally Qualified Health Centers on Utilization and Emergency Department Visits in Massachusetts," ed. Jingjing Qian, *PLOS ONE* 15, no. 12 (December 3, 2020): e0243279, https://doi.org/10.1371/journal.pone.0243279.

[40] National Association of Community Health Centers. 2024. *Massachusetts Health Center Fact Sheet. February.* https://www.nachc.org/wp-content/uploads/2024/02/StateFactSheet_MA_2022UDS_Feb2024.pdf.

Part of the funding problem exists due to two reasons. First, public insurance programs such as Medicaid and Medicare pay below-market rates to CHCs.[41] Second, private insurance operators such as Blue Cross Blue Shield pay less to community hospitals than to comparable academic facilities.

The first part of the problem, public insurance reimbursements, is causing funding issues for CHCs, as Medicaid and Medicare only pay hospitals 75 to 90 percent of the actual treatment cost for patients. This low reimbursement rate raises issues for hospitals, as with the rising cost of labor to hire employees, the rate of reimbursements coming from public insurance providers isn't enough. The American Health Association confirms this problem, as in Massachusetts, over 60% of costs are attributable to salaries and wages, and public insurance billing to hospitals is not keeping up with the wage increases and inflation.[42] As a result, CHCs in Massachusetts face reimbursement shortfalls when treating patients. In addition, 13% of uninsured patients seek treatment at CHCs, far larger than the state average of 2%. As a result, they rely on the Massachusetts' Health Safety Net (HSN), which reimburses hospitals for uninsured patients. However, HSN faces a shortfall of $198 million and is expected to grow to more than $230 million by the end of the fiscal year. As a result, the Massachusetts House passed a $230 million transfer to the HSN account.

Medicare reliance has introduced several issues for Massachusetts CHCs, namely workplace strain. As budget shortfalls increase, CHCs are facing difficulty recruiting and retaining staff. This issue isn't unique to CHCs, as Massachusetts currently has the lowest share

[41] Thomas Lee, "Among Massachusetts Hospitals, the Gap Between Rich and Poor Widens," *The Boston Globe*, August 7, 2024, https://www.chiamass.gov/among-massachusetts-hospitals-the-gap-between-rich-and-poor-widens-the-boston-globe.
[42] Massachusetts Health & Hospital Association. "Saving the HSN, GIC Funding." *Monday Report*, May 5, 2025. https://www.mhalink.org/mondayreport/saving-the-hsn-gic-funding/.

of physicians working in primary care.[43] In an environment where few new medical school graduates are entering family medicine, CHCs are struggling to attract them as they pay lower salaries than hospitals or private hospitals. A driving cause of these patient issues can be seen through staffing shortages. Nationwide, 70% of CHCs have experienced shortages of physicians, nurses, or other specialties. It is no different in Massachusetts where Damian Archer, the chief executive officer of Outer Cape Health Services, a federally funded community health center, said that since COVID-19, staff turnover has increased and with "no affordable housing" in the area, it is "almost impossible" for new staff to find a place to live."[44]

As a result, 74% of Massachusetts CHCs have a waitlist for primary care services, 84% of Massachusetts CHCs have a waitlist for behavioral health services, and 82% of Massachusetts CHCs that have a dental program have a waitlist for new dental patients.[45] According to the Massachusetts League of Community Health Centers, existing patients must wait an average of 44 days for a routine exam, and new patients average 80 days to be seen by a primary care provider.

Community Health Centers Under Medicaid Expansion

CHCs focus on providing comprehensive, inclusive, and quality primary healthcare services to disadvantaged individuals. Though they serve those in both urban and rural areas, CHCs are most crucial to people living in rural communities, where many residents are low-

[43] Alison Kuznitz, "Mass. Health Care Regulators Recommend Fixes for Strained Primary Care System," *WBUR*, January 17, 2025, https://www.wbur.org/news/2025/01/17/primary-care-massachusetts-staff-wait-times.
[44] Berger, Ava. 2025. "Rural Community Health Centers Face Workforce, Patient Population Challenges." Boston Business Journal, January 1, 2025. https://www.bizjournals.com/boston/news/2025/01/01/rural-community-health-centers.html.
[45] Mohammed, Zeina. "Community Health Centers Push for State Support amid Workforce Shortages." The Boston Globe, June 20, 2023.

income or uninsured.[46] If individuals are insured, fall below certain income thresholds, or meet additional criteria, they are often publicly covered by Medicaid.

Following the Supreme Court's 2012 ruling in *National Federation of Independent Business v. Sebelius*, states were granted the opportunity to expand Medicaid access to those with incomes "up to 138 percent of the federal poverty level" under the Affordable Care Act.[47] Six years after this decision, thirty-two states and D.C. had expanded Medicaid access.

By expanding Medicaid eligibility, previously uninsured CHC patients gained access to primary care, specialty care, and prescription drugs. This increased demand benefits CHCs as well by raising the clinics' revenue per patient, which can then be used to hire more workers, provide higher quality services, and invest in new medical technology.[48]

While communities post-Medicaid expansion have been able to funnel their reimbursement back into hiring more physicians, nurse practitioners, physician assistants, care coordinators, and administrative staff, some staff fields actually experienced greater workforce shortages following Medicaid expansion. In a 2017 report, it was found that behavioral health services, adult dental services, and specialty services faced significant staff shortages following the increased demand brought on by newly insured patients.[49] Still, CHC workforce volume has been seen to increase overall following Medicaid expansion. However, maintaining such infrastructure changes is only possible if Medicaid funding continues, which has been threatened by congressional attacks on the ACA.

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[46] Megan B. Cole, "Medicaid Expansion And Community Health Centers: Care Quality And Service Use Increased For Rural Patients," *Health Affairs* 37, no. 6 (2018): 900-907, https://doi.org/10.1377/hlthaff.2017.1542.
[47] Cole, "Medicaid Expansion," 900.
[48] Cole, "Medicaid Expansion," 900.
[49] Jane B. Wishner and Rachel A. Burton, "How Have Providers Responded to the Increased Demand for Health Care Under the Affordable Care Act?" *Policy File*, (2017).

In 2006, Massachusetts enacted Chapter 58 of the Acts of 2006, which aimed to provide near-universal healthcare access to residents.[50] In addition to increasing coverage under Medicaid and the State Children's Health Insurance Program, this law created two new programs—Commonwealth Care and Commonwealth Choice—to further expand health coverage.[51] With the implementation of this reform, the proportion of uninsured patients within Massachusetts CHCs decreased from 40.1% to 30.4%.[52] However, the proportion of the state's total uninsured population being served by the CHCs actually rose from 22% in 2006 to 36% in 2007, highlighting the importance of CHCs in providing care for individuals who lack health coverage.[53]

Despite the reduction in the number of uninsured patients within the CHCs, the overall patient volume grew by 11% between 2005 and 2007, driven by an influx of newly insured patients.[54] Due to the increase in patients with health insurance, CHC revenues rose significantly. However, these revenue gains were offset by the increased operating costs, which increased by 15% in 2007.[55] Prior to the reform, the Massachusetts Health Safety Net subsidized unpaid healthcare costs for individuals with inadequate insurance at CHCs. Because of the reform, uncompensated care dropped by 33% by 2009, resulting in decreased support from this program and further diminishing the revenue gains of CHCs.[56]

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[50] Blue Cross Blue Shield of Massachusetts. "10 Years of Impact: A Literature Review of Chapter 58 of the Acts of 2006." Bluecrossmafoundation.org, 2016. https://www.bluecrossmafoundation.org/publication/10-years-impact-literature-review-chapter-58-acts-2006.

[51] The Commonwealth Fund. "Massachusetts Health Care Reform--On Second Anniversary of Passage, What Progress Has Been Made?." www.commonwealthfund.org, n.d. https://www.commonwealthfund.org/publications/newsletter-article/massachusetts-health-care-reform-second-anniversary-passage-what.

[52] Leighton C. Ku et al. "How Is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform." Health Sciences Research Commons, 2025. https://hsrc.himmelfarb.gwu.edu/sphhs_policy_facpubs/277/.

[53] Ku et al., *How Is the Primary Care Safety Net Faring in Massachusetts?*

[54] Ku et al., *How Is the Primary Care Safety Net Faring in Massachusetts?*

[55] Ku et al., *How Is the Primary Care Safety Net Faring in Massachusetts?*

[56] Leighton Ku et al. "Safety-Net Providers after Health Care Reform." Archives of Internal Medicine 171, no. 15 (August 8, 2011): 1379. https://doi.org/10.1001/archinternmed.2011.317.

Since 2006, some CHCs have increased their margins, whereas others have decreased them. Regardless of their financial circumstances, however, CHCs continue to face a shortage of healthcare workers. This issue is illustrated by extended wait times in CHCs, among other factors. According to one report, the typical waiting period for an internal medicine appointment at a CHC increased from 33 days in 2006 to 50 days in 2008, revealing that an expansion of health coverage is insufficient to improve access to quality care.[57]

Rather, increased health insurance must be accompanied by additional funding and incentives to expand the healthcare workforce. In a study, it was found that higher Medicaid reimbursement rates led to an increase in the accessibility of healthcare for Medicaid recipients, as it resulted in a greater number of physicians being willing to accept Medicaid recipients more frequently.[58] Thus, higher Medicaid reimbursement rates—overseen by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services—could provide physicians in CHCs with more competitive salaries, allowing for greater worker recruitment and retention.[59]

Healthcare Workforce Challenges in Massachusetts

Primary Care Shortages in Massachusetts

Massachusetts' health care system, which emphasizes specialty care, has a low relative share of physicians working in primary care (1 in 7).[60] The crisis of primary care leads 41% of Massachusetts residents to report that they had difficulty accessing care, with the most cited

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[57] Ku et al., *How Is the Primary Care Safety Net Faring in Massachusetts?*

[58] Callison, Kevin, and Binh T. Nguyen. "The Effect of Medicaid Physician Fee Increases on Health Care Access, Utilization, and Expenditures." Health Services Research 53, no. 2 (April 16, 2017): 690–710. https://doi.org/10.1111/1475-6773.12698.

[59] Ford, Tiffany, and Jamila Michener. "Medicaid Reimbursement Rates Are a Racial Justice Issue." www.commonwealthfund.org, 2022. https://www.commonwealthfund.org/blog/2022/medicaid-reimbursement-rates-are-racial-justice-issue.

[60] Health Policy Commission, *A Dire Diagnosis.*

reason being an inability to get an appointment.[61] This shortage is especially acute in rural areas.[62]

A significant contributor to the crisis of primary care in Massachusetts is the fact that fewer new medical school graduates are choosing to work in primary care. In an interview with Harvard Medical School News, Zirui Song, faculty director of research at the Harvard Medical School Center for Primary Care, noted that primary care visits are reimbursed at a much lower rate than other medical appointments. Essentially, he said, "treating disease pays more than preventing disease."[63] As new graduates consider their options, the significant pay disparity between specialty fields and primary care may be a significant factor.

The second issue facing the field of primary care is that the majority of primary care providers are nearing retirement. Today, the average age of US primary care physicians is 55.[64] Further, 44% of family physicians were over the age of 55.[65] As hundreds of providers near retirement in Massachusetts, the shortages facing CHCs are likely to worsen.

In the face of this looming crisis, MassHealth is increasing financing to primary care providers in an effort to raise the salaries of providers and therefore attract new physicians to the field.[66] Additionally, the Massachusetts state Physicians Pathway Act allows internationally trained medical professionals to receive licensure in the United States if they work for three

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[61] Health Policy Commission, *A Dire Diagnosis.*

[62] Brown, Karen, 2025, "In Rural Massachusetts, Patients and Physicians Weigh Trade-Offs of Concierge Medicine - KFF Health News," KFF Health News, April 17, 2025, https://kffhealthnews.org/news/article/concierge-medicine-direct-primary-care-doctor-shortage-rural-western-massachusetts/.

[63] Miller, Jake, 2025, "Why Finding a Primary Care Doctor is so Hard," Harvard.edu, January 31, 2025, https://hms.harvard.edu/news/why-finding-primary-care-doctor-so-hard.

[64] Miller, Jake, "Why Finding a Primary Care Doctor is so Hard."

[65] Graham, Robert. n.d, "The State of Primary Care Physician Workforce: Massachusetts." Accessed July 1, 2025, https://www.graham-center.org/content/dam/rgc/documents/maps -data-tools/state-collections/phys-workforce/Massachusetts.pdf.

[66] Miller, Jake, "Why Finding a Primary Care Doctor is so Hard."

years in a rural or underserved community.[67] This new legislation allows international physicians to avoid redoing their medical residency in the United States and lessens the burdens of primary care shortages in rural Massachusetts. MassHealth and the Massachusetts legislators' decisions are an example of a concrete policy that can be scaled to remedy primary care shortages and their devastating consequences.

Healthcare in Gateway Cities

In Massachusetts, the term "gateway cities" refers to midsize urban centers like Lawrence, Fall River, Holyoke, and New Bedford - communities that historically served as hubs of immigration and industrial growth but now face economic stagnation and persistent health inequities.[68] These cities are home to a disproportionate share of low-income, immigrant, and racially diverse residents, yet they experience significant healthcare workforce shortages, especially in primary care, mental health, and linguistically competent services.[69]

A 2023 report from the Massachusetts Health Policy Commission (HPC) found that healthcare access gaps in gateway cities are largely driven by geographic maldistribution of providers.[70] For example, while Boston and Cambridge maintain relatively high provider densities, cities like Holyoke and Brockton face critical shortages in primary care, with some areas exceeding federal definitions of Health Professional Shortage Areas (HPSAs).[71]

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[67] "Governor Healey Signs Economic Development Bill to Strengthen Massachusetts' Global Leadership in Climatetech, Life Sciences and AI," 2024, Mass.gov, 2024, https:// www.mass.gov/news/governor-healey-signs-economic-development-bill-to-strengthen-massachusetts-global-leadership-in-climatetech-life-sciences-and-ai.

[68] Ben Forman et al., *Gateway Cities Vision for Dynamic Community Health*, MassINC, 2021.

[69] Edward M. Murphy and Alicia Modestino, "Massachusetts Gateway Cities: A Policy Blueprint," *MassINC*, July 2023, https://massinc.org/research/gateway-cities-blueprint.

[70] Murphy and Modestino, "Massachusetts Gateway Cities: A Policy Blueprint."

[71] Murphy and Modestino, "Massachusetts Gateway Cities: A Policy Blueprint."

Moreover, gateway cities are often underserved by large health systems and instead rely on community health centers (CHCs), which struggle to retain staff. High burnout rates, student loan burdens, and non-competitive salaries make recruitment difficult, especially for bilingual or culturally competent providers.[72]

Mental health care access is even more dire. In Fall River, a city with one of the highest rates of opioid overdose deaths in the state, there is just one licensed mental health provider for every 630 residents, compared to the state average of 1 per 280.[73] The shortage of providers who speak Spanish, Portuguese, or Cape Verdean Creole further exacerbates barriers for immigrants.

Policy interventions have been limited. While the Massachusetts Loan Repayment Program offers debt forgiveness to providers who serve in underserved areas, eligibility requirements and funding limitations have restricted its impact. Experts argue for expanded investments in training pipelines, such as partnerships with community colleges, health tech programs, and residency slots within gateway cities to grow a more stable, local workforce.[74]

Massachusetts' community health centers experience a variety of barriers to maintaining and recruiting medical staff in both gateway cities around Massachusetts. To begin, in gateway cities, one of the largest barriers to recruitment of physicians is competition with larger metropolitan areas and private providers. For example, in Brockton, one of Massachusetts' 26 gateway cities, the average pay for a physician is around $230,000 annually. In comparison, in Boston, just an hour away, the average pay is around $300,000 annually, increasing to nearly $430,000 in private practice.[75] This stark difference in compensation is an important factor

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[72] Murphy and Modestino, "Massachusetts Gateway Cities: A Policy Blueprint."
[73] Massachusetts Behavioral Health Partnership, *Community Needs Assessment: Fall River*, 2022.
[74] "What's at stake from GOP megabill's coverage losses," *Axios*, July 1, 2025.
[75] "Salary: Doctor in Massachusetts (June, 2025)." 2025. ZipRecruiter. https://www.ziprecruiter.com/Salaries/Private-Practice-Salary-in-Boston,MA#:~:text=While%20ZipRecruiter%20is%20seeing%20salaries%20as%20high,(90th%20percentile)%20making%20$434%2C321%20annually%20in%20Boston.&text=However%2C%20none%20pay%20more%20than%20th.

contributing to this issue, considering that 76% of physicians state that compensation was a major factor in deciding their first job's location and more than 30% stated that compensation was the primary factor they became doctors.[76] Additionally, the brutal working conditions currently present within Massachusetts' CHCs, with more than 70% reporting critical staffing shortages in 2024.[77] These shortages lead to significant burnout, a highly stressful working environment, and unstable financial dependency.

Additionally, the cultural makeup of gateway cities further contributes to the existing barriers contributing to staffing shortages in Massachusetts CHCs. There are numerous gateway cities where people of color make up the majority of the population, making these places massive melting pots with a variety of languages and cultures that physicians must competently be able to comprehend. For example, a local hospital in a Massachusetts gateway city surveyed its practitioners and found that a majority of their physicians believed their patients didn't properly understand their instructions for care. This barrier is especially dangerous and poses a major barrier to effective staffing in CHCs in Massachusetts.

Healthcare in Rural Communities

At the core of health equity is an often overlooked issue in healthcare: accessibility, and more specifically, the healthcare worker shortage. Massachusetts' community health centers have proven to be a leading provider of healthcare, experiencing growth from 200 to 300 new

[76] Charles, Shamard. 2023. "Physician compensation 2023: What doctors really think about their pay." MDLinx. https://www.mdlinx.com/exclusive/physician-compensation-2023-what-doctors-really-think-about-their-pay/4PXnob9THfTkZ3Lwibdc9T.

[77] "Community Health Centers' Progress and Challenges in Meeting Patients' Essential Primary Care Needs." 2024. Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2024/aug/community-health-centers-meeting-primary-care-needs-2024-FQHC-survey.

patients each month.[78] However, Massachusetts community health centers have primary care physician vacancy rates of 10%.[79] When the Implementation Science Center for Cancer Control Equity surveyed 123 employees from the Massachusetts League of Community Health Centers, they found that over half of the participating employees (48%) disagreed that community health centers have sufficient support regarding staffing.[80] Disparities in access to resources in rural and gateway cities have led to prolonged uneven distribution across the state.

The workforce shortage in Massachusetts community health centers (CHCs) is most notably seen in rural and gateway cities. A reported 107 Massachusetts cities and towns have no access to primary care physicians, and an estimated 725 additional healthcare workers would be needed to address this widening gap in accessibility.[81] In what are often referred to as healthcare deserts, communities are isolated from healthcare services. These underserved communities face a rising demand for healthcare access, yet simultaneously endure the most severe healthcare shortages. When selecting a community health center to practice in, serving underserved communities is often a priority, followed by the importance of accessing opportunities that accelerate professional growth and development.[82]

Rural and gateway cities in Massachusetts have fewer residency training opportunities and fewer training opportunities for physicians.[83] The location in which a physician chooses to

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[78] Judith A. Savageau et al., "Recruitment and Retention of Primary Care Physicians at Community Health Centers: A Survey of Massachusetts Physicians," *Journal of Health Care for the Poor and Underserved* 22, no. 3 (2011): 817–35, https://doi.org/10.1353/hpu.2011.0071.

[79] Savageau et al., "Recruitment and Retention," 818.

[80] Rebekka M Lee et al., "Assessing the Inner Setting among Massachusetts Community Health Centers: Opportunities for Multilevel Investigation and Expansion of Influences on Health Equity," *Implementation Science Communications* 6, no. 1 (April 10, 2025), https://doi.org/10.1186/s43058-025-00724-x.

[81] Kami Phillips, "Mass. = Primary Care Doctor Desert," CommonWealth Beacon, December 9, 2016, https://commonwealthbeacon.org/health-care/ma-primary-care-doctor-desert/.

[82] Savageau et al., "Recruitment and Retention," 824.

[83] "HPC Research Spotlights Challenges in Primary Care Delivery and Opportunities to Stabilize Provider Workforce | Massachusetts Health Policy Commission," Masshpc.gov, January 16, 2025, https://masshpc.gov/news/press-release/hpc-research-spotlights-challenges-primary-care-delivery-and-opportunities.

complete their residency is an indicator of the area in which the physician ultimately decides to practice.[84] Although there has been an increasing demand for family-trained physicians in Massachusetts, the proportion of family-trained physicians has remained relatively stagnant. This is partly due to the way Massachusetts funds its residency programs. Whereas most states use their Medicare funds, combined with Medicare GME funds, to fund residency programs, Massachusetts only relies on federal funding.[85] The reliance on federal funding prevents Massachusetts from having decision-making power regarding the location of residency programs. Consequently, it is challenging to incentivize residents to complete their residency in rural and gateway cities if programs are not available in those regions.

In a hearing of the United States Senate Committee on Health, Education, Labor, and Pensions, it was recorded that by 2030, the United States will be experiencing a "shortage of 42,600-121,300 physicians."[86] This sum includes a "shortage of 14,800-49,300 primary care physicians,"[87] who address a majority of health needs and practice in the context of family and community medicine. Stronger primary care systems have not only been correlated with "better health outcomes,"[88] but patients who see primary care providers (PCPs) first save "33 percent"[89] more than those who do not. Therefore, PCPs are central to improving healthcare access in rural areas, where low population density is unable to support various specialty care providers. Although the number of practicing PCPs in the United States is shrinking, the number of office

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[84] Kami Phillips, "Mass. = Primary Care Doctor Desert," CommonWealth Beacon, December 9, 2016, https://commonwealthbeacon.org/health-care/ma-primary-care-doctor-desert/.
[85] Phillips, "Mass. = Primary Care Doctor Desert."
[86] U.S. Congress, Senate, Committee on Health, Education, Labor, and Pensions, *Examining the Healthcare Workforce, Focusing On Addressing Shortages and Improving Care*, 115th Cong., 2nd sess., 2018, 1-43.
[87] U.S. Congress, Senate, Committee on Health Education, Labor, and Pensions, *Examining the Healthcare Workforce*, 9.
[88] U.S. Congress, Senate, Committee on Health Education, Labor, and Pensions, *Examining the Healthcare Workforce*, 10.
[89] U.S. Congress, Senate, Committee on Health Education, Labor, and Pensions, *Examining the Healthcare Workforce*, 11.

visits is predicted to increase "from 773,606 in 2020 to 893,098 in 2040."[90] This issue is even worse in rural areas, where rates of PCPs are significantly lower than the national average.

One financial barrier to PCP practice in rural areas is the funding and accessibility of community-based training programs (e.g., "Teaching Health Center GME program (THCGME) and Rural Health Clinics (RHC)).[91] Over the past 20 years, funding has been slashed for these programs, further contributing to the PCP shortage in rural communities. Additionally, because choosing primary care over a specialty totals up to "$3.5 million [lost] in career earning,"[92] Many family medicine programs and residential positions have been cut, exacerbating the PCP deficiency nationwide. To begin rectifying the shortage of PCPs in rural communities, Congress would need to increase funding for Title VII, Section 747 of the Public Health Service Act to $560 million a year, 14 times what it is now.[93]

Workforce Challenges and Shortages at Community Health Centers

Factors Limiting Physician Entry and Recruitment to Community Health Centers

CHCs offer lower salaries than their private-sector counterparts, which is one of the primary reasons healthcare workers leave for higher-paying jobs, exacerbating the workforce shortage crisis. A study by Health Affairs found that amongst public health employees aged 35 or below, 63% attributed their intent to leave due to low wages.[94] With the structure of CHCs themselves, they are often limited in their ability to generate higher amounts of money.

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[90] Andrew W. Bazemore et al., "U.S. Primary Care Workforce Growth: A Decade of Limited Progress, and Projected Needs Through 2040," *Journal of General Internal Medicine* 40, (2025): 339-346, https://doi.org/10.1007/s11606-024-09121-x.
[91] Bazemore, "U.S. Primary Care Workforce," 345.
[92] Robert L. Phillips and Barbara J. Turner, "The Next Phase of Title VII Funding for Training Primary Care Physicians for America's Health Care Needs," *Annals of Family Medicine* 10, no. 2 (2012): 163-168, https://doi.org/10.1370/afm.1367.
[93] Phillips and Turner, "The Next Phase," 163.
[94] Jonathon P. Leider et al. "The Exodus of State and Local Public Health Employees: Separations Started before and Continued throughout COVID-19," *Health Affairs (Project Hope)* 42, no. 3 (2023): 338–48, https://doi.org/10.1377/hlthaff.2022.01251.

The populations that CHCs serve are predominantly publicly insured or uninsured.[95] Medicare and Medicaid are their main sources of revenue, while Federally Qualified Health Centers (FQHCs) receive some additional federal funding through Section 330 of the Public Health Services Act, which also covers the costs of non-clinical services.

Many Community Health Workers (CHWs) staff these non-clinical operations, which include community outreach, health education, case management, transportation, interpreters, and legal services. They are defined by the Massachusetts Department of Public Health as public health workers whose understanding of the population's language, culture, or experiences enables them to facilitate the appropriate care. CHCs are facing obstacles with hiring CHWs as grants from philanthropies or government organizations are not sustainable, and MassHealth does not directly reimburse their services despite their pivotal role in bridging patients with medical professionals.[96,97]

With boards composed of local community members, FQHCs have comparably less market leverage, contract negotiation teams, and general resources than managed care organizations. Massachusetts' Center for Health Information and Analysis found that the top quartile of providers in Massachusetts received 57% of all physician provider payments (the top five being large multi-hospital systems), whereas the bottom quartile only received 10%. Large healthcare provider systems have the power to negotiate high payment rates that direct funds

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[95] "A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action," *Massachusetts Health Policy Commission,* 45, https://masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and.

[96] Jeongyoung Park et al, "The Use of Community Health Workers in Community Health Centers," *Medical Care,* no. 59 (2021): 457-562, https://doi.org/10.1097/MLR.0000000000001607.

[97] "State Community Health Worker Policies: Massachusetts." National Academy for State Health Policy, April 2, 2025, https://nashp.org/state-tracker/state-community-health-worker-policies/massachusetts/.

away from FQHCs.[98] FQHC leaders have additionally reported stagnant and low Medicaid reimbursement rates, hindering efforts to retain staff.[99]

In a study published in the American Journal of Public Health, 30 of 44 public health occupations were found to be paid at least 5% less in government than in the private sector. The largest salary disparities correlated with administrative, research, and technical roles. Government industries, conversely, paid more than private industries for social assistance and mental health workers, yet these occupations were hired more frequently at specialized sites such as substance abuse centers, nursing care facilities, or nonprofit organizations rather than CHCS or hospitals. Private-sector employers have a higher capability of increasing salaries, improving benefits, providing bonuses, and investing in recruitment operations, making them more attractive to healthcare workers than government-funded sites, which face increased challenges when adjusting salaries. Using the US Department of Labor's Occupational Employment and Wage Survey, results indicated that job security, competitive benefits, support for the mission of the organization, and training opportunities for upward mobility were important factors that public health students would consider in working for government-funded centers, even if their salary was compromised.[100]

Student loan repayment programs (LRPs) are one tool that can provide recruitment incentives. The average medical school-related debt for students amounted to $202,453 as of 2023, and as 50% of medical students graduated with loan debt greater than $150,000, support

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[98] Aditya Mahalingam-Dhingra, "Supporting Federally Qualified Health Center Participation in Value-Based Payment to Improve Quality and Achieve Savings," *Milbank Memorial Fund,* https://www.milbank.org/wp-content/uploads/2024/09/Supporting-Federally-Qualified-Health-Center-Participation-in-Value-Based-Payment_FINAL.pdf.

[99] Celli Horstman et al, "Community Health Centers Need Increased and Sustained Federal Funding." *The CommonWealth Fund,* September 25, 2025, https://www.commonwealthfund.org/blog/2023/community-health-centers-need-increased-and-sustained-federal-funding.

[100] Heather Krasna et al, "Salary Disparities in Public Health Occupations: Analysis of Federal Data, 2021–2022," *American Journal of Public Health* 114, no. 3 (2024): 329–39, https://doi.org/10.2105/AJPH.2023.307512.

for this program is growing.[101] The Massachusetts Loan Repayment Program provides financial assistance on the condition that the health professional makes a two-year commitment to practice full-time (or the equivalent in part-time) in one of the state's identified medical shortage areas. The program offers up to $50,000 in loan forgiveness and accepts professionals from the dental, medical, and mental health fields.[102] From the results of a case on the effectiveness of LRPs funded by states, LRPs funded jointly by states and the National Health Service Corps, and loan forgiveness programs, 66.1% of safety net practice administrators reported that recruiting clinicians was still difficult but generally easier, though only 34.8% reported it was less expensive. The programs are perceived as beneficial by most healthcare centers, and with more funding and attention, could serve as a viable solution to ease the healthcare workforce crisis.[103]

Factors Inhibiting Staff Retention and Driving Practitioners to Leave Community Health Centers

Most CHCs in Massachusetts reported that the top recruitment challenge was a shortage of eligible applicants across all operations. Physicians and registered nurses were the most difficult to recruit, while medical assistants were the most difficult to retain.[104] Although Massachusetts has the highest physician-to-patient ratio of any other state, it faces challenges in workforce distribution. Almost 40% of Massachusetts physicians are working in Suffolk County, which only contains 11% of the population. An issue of workforce allocation is also escalating,

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[101] Brendan Murphy, "Medical student financial FAQ: Insight on loan forgiveness, repayment," *AMA,* January 5, 2025, https://www.ama-assn.org/medical-students/medical-school-life/medical-student-financial-faq-insight-loan-forgiveness.
[102] "Massachusetts Loan Repayment Program (MLRP) for Health Professionals," Mass.gov, accessed July 1, 2025, https://www.mass.gov/info-details/massachusetts-loan-repayment-program-mlrp-for-health-professionals.
[103] Donald E. Pathman, "Outcomes of States' Loan Repayment and Forgiveness Programs From the Perspective of Safety Net Practice Administrators," *JABFM* 35, no.5 (2022): 1015-25, https://doi.org/10.3122/jabfm.2022.AP.220092.
[104] "Massachusetts Health Care Workforce Survey." *CHIA,* https://www.chiamass.gov/massachusetts-healthcare-workforce-survey.

as many doctors are choosing to pursue sub-specialities over primary care.[105] With lower salaries, higher rates of burnout, and immense loads of paperwork, primary care has become a less appealing profession. Yet, according to Dr. G. Richard Olds, increased reliance on subspecialty-driven care will ultimately be more expensive for all.[106]

When it comes to a physician's trajectory, the bottleneck is at securing a residency. Over 7,000 medical school graduates were unable to secure residencies in 2024. Several states, including Arizona, Texas, and Florida, have enabled Associate Physician licensing to integrate these graduates into clinical settings under the supervision of a licensed physician. Goldwater Institute advises broader eligibility for Associate Physician licensure, support for the position as a viable career option, and reduced requirements for the supervising physician.[107]

Another factor inhibiting the inflow of healthcare workers includes processing and training delays. Credentialing out-of-state physicians can take from 6 months to a year, which, for many candidates, is too long to wait for.[108] Considering internationally trained physicians, it would take even longer to have to repeat residency. The Economic Development Bill, signed by Governor Healey in January of 2025, contains a Physician Pathway Act, making it 1 of 9 states to establish an accelerated system for international physicians.[109] Physicians would receive a limited license to practice at an FQHC, CHC, or other healthcare facility approved by BORIM (Massachusetts Board of Registration in Medicine) for at least one year before being issued a

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[105] Eric Lu, "Massachusetts creates permanent licensing pathway for internationally-trained physicians," *Niskanen Center,* March 3, 2025, https://www.niskanencenter.org/massachusetts-creates-permanent-licensing-pathway-for-internationally-trained-physicians/.

[106] Avir Mitra, "Why don't young doctors want to work in primary care?" *WHYY*, June 23, 2016, https://whyy.org/segments/why-dont-young-doctors-want-to-work-in-primary-care/.

[107] "Expanding Healthcare Access: The Untapped Potential of Associate Physicians," *Goldwater Institute,* March 27, 2025, https://www.goldwaterinstitute.org/expanding-healthcare-access-the-untapped-potential-of-associate-physicians/.

[108] Lia Spiliotes, "Let's Reverse the Rural Physician Shortage," *CHP Berkshires*, July 10, 2019, https://chpberkshires.org/lets-reverse-the-rural-physician-shortage/.

[109] Lu, "Massachusetts creates permanent licensing pathway for internationally-trained physicians."

restricted license to practice at a physician shortage area for at least two years. These physicians could then apply to BORIM for a full, unrestricted license.[110]

The average cost to replace a registered nurse ranges from $45,100 to $67,500, and the average time to recruit ranges from 59 to 109 days.[111] Recruiting and retaining physicians and nurses at CHCs is therefore critical to its cost and operational efficiency.

The Impact of Administrative Burden on Healthcare Professionals at Community Health Centers

In Massachusetts, 81% of physicians say that increasing documentation requirements decreased the quality of their job.[112] As electronic health records and online forms of patient communication become commonplace, so too does the burden on healthcare workers. This issue is especially detrimental in CHCs where providers are already stretched thin and are often asked to work additional hours due to workplace shortages. In surveys, physicians cited the paperwork associated with modern primary care as one of the driving forces behind increased levels of burnout and said that administrative tasks made them feel less fulfilled in their roles.[113] Because CHCs disproportionately serve patients on Medicaid, a significant portion of the administrative tasks facing physicians relate to prior authorization. In numerous situations, Medicaid requires that a treatment or medication be approved as medically necessary (dubbed prior authorization) by them as insurers in addition to the physician who prescribed or recommended that

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[110] "Board Statement on Recent Law Regarding New Licensing Pathway," *Mass.gov,* https://www.mass.gov/info-details/board-statement-on-recent-law-regarding-new-licensing-pathway.
[111] "Rural facilities have options to address staffing shortages," *NRHA,* October 8, 2024, https://www.ruralhealth.us/blogs/2024/10/rural-facilities-have-options-to-address-staffing-shortages.
[112] "A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action," 2025, Masshpc.gov, Massachusetts Health Policy Commission, https://masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and.
[113] Health Policy Commission, *A Dire Diagnosis.*

treatment.[114] This step not only interferes with medical professionals' ability to do their job but demands extra hours of paperwork from providers. The time lost to prior authorizations and other government-related administrative tasks comes at the expense of patient care.[115]

Lessening the administrative burden on healthcare providers is already a focus of many legislators. Last year, both chambers of the US Congress held hearings related to the increasing amount of paperwork and the consequences that it has on primary care.[116] In a statement following the Senate hearing, "Reducing Paperwork, Cutting Costs: Alleviating Administrative Burdens in Health Care," Senator Sheldon Whitehouse (D-RI) suggested that the Center for Medicare and Medicaid services "set common standards for common prior authorization requirements across insurance plans…no prior authorization without prior authorization."[117]

Healthcare Challenges at Rural Community Health Centers

Rural and gateway cities in Massachusetts are concentrated in the counties of Berkshire, Hampden, Franklin, Hampshire, Barnstable, Essex, and Suffolk. Many of these counties—particularly Franklin and Hampden—have seen a decline in employment within the Education and Health Services sector over the past year.[118] The decline in Health Services employment appears to be especially concentrated among nurses and physicians—the healthcare professionals most directly involved in patient care—as reflected in the high turnover and vacancy rates for

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[114] "Prior Authorization for MassHealth Providers," 2025, Mass.gov, 2025, https://www.mass.gov /prior-authorization-for-masshealth-providers.

[115] Health Policy Commission, *A Dire Diagnosis.*

[116] Payerchin, Richard, 2024, "Senators Hear Administrative Burdens and Potential Solutions That Could Help Physicians, Patients," MedicalEconomics, May 8, 2024, https://www.medicaleconomics.com/view/senators-hear-administrative-burdens-and-potential-solutions-that-could-help-physicians-patients.

[117] Whitehouse, Sheldon, 2024, "Opening Statement of Chairman Whitehouse Senate Budget Committee 'Reducing Paperwork, Cutting Costs: Alleviating Administrative Burdens in Health Care,'" https://www.budget.senate.gov/imo/media/doc/050824chairmanwhitehouseopening statement.pdf.

[118] U.S. Department of Labor. 2025. "QCEW State and County Map Massachusetts." U.S. Bureau of Labor Statistics. 2025. https://data.bls.gov/maps/cew/MA?period=2024-Q4&industry=1025&pos_color=blue&neg_color=orange&chartData=3&ownerType=5&distribution=1&Update=Update#tab1.

registered nurses, who are consistently outnumbered by nurse practitioners and physician assistants at CHCs.[119,120] The lack of growth in the nurse and physician workforce is not new for Massachusetts. In 2007, the state released the Massachusetts Health Care Reform Plan, which—despite being associated with a rapid increase in overall healthcare employment—did not result in the desired expansion of the patient care workforce itself.[121]

Studies show that the most important factors influencing primary care physicians to remain at rural CHCs include higher overall practice satisfaction—specifically, not feeling overworked or professionally isolated, and feeling a sense of connection to the local community.[122] There is especially great importance in physicians who were originally from somewhere non-rural to be prepared for life in rural areas and feel connected and comfortable within their new community on a personal level. Feeling connected to their community not only encourages physicians to stay in their rural workplace for a prolonged period of time but also allows them to connect with locals and better understand their day to day lifestyles which is important when treating locals who often tend to be minority and underserved populations. On the other hand, satisfaction is lowest for physicians in terms of their current and likely future income. In fact, non-competitive salaries is stated as one of the largest reasons for the reigning healthcare workforce shortage.

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[119] Center for Health Information and Analysis. 2025. "Massachusetts Health Care and Human Services Workforce Survey." Massachusetts State Government. February 13, 2025. https://www.mass.gov/doc/ma-health-care-and-human-services-workforce-survey-presentation-from-the-center-of-health-information-and-analysis-chia-0/download.

[120] Rosenblatt, Roger A., C. Holly A. Andrilla, Thomas Curtin, and L. Gary Hart. 2006. "Shortages of Medical Personnel at Community Health Centers." *JAMA* 295 (9): 1042. https://doi.org/10.1001/jama.295.9.1042.

[121] Staiger, Douglas O., David I. Auerbach, and Peter I. Buerhaus. 2011. "Health Care Reform and the Health Care Workforce — the Massachusetts Experience." *New England Journal of Medicine* 365 (12): e24. https://doi.org/10.1056/nejmp1106616.

[122] Stenger, Joseph, Suzanne B. Cashman, and Judith A. Savageau. 2008. "The Primary Care Physician Workforce in Massachusetts: Implications for the Workforce in Rural, Small Town America." *The Journal of Rural Health* 24 (4): 375–83. https://doi.org/10.1111/j.1748-0361.2008.00184.x.

The issue of low salaries at rural CHCs is closely tied to a broader challenge: inadequate government grant funding. While CHCs collectively receive substantial public funding, rural centers are often overshadowed by their urban counterparts, which tend to secure larger grants—even though they may serve smaller populations. Addressing this disparity through data-driven research and advocating for a more equitable distribution of CHC funding could be a crucial first step in tackling the non-competitive wages that are driving many professionals to prefer working in healthcare facilities in more urban areas.

Burnout also remains a significant source of dissatisfaction among physicians and nurses working in rural Community Health Centers (CHCs). According to one survey, approximately 27% of nurses reported experiencing burnout-related challenges, a phenomenon largely driven by chronic understaffing.[123] This shortage often compels healthcare workers to work extended hours and take on patient loads that exceed safe and manageable limits. Such conditions not only jeopardize provider well-being but also compromise the quality of patient care. Notably, research has found that for every additional patient added to a registered nurse's workload beyond recommended levels, the risk of patient mortality increases by 7%.

One potential solution is the implementation of strict patient-to-nurse ratio limits, which could help mitigate burnout and improve workforce retention. However, this approach is only feasible if a sufficient number of healthcare professionals are available to meet these standards. An alternative and complementary strategy involves integrating leisure activities within healthcare facilities.[124] Studies have shown that leisure activities can significantly reduce

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[123] Markman, Joe. 2025. "2025 State of Massachusetts Nursing Survey: RNs Raise Alarms over Patient Care Quality, Unsafe Staffing, and Growing Violence amid Deepening Healthcare Crisis." Proquest.com. 2025. https://www.proquest.com/docview/3200108428?parentSessionId=WNgFQjXhrnGA6cboRn5GyEpKw9HBPCqgT1fPUu5nvhY%3D&pq-origsite=primo&accountid=11311&sourcetype=Wire%20Feeds.

[124] Dieser, Rodney B., Christopher R. Edginton, and Renee Ziemer. 2017. "Decreasing Patient Stress and Physician/Medical Workforce Burnout through Health Care Environments: Uncovering the Serious Leisure Perspective at Mayo Clinic's Campus in Rochester, Minnesota." *Mayo Clinic Proceedings*92 (7): 1080–87. https://doi.org/10.1016/j.mayocp.2017.03.017.

occupational stress and burnout. Encouraging short breaks—such as walks outdoors or attending brief musical performances—can promote taking mental breaks for staff while also fostering stronger relationships between patients and healthcare workers. This form of informal engagement could be particularly valuable in rural CHCs, where providers often serve distinct and underserved populations where community trust is critical to effective care delivery.

In response to workforce shortages in rural CHCs, several physician recruitment initiatives have been developed—many specifically targeting underserved areas.[125] For instance, the National Health Service Corps (NHSC) Scholarship Program provides full tuition and living expense coverage to primary care trainees in exchange for a two-year service commitment in a medically underserved area. This initiative has demonstrated measurable success in improving physician retention. Similarly, the NHSC Loan Repayment Program incentivizes physicians to practice in Health Professional Shortage Areas (HPSAs) by offering loan forgiveness, a strategy that has not only increased retention but also received highly positive feedback from participants. Expanding this program to include a larger cohort of physician trainees is widely supported and believed to lead to promising outcomes.

On a broader scale, the J-1 Visa Waiver Program offers another recruitment pathway by allowing international medical graduates to remain in the United States, provided they commit to practicing in HPSAs for a designated number of years. Like the NHSC initiatives, this program has shown positive results and is likewise recommended for expansion. While these recruitment mechanisms have made strides in addressing workforce shortages, long-term solutions must also prioritize workplace sustainability. Without sufficient structural support to address issues such as chronic understaffing and burnout, recruitment alone cannot ensure lasting retention. Pairing

[125] Walensky, Rochelle P., and Nicole C. McCann. 2025. "Challenges to the Future of a Robust Physician Workforce in the United States." *New England Journal of Medicine* 392 (3): 286–95. https://doi.org/10.1056/nejmsr2412784.

these initiatives with efforts to improve workplace conditions—such as implementing safe staffing ratios and integrating stress-reducing interventions like leisure activities—offers a more comprehensive and sustainable approach to strengthening rural healthcare systems.

Existing Policy Approaches to Address Community Health Center Staffing Challenges

Workforce Development

Healthcare workforce shortages are driven in part by economic barriers that discourage entry into healthcare careers. Offsetting the financial burden that stifles entry into the healthcare space may increase healthcare employment and worker retention.

Colorado's *Colorado Healthcare Corp* combines both volunteerism and national service to address state healthcare shortages.[126] The program, created by the Governor Jared Polis administration in 2022, aims to expand the state's healthcare workforce by recruiting AmeriCorps members with medical certifications and training individuals interested in earning certifications.[127] Participating healthcare facilities provide training for members under the 2022 *Care Forward Colorado* program*,* providing free healthcare training for aspiring professionals at various community and technical colleges across the state.[128] Enrolled students receive tuition and materials at no charge. To facilitate and encourage participation, participants in Colorado Healthcare Corp receive housing support, health, dental, and child care benefits, as well as a living allowance in $1,292 biweekly installments.[129] Members also earn education benefits via the Segal AmeriCorps Education Award for student loan repayment or to put toward future education

[126] Falkner, Rebekah. "Health Care Workforce Investment: How States Are Leading the Way." NASHP, April 15, 2025. https://nashp.org/health-care-workforce-investment-how-states-are-leading-the-way/.
[127] Falkner. "Health Care Workforce Investment: How States Are Leading the Way."
[128] Falkner. "Health Care Workforce Investment: How States Are Leading the Way."
[129] "Colorado Healthcare Corps." Serve Colorado. Accessed July 2, 2025. https://servecolorado.colorado.gov/healthcare-corps.

expenses.[130] This program entices employment opportunities in the state's healthcare sector, substantially relieving economic challenges associated with costly medical training.

Behavioral health services in Ohio faced unprecedented imbalances between supply and demand. While the demand for services grew by 353% between 2013 to 2019, the workforce only grew by 174%.[131] This imbalance leaves many patients vulnerable and in need of services that hospitals cannot provide. Healthcare workers are strained in the process of overexerting themselves to attempt to meet this demand. The state of Ohio, however, has made strides to grow its behavioral health workforce. With $85 million of allocated federal funding, Ohio invested in increasing affordability and thus attainability for aspiring students entering the behavioral health sector. Federal funding contributed to paid internships and scholarship opportunities for behavioral health certificates at various educational institutions under the Ohio Great Minds Fellowship, launched in May 2023.[132] Fellows are eligible for the use of $10,000 to cover the cost of licenses, certifications, exams, paid internships, and work opportunities. Funding also contributed to the creation of a technical assistance center where students receive assistance navigating their funding options.

One policy resolution for the increasing depletion of healthcare workers could be to improve financial and social protections for these individuals. A solution nonspecific to rural communities could be to petition for Bill S.1718, which has been presented before the 194th General Court of the Commonwealth of Massachusetts.[133] This bill requires health care employers to annually perform risk assessments to identify workplace violence, particularly in areas with historically elevated crime rates or existing security concerns. Furthermore, the bill

[130] "Colorado Healthcare Corps." Serve Colorado.
[131] Falkner. "Health Care Workforce Investment: How States Are Leading the Way."
[132] Falkner. "Health Care Workforce Investment: How States Are Leading the Way."
[133] "Bill S.1718," Malegislature.gov, 2025, https://malegislature.gov/Bills/194/S1718/PrimarySponsorSummary.

allows employees who experience assaults while performing their duties to take paid leave without using their accrued leave time, providing greater protections to the workers who place themselves at the forefront of patient care each day. More specifically, for rural communities in Massachusetts, one can directly address the social factors that dissuade workers from staying in their jobs by confronting the housing challenges faced by rural health care workers. One suggestion posed by the National Rural Health Association proposes the establishment of rural health care facilities to lease or purchase housing units for workers without adverse impacts on cost reports or reimbursement, coupled with subsidies expanding rural childcare programs to encourage new families to move to these communities.[134] At large, addressing the problem of worker retention requires examining noninstitutional, non-medical factors that pull individuals towards communities and keep them there.

Some of the major existing policies in Massachusetts that attempt to alleviate the current staffing shortage in CHCs include incentives to draw physicians to underserved areas. For example, the MA Repay program aims to encourage current medical students to work in areas that are experiencing the brunt of the current staffing crisis, by taking away up to $30,000 in student loan repayment.[135] It covers more than 300 awardees across the state who have committed to numerous years of service in underserved areas across Massachusetts. However, despite the important step that this program takes to provide incentives for physicians to choose underserved areas over more popular ones, it does not alleviate the massive shortage of culturally competent care in Massachusetts' CHCs, especially in Gateway Cities.[136] Additionally,

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[134] Health Resources and Services Administration. Health Professional Shortage Areas Dashboard. Updated September 2023. Accessed July 8, 2025. https://data.hrsa.gov/topics/health-workforce/shortage-areas

[135] "Massachusetts Loan Repayment Program (MLRP) for Health Professionals." n.d. Mass.gov. Accessed July 1, 2025. https://www.mass.gov/info-details/massachusetts-loan-repayment-program-mlrp-for-health-professionals.

[136] Massachusetts Department of Public Health. 2005. *Community Health Workers: Essential to Improving Health in Massachusetts. Findings from the Massachusetts Community Health Worker Survey*. Division of Primary Care and Health

Massachusetts has launched a variety of Community Health Worker Initiatives (CHWI), ranging from behavioral training programs to supervisor training.[137] These programs aim to alleviate the current staffing shortages by implementing grants to augment slots available in training programs and increasing the number of CHWs across Massachusetts. Furthermore, the Workforce Development Capital Grant Program builds on the incentivization of other programs by offering funding to institutions and organizations in rural areas and Gateway Cities to acquire equipment, renovate facilities, and improve technology to prepare students for health careers.[138] This program serves to minimize the skills gap that greatly contributes to underrepresented populations in healthcare and thus the glaring lack of culturally competent healthcare. One reason why these programs are not solving the current shortage, though, can be attributed in part to the lower pay that CHWs receive compared to physicians, as well as a lack of health insurance, which drives many potential workers away.[139]

Addressing Staffing Shortages via Telehealth Support

Healthcare workforce shortages are driven in part by economic barriers that discourage entry into healthcare careers. Offsetting the financial burden that stifles entry into the healthcare space may increase healthcare employment and worker retention.

During the COVID-19 pandemic, the number of telehealth visits increased dramatically. Notably, the number of outpatient visits conducted via telehealth in Massachusetts increased

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Access, Bureau of Family and Community Health. March 2005. https://www.mass.gov/files/documents/2016/07/nf/comm-health-workers-narrative.pdf.

[137] "Community Health Worker Initiatives." n.d. Massachusetts League of Community Health Centers. Accessed July 1, 2025. https://www.massleague.org/programs-initiatives/clinical-quality-initiatives/community-health-worker-initiatives/.

[138] "Workforce Development Capital Grant Program." 2025. Massachusetts Life Science Center. https://www.masslifesciences.com/programs/workforcecapital/.

[139] Massachusetts Department of Public Health. 2005. *Community Health Workers: Essential to Improving Health in Massachusetts. Findings from the Massachusetts Community Health Worker Survey*. Division of Primary Care and Health Access, Bureau of Family and Community Health. March 2005. https://www.mass.gov/files/documents/2016/07/nf/comm-health-workers-narrative.pdf.

from 1% in 2019 to 31% in 2020.[140] Even after the pandemic, telehealth remains a compelling option for CHCs and hospitals, particularly in rural areas and gateway cities.[141] In addition to providing accessible healthcare services to individuals in rural areas without the burden of long-distance travel, telehealth can alleviate the issue of healthcare workforce shortages in underserved areas.[142] According to the Center for Health Information and Analysis, in 2023, 41% of Massachusetts residents had trouble accessing care, most commonly due to difficulties securing timely appointments.[143] Due to workforce shortages, patients are not receiving the care they need, and healthcare professionals are overworked to fill the gaps. Based on a 2023 survey conducted by the Massachusetts Medical Society, 55% of physicians in Massachusetts experience burnout, which can lead to reduced quality of care.[144] Telehealth has the potential to mitigate such issues by providing greater flexibility for providers and allowing healthcare providers from other states or regions to fill gaps caused by shortages and provide mentorship, thus reducing the burden on workers in understaffed clinics.[145]

Although telehealth presents several benefits, it also introduces disparities in healthcare access. According to studies, patients from rural areas are 8.3 percentage points less likely to use telehealth services than those from urban areas due to the digital divide, which stems from

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[140] Commonwealth of Massachusetts-Health Policy Commission. "Telehealth Use in the Commonwealth and Policy Recommendations." Masshpc.gov. 2023. https://masshpc.gov/sites/default/files/2023-04/Telehealth%20Use%20in%20the%20Commonwealth%20and%20Policy%20Recommendations_0.pdf.

[141] Commonwealth of Massachusetts-Health Policy Commission, *Telehealth Use.*

[142] Russell-Wood, Karsten. "Telehealth's Impact on Rural Hospitals: A Literature Review." National Rural Health, February 6, 2025. https://www.ruralhealth.us/blogs/2025/02/telehealth-s-impact-on-rural-hospitals-a-literature-review.

[143] Massachusetts Health Policy Commission. "HPC Research Spotlights Challenges in Primary Care Delivery and Opportunities to Stabilize Provider Workforce | Massachusetts Health Policy Commission." Masshpc.gov, January 16, 2025. https://masshpc.gov/news/press-release/hpc-research-spotlights-challenges-primary-care-delivery-and-opportunities.

[144] Massachusetts Medical Society. "Massachusetts Medical Society: Massachusetts Medical Society Survey Raises Concern about Stability of State's Physician Workforce." Massmed.org, 2023. https://www.massmed.org/News/Press-Releases/Massachusetts-Medical-Society-survey-raises-concern-about-stability-of-state-s-physician-workforce/.

[145] National Consortium of Telehealth Resource Centers. "5 Ways Telehealth Can Improve Health Care Workforce Retention," August 12, 2022. https://telehealthresourcecenter.org/news/audio-only-visits-critical-to-bridging-the-digital-divide/.

disparities in access to reliable technology and digital literacy skills.[146] Rural residents, who are likely to benefit significantly from telehealth, face many barriers in taking advantage of this resource. Thus, the widespread use of telehealth must be coupled with efforts to bridge the digital divide, maximizing both the availability of qualified healthcare professionals and the efficiency of remotely delivering healthcare services everywhere.

Key Case Studies

National Case Studies

National Health Service Corps

Currently, the National Health Service Corps (NHSC) offers loan repayment assistance and scholarships to primary care providers who work in an NHSC-approved site in a Health Professional Shortage Area (HPSA).[147] This supports work in areas that otherwise face crippling

[146] Commonwealth of Massachusetts-Health Policy Commission. *Telehealth Use*.
[147] HRSA. 2024. "NHSC Loan Repayment Program | NHSC." Nhsc.hrsa.gov. 2024. https://nhsc.hrsa.gov/loan-repayment/nhsc-loan-repayment-program.

workforce shortages. In fiscal year 2024, NHSC supported nearly 25,000 clinicians who, in 2023, served roughly 19.3 million patients.[148] Primary care providers may receive up to $75,000 for an initial two-year term. All providers are eligible for up to $50,000 for this period. Additionally, the program offers half-time service options of up to $37,500 for primary care providers and $25,000 for all providers.[149] After the initial two-year period, professionals are eligible for continuation repayment assistance for additional loans upon application and acceptance. The NHSC loan repayment program offers additional financial assistance for professionals proficient in Spanish in an attempt to support cultural competency and address language barriers. This status is confirmed via a language proficiency assessment. Primary care professionals may receive up to $80,000 for full-time participants and up to $42,500 for half-time participants.[150] Non-primary care professionals are eligible for up to $55,000 for full-time participants and $30,000 for half-time participants.[151] The exact funding amount is determined by outstanding loan amounts. In 2021, approximately 35% of NHSC placements were in rural areas.[152]

A survey was conducted to gather information on the NHSC Loan Repayment Program (LRP) and clinicians' perceived needs, challenges, resources, reasons for applying (to both their job and the Loan Repayment Program), and factors influencing retention. The majority of respondents reported staffing shortages as a workplace challenge.[153] The majority of respondents,

[148] HRSA. 2024. “NHSC Loan Repayment Program | NHSC.”
[149] HRSA. 2024. “NHSC Loan Repayment Program | NHSC.”
[150] HRSA. 2024. “NHSC Loan Repayment Program | NHSC.”
[151] HRSA. 2024. “NHSC Loan Repayment Program | NHSC.”
[152] Rowan, Kathleen, Savyasachi V. Shah, Alana Knudson, Stas Kolenikov, Jennifer Satorius, Carolyn Robbins, and Hayden Kepley. “Health Professional Retention in Underserved Areas: Findings from the National Health Service Corps Loan Repayment Program Participants in the United States, 2019–2021 - Journal of Public Health Policy.” SpringerLink, August 24, 2024. https://link.springer.com/article/10.1057/s41271-024-00516-y#Tab3.
[153] Rowan, Shah, Knudson, Kolenikov, Satorius, Robbins, and Kepley. “Health Professional Retention in Underserved Areas: Findings from the National Health Service Corps Loan Repayment Program Participants in the United States, 2019–2021 - Journal of Public Health Policy.”

over 80%, listed benefits and paid time off as a key resource and support.[154] Over 90% of respondents reported financial assistance as their reason to apply to the Loan Repayment Program.[155] Regarding factors influencing intention to stay in their job, the top factor was salary and work hours/schedule.[156] Clearly, finances are a dominant factor influencing healthcare career decision-making, and thus, loan repayment is a critical intervention.

Additionally, the NHSC administers a scholarship program, provides financial assistance for related education costs, including library, technology, laboratory, and graduation fees.[157] Healthcare professionals must serve between 2 and 4 years at the site, as funding cannot exceed four years.[158]

The NHSC has received funding from myriad sources throughout its history. In the past, it has received discretionary appropriations, but with the passage of the 2025 Further Continuing Appropriations Act, 70% of NHSC's annual funding comes from the Community Health Center Fund (CHCF).[159] In fiscal year 2021, the American Rescue Plan Act issued an $800 million appropriation to expand loan and scholarship awards, as well as reserved $100 million in state funding for loan repayments.[160] From 2011 through 2023, more than 91,579 loan repayments and scholarships have been awarded to professionals who work in a variety of settings.[161]

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[154] Rowan, Shah, Knudson, Kolenikov, Satorius, Robbins, and Kepley. "Health Professional Retention in Underserved Areas: Findings from the National Health Service Corps Loan Repayment Program Participants in the United States, 2019–2021 - Journal of Public Health Policy."

[155] Rowan, Shah, Knudson, Kolenikov, Satorius, Robbins, and Kepley. "Health Professional Retention in Underserved Areas: Findings from the National Health Service Corps Loan Repayment Program Participants in the United States, 2019–2021 - Journal of Public Health Policy."

[156] "NHSC Scholarship Program Overview." NHSC. Accessed July 30, 2025. https://nhsc.hrsa.gov/scholarships/overview.

[157] "Medicaid Graduate Medical Education Payments: A 50-State Survey." n.d. Accessed July 31, 2025. https://nosorh.org/wp-content/uploads/2016/02/Data-and-Medicare-Expansion-Tim-Henderson-Medicaid_GME_2015_Data.pdf.

[158] "Medicaid Graduate Medical Education Payments: A 50-State Survey."

[159] "The National Health Service Corps." 2025. Congress.gov. 2025. https://www.congress.gov/crs-product/R44970.

[160] "The National Health Service Corps."

[161] "The National Health Service Corps."

MHS Genesis as a Case Study for a Large-Scale Standardized Medical Records System

In 2024, the Department of Defense finished the nearly decade-long implementation of the MHS Genesis system. The electronic health records (EHR) system, which standardizes patient records for service members and their families and compiles all medical records (inpatient, outpatient, those from military and civilian hospitals, and other medical information) into a single online system, now supports more than 9.5 million beneficiaries.[162] The system has been praised by military officials for improving the accessibility of records, improving patient care and safety, and improving physician workflows.[163] However, during the initial update of military EHRs, Cerner, one of the companies awarded the Genesis contract, was accused of endangering patient care through its outdated and flawed interface and leading to an increase in physician resignations.[164]

Before considering standardizing medical records exchange more broadly, it's important to understand the differences between a system that benefits patients and providers and one that needlessly endangers patient care. Research conducted in Turkey between 2010-2011, which assessed the factors that influence the effective implementation of EHR systems in healthcare settings, gives particular insight into both the successes and failures of MHS Genesis implementation.[165] That research found that key factors critical to determining the success of the implementation were the system's alignment with the needs of the setting, the ease of use of the

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[162] Cornwell, Ken, 2024, "MHS GENESIS Leader Reflects on Challenges, Successes as He Prepares to Pass the Torch," Military Health System, Health.mil, August 10, 2024, https://www.health.mil/News/Dvids-Articles/2024/08/10/news478249.
[163] "MHS GENESIS: The Electronic Health Record," n.d, Military Health System, https://health.mil/Military-Health-Topics/Technology/MHS-GENESIS.
[164] Allen, Arthur, 2021, "'We Took a Broken System and Just Broke It Completely,'" Politico, 2021, https://www.politico.com/story/2018/03/08/veterans-military-health-system-trump-38623
[165] Woody II, Edward W. 2020, "MHS Genesis Implementation: Strategies in Support of Successful EHR Conversion," *Military Medicine* 185 (9-10), https://doi.org/10.1093 /milmed/usaa184.

interface, and the ease of learning/adopting the system.[166] An easily applicable learning from the research is related to what a Military Medicine article identified as one of the primary obstacles for the implementation of EHRs in healthcare settings: technophobia.[167] Many physicians and nurses are wary of new technologies and are easily soured on their implementation by software bugs or issues.[168] Military Medicine suggested that training sessions specifically adjusted to the needs of a healthcare setting were critical to make physicians view MHS Genesis as a positive development.[169] Additionally, the group recommended that each office implementing the system designate a few staff as "super-users" who, in exchange for benefits or extra pay, would be trained to handle low-level IT issues as they arise.[170]

Helping offices have a smooth transition to new systems, as well as incorporating their feedback and tailoring the system to their circumstances, are crucial steps to ensuring that EHRs reduce administrative burden rather than contribute to it. With these obstacles and potential solutions in mind, the data on the efficacy of the MHS Genesis in improving patient care is mixed but gives reason for optimism. When the DOD first collected data in 2022, just 24% of system users said that "the electronic health record enables me to deliver high quality care," however, when asked the same question just 12 months later 5% more people responded in the affirmative.[171] That pattern of growth holds on the statement "the electronic health record allows me to deliver patient-centered care," which jumped from 35% to 39% in the same time frame.[172]

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[166] Spatar, Daria, Orhun Kok, Nuri Basoglu, and Tugrul Daim. 2019, "Adoption Factors of Electronic Health Record Systems," *Technology in Society* 58 (August): 101144, https://doi.org/10.1016/j.techsoc.2019.101144.
[167] Woody II, Edward W, 2020, "MHS Genesis Implementation: Strategies in Support of Successful EHR Conversion."
[168] Woody II, Edward W, 2020, "MHS Genesis Implementation: Strategies in Support of Successful EHR Conversion."
[169] Woody II, Edward W, 2020, "MHS Genesis Implementation: Strategies in Support of Successful EHR Conversion."
[170] Woody II, Edward W. 2020, "MHS Genesis Implementation: Strategies in Support of Successful EHR Conversion."
[171] "ELECTRONIC HEALTH RECORDS DOD Has Deployed New System but Challenges Remain Report to Congressional Committees United States Government Accountability Office," 2024, *Government Accountability Office*, https://www.gao.gov/assets/gao-24-106187.pdf.
[172] Government Accountability Office, "ELECTRONIC HEALTH RECORDS DOD Has Deployed New System but Challenges Remain Report to Congressional Committees"

This data is encouraging in that it demonstrates the growing popularity of the system and the potential to improve patient care, but policy-makers must also be wary to explicitly incorporate physician feedback because these statistics still lag behind legacy system approval ratings.[173]

Medicare Primary Care Incentive Program in Rural Areas

The Primary Care Incentive Program contributed to significant long-term increases in Medicare providers. According to a study conducted between 2005 and 2011, in counties across the country, there was a nearly 19% increase in providers per county who were PCIP bonus eligible and submitted at least one claim.[174] This data held true in Physician Shortage Areas (often rural), where PCIP bonus-eligible providers increased by 1 during the studied period.[175] Further, in 2009, the Rural Policy Research Institute (RUPRI) produced research on the effects and influence of the Medicare PCIP in rural areas.[176] The researchers surveyed more than 1000 rural healthcare settings and found that 75% of rural primary care practitioners qualified for the program.[177] They also found that the average physician brought in $8000 in extra Medicare revenue annually. Importantly, RUPRI concluded that the 60% Medicare threshold to qualify for the PCIP bonus was appropriate for rural settings.[178]

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[173] Government Accountability Office, "ELECTRONIC HEALTH RECORDS DOD Has Deployed New System but Challenges Remain Report to Congressional Committees"

[174] The Lewin Group, 2014, "Health Practitioner Bonuses and Their Impact on the Availability and Utilization of Primary Care Services," Office of the Assistant Secretary for Planning and Evaluation, December 21, 2014, https://aspe.hhs.gov/reports/health-practitioner-bonuses-their-impact-availability-utilization-primary-care-services-0.

[175] The Lewin Group, "Health Practitioner Bonuses and Their Impact on the Availability and Utilization of Primary Care Services."

[176] Shane, Dan, A Clinton MacKinney, Fred Ullrich, Keith J Mueller, Paula Weigel, Rural Health Research & Policy Centers, and RUPRI Center for Rural Health Policy Analysis, University of Iowa College of Public Health, Department of Health Management and Policy. 2013. "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program." *Rural Policy Brief*, no. 2013 16 (January): 1–6. https://pubmed.ncbi.nlm.nih.gov/25399465/.

[177] RUPRI Center for Rural Health Policy Analysis, "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program."

[178] RUPRI Center for Rural Health Policy Analysis, "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program."

Of the 25% of practices that didn't qualify for the PCIP bonus, the average share of primary care provided was just 29%.[179] That percentage indicates that the qualifications implemented under the original system were effective in identifying rural practices that were underfunded because of low primary care reimbursement rates. One drawback of the PCIP system is that it benefited larger practices more than it did smaller settings.[180] In an office with 15 primary care physicians and 7 non-physician practitioners, the PCIP would result in $141,000 extra in revenue annually.[181] However, in small settings, like many CHCs in Massachusetts, the bonus payments typically didn't allow for practices to hire additional staff.[182] In order to ensure that Massachusetts's CHCs are able to take advantage of a new PCIP, bonuses should be scaled to meet the needs of small centers.

State-Level Case Studies

Arkansas' Targeted Funding Strategy for Rural and Underserved Areas

Having a targeted funding strategy for rural and underserved areas has proven effective in other states, such as Arkansas. Arkansas, a predominantly rural state facing its own health disparities, exemplifies this approach. Although 14% of the U.S. population lives in rural areas, nearly half (42%) of Arkansas' residents live in rural communities.[183] In September 2019, the University of Arkansas for Medical Sciences (UAMS) Rural Track Program received $4.6

[179] RUPRI Center for Rural Health Policy Analysis, "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program."
[180] RUPRI Center for Rural Health Policy Analysis, "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program."
[181] RUPRI Center for Rural Health Policy Analysis, "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program."
[182] RUPRI Center for Rural Health Policy Analysis, "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program."
[183] David Wise, "UAMS Receives $750,000 for Rural Residency Program in Northwest Arkansas," UAMS News, September 2, 2020, https://news.uams.edu/2020/09/02/uams-receives-750000-for-rural-residency-program-in-northwest-arkansas/.

million in funding to address the healthcare worker shortage in rural regions. The UAMS Regional Campuses, established in 1973, aim to reduce the rural healthcare worker shortage through residency training programs in these communities. From 2022 to 2023, the program trained 262 health professions students, 153 family medicine residents, and 1,849 high school and college students.[184] During 2023 to 2024, it trained 220 health professions students, 153 family medicine residents, and 1,479 high school and college students, while engaging a total of 10,937 students through presentations and events.[185]

The program creates a pipeline for students to enter the healthcare workforce, emphasizing recruitment from rural and underserved areas, as these students are more likely to practice in such regions.[186] For high school students, the program offers early exposure to medical fields through initiatives like "Find Your Future in Healthcare" and "Hands-on Health Care." The pipeline continues through college, providing advising, MCAT prep, mock interviews, and job shadowing opportunities. For medical students, rural track programs are available, including the Honors Rural Track Program, which partners with the UEMS Little Rock Family Medicine Residency Program to provide rural residency training in Arkansas.[187] This allows medical students to gain experience working with the state's rural and underserved populations. Residents spend their first year training in urban settings before moving to rural areas for their second and third years.[188]

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[184] "2022 – 2023 Annual Report | UAMS Regional Campuses," Regional Campuses, 2022, https://regionalcampuses.uams.edu/about/annual-reports/2022-2023-annual-report/?utm_source=chatgpt.com.
[185] "Regional Campuses 2023-24 Annual Report," accessed July 20, 2025, https://regionalcampuses.uams.edu/wp-content/uploads/2025/07/2023-24-Regional-Campuses-Annual-Report-FINAL.pdf.
[186] "University of Arkansas-School of Medical Sciences Receives $4.6M Grant to Address Rural Physician Shortage," ProQuest, September 4, 2019, https://www.proquest.com/docview/2284651470?accountid=11311&parentSessionId=0PypGwBTVF%2FUSbt8Z2YnbjX0l67%2FlXEaAowJcPj%2Bp8U%3D&pq-origsite=primo&sourcetype=Wire%20Feeds.
[187] "2022 – 2023 Annual Report | UAMS Regional Campuses," Regional Campuses, 2022, https://regionalcampuses.uams.edu/about/annual-reports/2022-2023-annual-report/?utm_source=chatgpt.com.
[188] "What Is a Rural Track? | UAMS South Regional Campus," South Regional Campus, 2025, https://regionalcampuses.uams.edu/south/residency/why-choose-us/what-is-a-rural-track/.

Additionally, part of the funding aims to strengthen partnerships with Community Health Centers of Arkansas through the Rural Practice Scholarship Program.[189] The University of Arkansas School of Medicine ranks among the top 10% for retaining and recruiting primary care physicians in rural and underserved areas.[190]

Thus, UAMS's approach has successfully attracted future healthcare workers to rural regions. A similar residency pipeline could be established in rural Massachusetts, supported by targeted funding. UAMS receives federal funding from the HRSA Rural Residency Planning & Development grants. Although this funding specifically targets attracting rural healthcare workers, the funds outlined in S.900, "An Act to promote primary care through Medicaid graduate medical education funding," are a joint state-federal program. This would give Massachusetts greater flexibility in allocating its funds. Since the funding is loosely defined, Massachusetts could adapt it to develop a rural residency program similar to the UAMS Honors Rural Track program.

New Mexico's Community Health Worker program

New Mexico has a rich ancestry rooted in Native American culture, which has shaped its linguistic and cultural diversity. About a third of New Mexicans (33%) over the age of four speak a language other than English at home, and Spanish is the second most spoken language in the state, with 26.04% of residents speaking Spanish.[191] Furthermore, New Mexico faces notable health disparities: one in five women in the state experiences poverty, and New Mexico has the

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[189] "Health Centers | CHC-AR," CHC-AR, 2025, https://www.chc-ar.org/health-centers.

[190] "Fast Facts | UAMS College of Medicine," College of Medicine, 2021, https://medicine.uams.edu/about/fast-facts/.

[191] "New Mexico, United States: Official and Widely Spoken Languages | TRAVEL.COM®," TRAVEL.COM®, May 17, 2025, https://travel.com/regions/north-america/united-states/new-mexico/new-mexico-united-states-official-and-widely-spoken-languages/.

highest number of alcohol-related deaths in the U.S. Additionally, New Mexico has one of the highest suicide rates, and a quarter of low-income residents report fair to poor health.[192]

The New Mexico Community Health Worker program uses a combination of Medicaid funds, grants, and tax dollars to support community health workers in low-income areas and federally qualified health centers, which serve underserved populations.[193] SB 58, the Community Health Workers Act, along with its implementation through the New Mexico Administrative Code (NMAC) 7. 7.29.5.5, Certification of Community Health Workers, establishes screening procedures and comprehensive certification processes to recruit community healthcare workers.[194]

For example, the One Hope Centro de Vida Health Center was established in the International District in East Central Albuquerque. Starting in the 1970s, the district experienced increased violence, prostitution, with poverty rates exceeding 50%. It is also the most culturally diverse region in New Mexico, home to Hispanics, whites, Native Americans, African Americans, and Asians.[195] This cultural diversity adds complexity to providing healthcare services that are linguistically accessible. The One Hope Centro de Vida Health Center and its community healthcare workers have offered services beyond clinical treatment to address the

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[192] Sarah Klein et al., "PROGRAM at a GLANCE CASE STUDY PRIMARY CARE for LOW-INCOME POPULATIONS How New Mexico's Community Health Workers Are Helping to Meet Patients' Needs Will Tackling Entrenched Problems like Poverty and Criminal Recidivism Improve Health? Consulting Writer and Editor the Commonwealth Fund Roosa Tikkanen," 2020, https://www.commonwealthfund.org/sites/default/files/2020-02/Klein_New_Mexico_community_hlt_workers_hotspotting_cs_v2.pdf.

[193] FQHC Associates, "What Is a Federally Qualified Health Center (FQHC)?," FQHC.org, 2024, https://www.fqhc.org/what-is-an-fqhc.

[194] "ACT RELATING to HEALTH CARE; ENACTING the COMMUNITY HEALTH WORKERS ACT; PROVIDING for DEPARTMENT of HEALTH CERTIFICATION of COMMUNITY HEALTH WORKERS; PROVIDING for RULEMAKING, FEES, CRIMINAL BACKGROUND SCREENING and DISCIPLINE RELATING to CERTIFIED COMMUNITY HEALTH WORKERS; CREATING a BOARD of CERTIFICATION of COMMUNITY HEALTH WORKERS. BE IT ENACTED by the LEGISLATURE of the STATE of NEW MEXICO," accessed July 20, 2025, https://www.nmlegis.gov/Sessions/14%20Regular/final/SB0058.pdf.

[195] Community Health Workers Act, SB 58 (N.M. 2014).

social determinants of health by developing tailored plans that consider patients' financial barriers to affording medications and screening tests.[196]

Community health workers are placed in vulnerable communities, many of whom come from low-income backgrounds themselves. They often share the same socioeconomic barriers, ethnicity, language, and economic backgrounds as their patients, making them well-suited to serve these populations. These workers have helped bridge linguistic and cultural gaps in healthcare access, addressing social aspects of health often overlooked in traditional clinical settings. The NM Department of Health, Office of Community Health Workers, has developed training pathways and certification for specialized aspects of healthcare, and community health workers are reimbursed through state-level New Mexico Medicaid and grant funding from entities such as the CDC Health Disparities Grant.[197]

Despite the funding support, the main challenge of the New Mexico Community Health Worker program is meeting the increasing demand for linguistically and culturally competent healthcare for New Mexico's residents, where 40% of the population lives below the poverty line. To strengthen the training pipeline, Massachusetts could establish a certification program through the Massachusetts Association of Community Health Workers to recruit healthcare workers from rural regions across Massachusetts who demonstrate cultural and linguistic competence. Similarly, H.1289 could adopt a similar model of location-based wages and reimbursements for community health workers from diverse backgrounds who return to work in rural areas.

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[196] Community Health Workers Act, SB 58 (N.M. 2014).

[197] "State Community Health Worker Policies: New Mexico - NASHP," NASHP, April 2, 2025, https://nashp.org/state-tracker/state-community-health-worker-policies/new-mexico/.

Missouri's Associate Physician Licensure Program

Missouri was among the first states to enact legislation related to associate physician (AP) licensing. In its model, the assistant physician must be a legal resident of the United States, a graduate from medical school who has not completed residency, and must have passed Steps 1 and 2 of the US Medical Licensing Examination (USMLE).[198] The graduate must secure their own collaborative practice agreement, treating patients directly with a licensed physician for 30 days before gaining the mobility to practice within a 50-mile radius, as long as 10% of their charts are reviewed by the collaborating physician every two weeks.[199] Missouri's license does not expire after 2 or 3 years, as it does in Arizona and Louisiana.[200]

A study was conducted by the Journal of the American Medical Association following the first year of Missouri's program. The Board licensed 99 APs in 2017, 92 (92.9%) of whom were international medical school graduates, with none of the U.S. medical school graduates having trained in Missouri. Only 25 (25.5%) APs had secured a collaborative agreement, and 20 (80.0%) of them were working in a federally designated professional shortage area.[201]

This study recognized its limitations on data regarding applicants, practice settings, and employers, as well as the ability to evaluate licensure across multiple years.[202] Additional limitations of referencing this study include its small sample size and scope of data. There have been notable changes to Missouri's legislation since, and the first year of a new development is

198 Grant S. Hoekzema and James J. Stevermer, "Characterization of Licensees During the First Year of Missouri's Assistant Physician Licensure Program," JAMA 320, no. 16 (2018): 1706–1707, https://doi.org/10.1001/jama.2018.11191.

199 Grant S. Hoekzema and James J. Stevermer, "Characterization of Licensees During the First Year of Missouri's Assistant Physician Licensure Program," JAMA 320, no. 16 (2018): 1706–1707, https://doi.org/10.1001/jama.2018.11191.

200 States with Enacted and Proposed Associate Physician Legislation," Federation of State Medical Boards, last updated April 2025, https://www.fsmb.org/siteassets/advocacy/policies/associate-physician-legislation-by-state-key-issue-chart.pdf.

201 Grant S. Hoekzema and James J. Stevermer, "Characterization of Licensees During the First Year of Missouri's Assistant Physician Licensure Program," JAMA 320, no. 16 (2018): 1706–1707, https://doi.org/10.1001/jama.2018.11191.

202 Hoekzema and Stevermer, "Characterization of Licensees During the First Year of Missouri's Assistant Physician Licensure Program."

expected to encounter some gaps and challenges. In 2018, SB718 amended the 2014 bill by extending the application period from two to three years, increasing the number of APs that a collaborating physician can supervise from three to six, lowering the number of charts that need review by the collaborating physician to a maximum of 10% per month, and widening the scope of practice for APs. HB1010, a bill proposed to take effect in late August of this year, would make APs eligible for full physician licensure if they complete a set of standards, some of which include passing USMLE Step 3, practice for five years as an AP and gain experience in five core categories of medicine, and receive letters of recommendation.[203,204] Notably, each state that has implemented a form of associate physician licensure has implemented a unique program; this study only accounts for Missouri's pioneering program.

Multi-State Nurse Licensure Compact

Similar to the Interstate Medical Licensure Compact (IMLC), the Nurse Licensure Compact (NLC) streamlines the process of nurses becoming licensed in multiple states. In a 2024 study by the *Journal of Nursing Regulation,* nurses in five NLC-participating states—Alaska, Kansas, Minnesota, Nevada, and Vermont—were surveyed to gauge their opinions on the benefits and drawbacks of the NLC. Comparable to the IMLC, the NLC confers several benefits to healthcare providers: easier provision of in-person and virtual care across state borders, simplified processes for obtaining multistate licenses, and increased health equity for patients. Due to the NLC, the number of nurses providing services—whether in-person or via

[203] FSMB, "States with Enacted and Proposed Associate Physician Legislation."
[204] Missouri, House, HB1010, 103rd General Assembly, 1st session, introduced in House January 23rd, 2025, https://house.mo.gov/bill.aspx?bill=HB1010&year=2025&code=R.

telehealth—in multiple states increased by 10% since the most recent survey.[205] In addition, the number of nurses who held licenses in at least two states increased by 6%, and 96% of nurses viewed the multistate license offered through the NLC as enhancing their work experience.[206] With the entry of states into the NLC, healthcare workers are instantly witnessing the benefits of this program, allowing them to provide care to diverse populations in different states and regions.

Complementing these results, a 2020 study revealed that states participating in the IMLC witnessed a 50% increase in telehealth visits compared to 2019, demonstrating the capacity of the IMLC to scale telehealth services to meet patient demand.[207] Additionally, in a separate study, it was reported that 30% of physicians leverage the IMLC to provide care to underserved areas, such as rural ones.[208] Massachusetts' participation in compacts such as the NLC and IMLC would enable providers from other states to fill in staffing shortages in rural CHCs via telehealth and in-person services. In addition, entry into the compact would grant healthcare workers the freedom and flexibility to provide care to patients in other states without the burden of excessive paperwork. These added resources could increase access to mentorship and professional opportunities, reduce burnout for clinical staff, and enhance overall job satisfaction, supporting employee retention.

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[205] Zhong, Elizabeth H, et al. "Highlights of the Nurse Licensure Compact Survey Findings: Nurses' Needs, Experiences, and Views." Journal of Nursing Regulation 15, no. 2 (2024): 38–44. https://doi.org/10.1016/s2155-8256(24)00054-1.

[206] Zhong, EH., et al., *Highlights of the Nurse Licensure Compact.*

[207] Deyo, Darwyyn, Sriparna Ghosh, and Alicia Plemmons. "Access to Care and Physician-Practice Growth after the Interstate Medical Licensure Compact." Social Science Research Network, January 1, 2023. https://doi.org/10.2139/ssrn.4629647.

[208] Interstate Medical Licensure Compact Commission, "IMLCC Data Study Year 6 - Information Release," 2023, https://imlcc.com/wp-content/uploads/2023/06/IMLCC__Year6_DataStudy-For-Publication-6-6-2023.pdf.

North Carolina's Area Health Education Centers

North Carolina opened nine Area Health Education Centers (AHECs), which aimed to increase rural opportunities for residency and other medical training programs.[209] As a result of these programs, retention rates for hospitals in western North Carolina, which contains the highest rural population of the state, increased to 90%.[210] Compared to the national average retention rate of 25% in rural areas, the introduction of the AHECs significantly increased rural areas' physician populations within the state, combating the significant disparities that many previously experienced in the state.[211]

Georgia's Rural Hospital Tax Credit Program

Instituted in 2016 and effective starting January 1st of 2017, the state of Georgia implemented the Georgia Rural Hospital Tax Credit Program under O.C.G.A. Code of Georgia Title 48, Chapter 7, Article 2 (GA Code § 48-7-29.20).[212] The code stated that individuals willing to make financial contributions to rural hospital organizations would qualify for a tax credit for a specific amount. Within the code, "rural" was defined as areas in Georgia with a population of 50,000 residents or fewer.

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[209] Klein, Sarah, and Patricia R. Schoenbrun. 2024. "An Enticing Offer: How Some Rural Communities Are Winning the Competition for New Clinicians." The Commonwealth Fund. https://www.commonwealthfund.org/publications/2024/dec/how-some-rural-communities-are-winning-new-clinicians#:~:text=While%20the%20program%20isn't,funding%20from%20a%20local%20philanthropy.

[210] Klein, Sarah, and Patricia R. Schoenbrun. 2024. "An Enticing Offer: How Some Rural Communities Are Winning the Competition for New Clinicians." The Commonwealth Fund. https://www.commonwealthfund.org/publications/2024/dec/how-some-rural-communities-are-winning-new-clinicians#:~:text=While%20the%20program%20isn't,funding%20from%20a%20local%20philanthropy.

[211] Klein and Schoenbrun."An Enticing Offer: How Some Rural Communities Are Winning the Competition for New Clinicians."

[212] 2024 CODE OF GEORGIA :: Title 48 - REVENUE AND TAXATION (§§ 48-1-1 — 48-18-1) :: Chapter 7 - INCOME TAXES (§§ 48-7-1 — 48-7-170) :: Article 2 - IMPOSITION, RATE, AND COMPUTATION; EXEMPTIONS (§§ 48-7-20 — 48-7-42) :: Section 48-7-29.20 - [Repealed and Reserved Effective 12/31/2029] Tax credits for contributions to rural hospital organizations. (2024). Retrieved August 11, 2025, from Justia Law website: https://law.justia.com/codes/georgia/title-48/chapter-7/article-2/section-48-7-29-20/.

Georgia was and still is, to some degree, a state with prevalent healthcare worker shortages. In fact, Georgia ranks in the bottom half nationally for primary care physician availability, and 143 of Georgia's 159 counties are designated as Health Professional Shortage Areas (HPSAs).[213]

A longitudinal cross-sectional study using hospital financial data from the Centers for Medicare and Medicaid Services was conducted to compare the financial health of rural hospitals before and after implementation of the Georgia Rural Hospital Tax Program. The study revealed that two years after implementation of the program, there was a clear increase in financial health in participating rural hospitals - approximately a 23% increased probability of good or excellent financial health.[214] This meant that hospitals became considerably more profitable due to the policy. Hospitals now had the means to provide better patient care with the increased funding and became more financially stable overall, which would become a factor that is able to not only retain staff but also hire new workers.

Another study on the effects of the program was done using data from telephone interviews with 21 hospital executives and administrators of eligible rural hospitals. This study found that the general opinions about the program were overwhelmingly positive.[215] With greater financial security, hospitals were then able to allocate resources toward retaining healthcare workers by addressing the issue of non-competitive wages directly.

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[213] Georgia Physician Shortage Facts. (2024, February 21). Retrieved from Cicero Institute website: https://ciceroinstitute.org/research/georgia-physician-shortage-facts/.

[214] Apenteng, B. A., Opoku, S. T., Owens, C., Akowuah, E., Kimsey, L., & Peden, A. (2021). Assessment of the Financial Health of Rural Hospitals After Implementation of the Georgia Rural Hospital Tax Credit Program. JAMA network open, 4(7), e2117791. https://doi.org/10.1001/jamanetworkopen.2021.17791.

[215] Opoku, S. T., Apenteng, B. A., Owens, C., Kimsey, L., Peden, A., Ekpo, I., Mase, W. A., & Akowuah, E. (2021). Georgia Rural Hospital Tax Credit: Perspectives of Rural Health Executives. The Journal of rural health : official journal of the American Rural Health Association and the National Rural Health Care Association, 37(2), 328–333. https://doi.org/10.1111/jrh.12529.

Maryland's All-Payer Rate-Setting System

In Maryland, the state employs a unique all-payer rate-setting system that ensures that all third parties end up paying the same rate.[216] This is made possible by a 36-year-old Medicare waiver that exempts Maryland from the Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS). As a result, the state can set its own rates and has improved results for patients and hospitals—especially applicable for Massachusetts CHCs that suffer from lower reimbursements from private insurance providers.

Some of the advantages of the waiver system include that the common payment method reduces the burden on administrators, simplifies negotiation, and improves price transparency for patients.[217] Most importantly, for Massachusetts CHCs, is that with a common price that private and public insurance must pay, the all-payer rate ensures that the CHCs would have enough funds to cover operations, and Maryland actually includes an extra surcharge to support uninsured residents—something worth looking into as a replacement for the Massachusetts Health Safety Net.

The first model of Maryland's contract, known as the "Maryland All-Payer Medicare Model Contract," was a five-year pilot program that proved successful with the $300 million in cost reduction.[218] That is the model most likely directly applicable to CHCs in Massachusetts right now, as the second stage of Maryland's model, known as the Total Cost of Care Model, is much more comprehensive and requires more in-depth planning by administrators and

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[216] Centers for Medicare & Medicaid Services. "Maryland All-Payer Model." *CMS.gov.* Updated March 2, 2020. https://innovation.cms.gov/innovation-models/maryland-all-payer-model.

[217] Centers for Medicare & Medicaid Services. "Maryland All-Payer Model." CMS.gov. Updated March 2, 2020. https://innovation.cms.gov/innovation-models/maryland-all-payer-model.

[218] Maryland Health Services Cost Review Commission. "Maryland's Total Cost of Care Model." Maryland.gov. https://hscrc.maryland.gov/Pages/tcoc.aspx.

government coordination.[219] Part of the new agreement that began in January 2019 is that Maryland agreed that the total spending on hospital services could not increase by more than 3.58% a year, and for Medicare, they had to have a growth rate below the national average.

Virginia's Housing Subsidies for Community Healthcare Workers

In the Richmond/Henrico Health District of Virginia, community health workers were embedded in low-income housing for 10 years. From 2013 to 2020, the Community Health Workers (CHW) program in the Richmond/Henrico Health District of the Virginia Department of Health (VDH) established resource center offices from which CHWs worked. The Richmond Henrico health district is one of Virginia's most populous districts and consists of a mixture of suburban, rural, and urban communities.[220] In a 2024 survey of the district's residents, 24.8% of respondents reported difficulties accessing healthcare services, emphasizing the need for improved access and affordability.[221] The result of the longitudinal cohort study focused on the benefits brought to this community and suggests that embedding community health workers within rural communities yields better health outcomes. First, CHWs are a cost-effective strategy, reducing the use of more expensive interventions like emergency rooms and costly medical devices. Further, this approach encourages mutual trust and understanding between community residents and health workers since the CHWs would understand and use the appropriate messaging to enable rural communities to adopt health-promoting practices.

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[219] Maryland Health Services Cost Review Commission. Maryland's Total Cost of Care Model: Background and Summary. https://hscrc.maryland.gov/Documents/Modernization/TCOC%20Background%20and%20Summary%20_5_23_18%20.pdf.

[220] Obasanjo, Iyabo, Monica Griffin, Alison Scott, Sarena Oberoi, Charles Westhoff, Patrice Shelton, and Stephanie Toney. 2022. "A Case Study of a Community Health Worker Program Located in Low-Income Housing in Richmond, Virginia." *Journal of Community Health* 47 (2): 316–23. https://doi.org/10.1007/s10900-021-01057-1.

[221] "Community Health Assessment (CHA) - Richmond City Health Department." 2024. Richmond City Health Department. October 11, 2024. https://www.vdh.virginia.gov/richmond-city/cha/.

Indiana's Subsidization of Childcare Services for Healthcare Workers

A successful case study of establishing childcare services is the Appleseed Childhood Education and Franciscan Health, Rensselaer, Indiana.[222] In fall 2022, Appleseed Childhood Education and Franciscan Health launched a joint effort in Rensselaer, Indiana, to tackle two pressing issues facing the rural community: a shortage of quality early childhood education (ECE) options and ongoing challenges in attracting and keeping healthcare professionals at the local hospital. The goal was to develop a long-term, community-rooted solution that would strengthen both family support systems and the healthcare workforce. The partnership aimed to serve a dual purpose of improving access to early learning for local children while also making Rensselaer a more appealing place for young professionals to live and work. By 2023, the collaboration resulted in the opening of a $1 million, 7,500-square-foot ECE center, the first such facility in the area since 2018.[223] The new center helps fill a long-standing gap in services and is already contributing to the town's broader efforts to attract families, support working parents, and revitalize the local economy.

A trishare model of childcare could distribute the costs to the state, employer, and parents.[224] In 2019, Grand Rapids, Michigan, piloted the nation's first Tri-Share childcare program, which later emerged as a national model for affordable childcare during the COVID-19 pandemic. Officially launched statewide in 2021, the MI Tri-Share model encourages the division of childcare costs equally among three parties: the employer, the employee, and the

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222 "Understanding Childcare Challenges in Rural America Strategic Recommendations and an Action Framework." 2024. Foundation for Rural Services. https://www.ntca.org/sites/default/files/documents/2024-10/understanding-childcare-challenges-in-rural-america.pdf.

223 "Understanding Childcare Challenges in Rural America Strategic Recommendations and an Action Framework." Foundation for Rural Services.

224 Rassoul, Elijah. 2024. "Cost-Sharing for Child Care: Looking at the Tri-Share Model | CLASP." CLASP. August 22, 2024. https://www.clasp.org/blog/cost-sharing-for-child-care-looking-at-the-tri-share-model/.

State of Michigan. A regional facilitator hub coordinates this three-way cost-sharing arrangement, serving as an intermediary between stakeholders. The program has demonstrated significant success, with Michigan allocating over $2.5 million to its expansion since 2022. In Massachusetts, this model can be enacted through the Massachusetts League of Community Health Centers, founded in 1972, a primary care association that oversees 50 health centers by providing services such as training, technical assistance, advocacy guidance, and more.[225] Serving over a million patients across 98% of Massachusetts zip codes, these centers have been at the forefront of implementing health policy to expand medical centers. Coordinating childcare services could be an extension of the services it already provides to rural healthcare workers and their communities.

Maryland's Rate Equity for Community Health Centers

In Maryland, the state employs a unique all-payer rate-setting system that ensures that all third parties end up paying the same rate.[226] This is made possible by a 36-year-old Medicare waiver that exempts Maryland from the Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS). As a result, the state can set its own rates and has improved results for patients and hospitals—especially applicable for Massachusetts CHCs that suffer from lower reimbursements from private insurance providers.

All-payer systems require hospitals to charge the same price for each service to each insurance, as used by countries such as Germany.[227] In Germany, all insurers and the

[225] Massachusetts League of Community Health Centers. "About - Massachusetts League of Community Health Centers," January 8, 2025. https://www.massleague.org/about/.
[226] Centers for Medicare & Medicaid Services. "Maryland All-Payer Model." *CMS.gov.* Updated March 2, 2020. https://innovation.cms.gov/innovation-models/maryland-all-payer-model.
[227] Rich Barlow, "You've Heard of Single-Payer. What about All-Payer Health Care?" *BU Today*, March 19, 2018, https://www.bu.edu/articles/2018/single-payer-vs-all-payer-health-care/.

representatives of hospitals negotiate a binding rate that all health insurance and all health systems would accept this price. However, in Maryland, instead of an insurance and hospital negotiation, the rates are set by the Health Services Cost Review Commission, and rates are not nationwide, but instead each hospital sets the same rates for all the insurance providers.[228]

Some of the advantages of the waiver system include that the common payment method reduces the burden on administrators, simplifies negotiation, and improves price transparency for patients.[229] Most importantly, for Massachusetts CHCs, is that with a common price that private and public insurance must pay, the all-payer rate ensures that the CHCs would have enough funds to cover operations, and Maruland actually includes an extra surcharge to support uninsured residents—something worth looking into as a replacement for the Massachusetts Health Safety Net. As a result, Maryland has saved $300 million in Medicare savings from the limits imposed on hospital cost growth and Medicare cost growth below the national average.

The first model of Maryland's contract, known as the "Maryland All-Payer Medicare Model Contract," was a five-year pilot program that proved successful with the $300 million in cost reduction.[230] That is the model most likely directly applicable to CHCs in Massachusetts right now, as the second stage of Maryland's model, known as the Total Cost of Care Model, is much more comprehensive and requires more in-depth planning by administrators and government coordination.[231] Part of the new agreement that began in January 2019 is that

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[228] Gerard Anderson and Bradley Herring, "The All-Payer Rate Setting Model for Pricing Medical Services and Drugs," AMA Journal of Ethics 17, no. 8 (August 2015): 770–775, https://doi.org/10.1001/journalofethics.2015.17.8.pfor1-1508.
[229] Centers for Medicare & Medicaid Services. "Maryland All-Payer Model." *CMS.gov*. Updated March 2, 2020. https://innovation.cms.gov/innovation-models/maryland-all-payer-model.
[230] Maryland Health Services Cost Review Commission. "Maryland's Total Cost of Care Model." *Maryland.gov*. https://hscrc.maryland.gov/Pages/tcoc.aspx.
[231] Maryland Health Services Cost Review Commission. *Maryland's Total Cost of Care Model: Background and Summary.* https://hscrc.maryland.gov/Documents/Modernization/TCOC%20Background%20and%20Summary%20_5_23_18%20.pdf.

Maryland agreed that the total spending on hospital services could not increase by more than 3.58% a year, and for Medicare, they had to have a growth rate below the national average.

Effect of CHC-Based or Rural-Based Training on Healthcare Staff Retention Rates Across Multiple States

Another study, which surveyed family physicians from at least a year to at most 15 years post-residency training, found that those from a CHC-based family medicine program were "2.7 times more likely to work in underserved settings than non-CHC trained family physicians."[232] Even within their own training pool, CHC-trained graduates were "2.4–3.4 times more likely" to work in CHCs, medically underserved areas, and rural health clinics.[233] In addition, CHC residency training was found to rank more favorably in comparison with non-CHC family medicine training among medical students. Study participants who trained in CHCs "had high practice satisfaction ratings, had a broad scope of practice, and felt they were well prepared."[234]

A second case study from 2013 utilized Medicare Part B claims filed from rural health clinics (RHCs), federally qualified health centers (FQHCs), and critical access hospitals (CAHs) to identify residents who trained in these areas from 2001-2005 to see if they were still practicing in these settings during 2009.[235] Results found that 52.6% of CAH-trained residents, 38.1% of RHC-trained residents, and 31.2% of FQHC-trained residents were still working in a similar

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232 Morris, Carl G, Brian Johnson, Sara Kim, and Frederick Chen. 2008. "Training Family Physicians in Community Health Centers: A Health Workforce Solution." *Family Medicine* 40 (4): 271–76. https://pubmed.ncbi.nlm.nih.gov/18382840/.

233 Morris, Carl G, Brian Johnson, Sara Kim, and Frederick Chen. 2008. "Training Family Physicians in Community Health Centers: A Health Workforce Solution." Family Medicine 40 (4): 271–76. https://pubmed.ncbi.nlm.nih.gov/18382840/.

234 Morris, Carl G, Brian Johnson, Sara Kim, and Frederick Chen. 2008. "Training Family Physicians in Community Health Centers: A Health Workforce Solution." Family Medicine 40 (4): 271–76. https://pubmed.ncbi.nlm.nih.gov/18382840/.

235 Robert L. Phillips, Stephen Petterson, and Andrew Bazemore, "Do Residents Who Train in Safety Net Settings Return for Practice?" *Academic Medicine* 88, no. 12 (2013): 1934-1940, https://doi.org/10.1097/ACM.0000000000000025.

setting come 2009.[236] Considering this study's methodology utilized Medicare claims, the number of residents working at RHCs, FQHCs, and CAHs was likely undercounted. Additionally, residents in pediatrics were likely missed because of the emphasis on Medicare. It is also unclear whether residents who completed training in 2005 continued to work continuously in rural and underfunded areas from their graduation date to when they were surveyed in 2009.[237]

An earlier analysis of rural training track (RTT) influence on rural practice tendencies from 2000 identified that "67% of [these] graduates have a primary office ZIP code in a rural community, and 61% practice in a designated HPSA [health professional shortage area]."[238] Additionally, "69% of graduates admit[ted] to a hospital in a rural community and 59% admitted to a hospital with fewer than 50 beds."[239] However, under current RTT funding conditions, it is unlikely that these programs will be able to produce the number of residents necessary to address health professional shortages. Still, RTT graduates appear to have a "durable rural ethos" with 76% remaining in their original rural practice site and 63% moving to another rural area, "which is twice the relocation-to-rural rate demonstrated by other rural practitioners."[240]

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[236] Robert L. Phillips, Stephen Petterson, and Andrew Bazemore, "Do Residents Who Train in Safety Net Settings Return for Practice?"

[237] Robert L. Phillips, Stephen Petterson, and Andrew Bazemore, "Do Residents Who Train in Safety Net Settings Return for Practice?"

[238] Thomas C. Rosenthal, "Outcomes of rural training tracks: a review," *The Journal of Rural Health* 16, no. 3 (2000): 213-216, https://doi.org/10.1111/j.1748-0361.2000.tb00459.x.

[239] Thomas C. Rosenthal, "Outcomes of rural training tracks: a review."

[240] Thomas C. Rosenthal, "Outcomes of rural training tracks: a review," *The Journal of Rural Health* 16, no. 3 (2000): 213-216, https://doi.org/10.1111/j.1748-0361.2000.tb00459.x.

Policy Recommendations

Amend and Enact Existing Bills

Amend and Enact Massachusetts Bill S.900, An Act to promote primary care through Medicaid graduate medical education funding.

I. Amend Bill S.900 to Incorporate the Targeted Strategy for Rural and Underserved Community Health Centers (CHCs) Outlined in the Song-Brown Healthcare Workforce Training Act.

The Massachusetts League for Community Health Centers should advocate for a provision in S.900 to incentivize residency training in rural and underserved areas, as outlined in the Song-Brown Healthcare Worker Training Act. Section 80 of S.900 allows "qualifying acute care hospitals and community health centers" to fund graduate medical education and residency programs through combined federal-state Medicaid, marking a historical transition from federal to state funding for healthcare training in the state.[241] While the bill mentions CHCs, it marks a historical transition from federal to state funding for healthcare training in the state.[242] Thus, Section 80 of S.900 should be amended to specifically include language on how GME funds are allocated and provide a clear definition of a "qualifying" institution that includes rural CHCs.

Background Research:

The Song-Brown Healthcare Workforce Training Act was signed into law in 1973 by Governor Ronald Reagan to increase the residency and medical training opportunities in California.[243] As part of the bill, the California Healthcare Workforce Policy Commission was established to identify underserved regions, including rural areas, and to increase the number of

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[241] "Bill S.900," Malegislature.gov, 2025, https://malegislature.gov/Bills/194/S900.
[242] "Bill S.900."
[243] "The Song-Brown Program" (California Health Care Foundation, February 2019), https://www.chcf.org/wp-content/uploads/2019/02/GMEFundingCASongBrown.pdf.

healthcare workers in these communities, as well as enhance the diversity of the healthcare workforce. From 2017 to 2018, the act proved successful, providing $30.6 million to residency programs for primary care physicians, with funding targeted in California's underserved regions, particularly the Central Valley, Central Coast, and Southern Border.[244]

Whereas most states use their Medicare funds, combined with Medicare GME funds, to fund residency programs, Massachusetts has historically relied on federal funding as its main source of funding.[245] The dependence on federal funding has prevented Massachusetts from having decision-making power regarding the location of residency programs. It was challenging to incentivize residents to complete their residency in rural and gateway cities if residency programs were not available in those regions.

S.900 is currently sponsored by State Senator Jake Oliveira (D) and was referred to the Senate Ways and Means Committee on June 16th, 2025.[246] Residency programs in Massachusetts are generally funded through GME funding through Medicare via Direct and Indirect Medicare funding. Although funding reallocation is regulated by Massachusetts statute, passing S.900 will allow the Massachusetts State Legislature to allocate a portion of future MassHealth GME funds to rural CHCs.

Amending the language of Section 80 of S.900 to implement targeted funding will first require identifying rural CHCs that should receive funding. In Massachusetts, priority areas should include rural regions that may face workforce shortages, such as the Community Health Center of Franklin County (CHCFC), a rural federally qualified health center located in

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[244] "The Song-Brown Program" (California Health Care Foundation, February 2019), https://www.chcf.org/wp-content/uploads/2019/02/GMEFundingCASongBrown.pdf.
[245] Phillips, "Mass. = Primary Care Doctor Desert."
[246] "MA - S900," BillTrack50, 2025, https://www.billtrack50.com/billdetail/1861069.

Greenfield and Orange, Massachusetts.[247] Other regions to target include Barnstable County and Berkshire County, classified as "rural level 1" under the Massachusetts State Office of Rural Health's Rural Definition. Additionally, the Massachusetts Loan Repayment Program offers support to healthcare workers who practice in underserved areas. Observing which community health centers apply for the Massachusetts Loan Repayment Program may be an indication that they are encountering workforce shortages and should consider implementing residency training.

After selecting rural CHCs, it should be determined whether the rural CHCs can support residency training programs. For example, the Accreditation Council for Graduate Medical Education (ACGME) offers an accreditation model for graduate medical education and residency training, along with site visits to evaluate whether sufficient physicians are willing to facilitate and if there are adequate examination rooms. Rural CHCs could partner with nearby medical facilities and programs that offer teaching support, such as the Rural Hospital Flexibility Program created by the MDPH State Office of Rural Health.[248]

To recruit residents from underrepresented backgrounds, ensuring that the residency programs created in rural CHCs provide professional development and career advancement opportunities can incentivize prospective healthcare workers to pursue these residency programs. This professional development can include training for various specialties, tailored mentorship, and patient simulations. To encourage residents to continue practicing in rural CHCs, Collaborative Healthcare Models can be introduced, where advanced practice providers support rural healthcare workers to reduce their patient burden.[249]

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[247] "CHCFC," CHCFC, n.d., https://www.chcfc.org/.

[248] "Overview of Rural Hospital Programs," Mass.gov, 2025, https://www.mass.gov/info-details/overview-of-rural-hospital-programs.

[249] Jackson Physician Search, "10 Strategies for Successful Rural Physician Recruitment," Jackson Physician Search, January 8, 2024, https://www.jacksonphysiciansearch.com/insights/10-strategies-for-successful-rural-physician-recruitment/.

Once the GME funding plan is modified to include explicit provisions for rural CHC residency training funding, a certain percentage of the total budget can be allocated to rural CHCs. In terms of allocating funding for rural CHCs, the proposed funding changes would require implementation by the Massachusetts Executive Office of Health and Human Services (EOHHS), which is in charge of supervising MassHealth programs and GME funding. Other organizations, such as the Massachusetts Health & Hospital Association, can engage in state lobbying efforts to advance the amendment by encouraging legislators to co-sponsor S.900 with the proposed amendment. The continued support of the Joint Committee on Healthcare Financing will be necessary to ensure the bill progresses within its timeline.[250]

Based on the Song-Brown Healthcare Workforce Training Programs, shown below is an estimate of the proposed re-allocation of funding (based on the Fiscal Year 2023-2024 report).[251] According to the funding model, ~57.4% is reserved for the creation of new Primary Care Residency (PCR) programs, and a similar percentage of the MassHealth GME budget can be allocated towards developing new residency programs in rural CHCs.

Total Primary Care Residency programs funding: $85,900,000

1. **Existing PCR programs' funding**: $24,700,000
2. **Existing Teaching Health Centers funding**: $7,500,000
3. **Expanding PCR programs' funding**: $4,400,000
4. **New PCR programs funding**: $49,300,000

Although S.900 provides a solid foundation for shaping future funding for residency programs in rural CHCs, its main limitation is the absence of a clear funding source. The bill

[250] "Joint Committee on Health Care Financing," Malegislature.gov, 2025, https://malegislature.gov/Committees/Detail/J24/194.
[251] "Primary Care Residency (PCR) Training Programs Grant Guide for Fiscal Year 2023-24" (Department of Health Care Access and Information), accessed August 12, 2025, Primary Care Residency (PCR) Training Programs Grant Guide For Fiscal Year 2023-24.

does not specify funding mechanisms beyond MassHealth GME, and the timeline is not immediate, as the first payments will not be made until July 2027. Since establishing new residency programs in rural CHCs may take several years, the delay in funding could postpone their impact. Additionally, dependence on Medicaid GME funding is uncertain, and recent budget cuts could undermine the bill's ability to ensure ongoing support for these programs. These cuts could disproportionately affect underserved communities in Massachusetts' rural areas. Lastly, while S.900 may facilitate the creation of residency programs in rural CHCs, recruiting and retaining prospective residents in these settings over the long term remains challenging. The success of the training pipeline depends on providing incentives to attract residents to these new programs. However, amending the framework of S.900 set the foundation for future funding opportunities for establishing new rural CHC residency programs. Taking steps to secure dedicated funding for rural CHC residency development will significantly help attract healthcare workers to these areas.

By drawing from the targeted funding of the Song-Brown Healthcare Worker Training Act, such as identifying rural and medically underserved sites, supporting residency placement in these communities, and enrolling residents from underserved backgrounds into S.900, it would ensure that providers have opportunities to receive training and would lead to greater initiation of healthcare workers in rural CHCs where healthcare is needed most.

II. Amend Bill S.900 to Specifically Address and Identify Key Rural Healthcare Centers.

The location of medical training is a key determinant of future work location.[252] Physicians tend to practice in the region in which they trained. Therefore, there is a clear need to increase

[252] "Massachusetts Loan Repayment Program (MLRP) for Health Professionals | Mass.gov." n.d. Www.mass.gov. https://www.mass.gov/info-details/massachusetts-loan-repayment-program-mlrp-for-health-professionals.

Graduate Medical Education (GME) programs in rural Massachusetts areas. GME programs receive funding primarily through Medicare and Medicaid, which ensure adequate access to clinical training. However, despite its abundance of teaching hospitals and healthcare prowess, Massachusetts is 1 of 7 states not using Medicaid payments to fund GMEs.[253] Massachusetts made Medicaid GME payments in the past, but due to budgetary constraints, the program was cut in 2010.[254] In their 2013 report, the Special Commission on Graduate Medical Education highlighted the need for increased GME funding through Medicaid and other means;[255] however, to date, the state has not resumed Medicaid GME payments.[256] Although Massachusetts receives Medicare GME payments, Medicaid payments are an attractive added benefit. States have flexibility in how they disburse Medicaid GME payments, and the federal government matches funds made by state Medicaid GME payments, which maximizes federal money allotment.[257] These funds can be used to provide training for a diverse array of healthcare professionals.

Behind Medicare, Medicaid is the second largest funder of Graduate Medical Education programs in the United States.[258] Under Medicaid, states have increased flexibility and receive federal matching of funds. In 2022, 44 states and the District of Columbia made Medicaid GME payments.[259] Despite its large patient population, Massachusetts does not make payments under its Medicaid fee-for-service program. A 50-State Survey on Medicaid GME payments reports that 32 states made Medicaid GME payments with the specific rationale being to produce more

[253] James, Cara V. 2017. "Racial/Ethnic Health Disparities among Rural Adults — United States, 2012–2015." *MMWR. Surveillance Summaries* 66 (23). https://doi.org/10.15585/mmwr.ss6623a1.
[254] James, Cara V. 2017. "Racial/Ethnic Health Disparities among Rural Adults — United States, 2012–2015."
[255] James, Cara V. 2017. "Racial/Ethnic Health Disparities among Rural Adults — United States, 2012–2015."
[256] Rowan, Shah, Knudson, et al. 2024. "Health Professional Retention in Underserved Areas: Findings from the National Health Service Corps Loan Repayment Program Participants in the United States, 2019–2021."
[257] James, Cara V. 2017. "Racial/Ethnic Health Disparities among Rural Adults — United States, 2012–2015."
[258] James, Cara V. 2017. "Racial/Ethnic Health Disparities among Rural Adults — United States, 2012–2015."
[259] Under Medicaid, states have increased flexibility and receive federal matching of funds. In 2022, 44 states and the District of Columbia made Medicaid GME payments

physicians. This statistic supports the crucial need to expand the physician workforce in underserved communities facing shortages.

Medicaid GME payments in Massachusetts are currently being reconsidered under Senate Bill 900, "An Act to promote primary care through Medicaid graduate medical education funding," of the Commonwealth of Massachusetts.[260] The bill requires the state to reimburse acute care hospitals supporting residency training in behavioral health, primary care, and other fields experiencing shortages.[261] The state secretary must identify an appropriate Medicaid GME funding amount and funding sources by July 1, 2026. Annual payments must begin by October 1, 2027. The bill was reported favorably in June 2025 and referred to the committee on Senate Ways and Means, where it awaits further consideration. This bill should make specific provisions for rural-based hospitals so that payments are specifically directed to rural hospitals.

Senate Bill 900 should be amended to specifically address the rural healthcare workforce shortage as a key motivator driving this bill's passage. Currently, the bill only calls for the re-implementation of Medicaid GME payments and details how this may be done; however, there can be additional language that supports why these payments are so crucial. Expanding the federal allotment for GME programs ensures improved access to clinical training. There is a clear need for increased GME programs in rural regions. Including this specific language in the bill's proposal would call further attention to the rural physician workforce shortage at the government level, and therefore ease future efforts to improve rural healthcare professional recruitment. Further, in the July 1, 2026, update to Senate Bill 900, legislators should identify rural Massachusetts hospitals, clinics, or centers to receive funding to ensure that rural areas are not overlooked.

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[260] "Bill S.900." 2025. Malegislature.gov. 2025. https://malegislature.gov/Bills/194/S900.
[261] "MA - S900." 2025. BillTrack50. 2025. https://www.billtrack50.com/billdetail/1861069.

Cost-Benefit Analysis:

One study supports that 1 PCP per 10,000 individuals results in an 11% decrease in emergency department visits, 6% decrease in hospital inpatient admissions, and a 7% decrease in surgery.[262] Increasing primary care physicians supports a healthier, more proactive population. Using New Mexico as a model for state GME Medicaid payments, the potential costs of a Massachusetts program can be evaluated. The University of New Mexico (UNM) Medical Center is the predominant GME training institution in the state. Currently, UNM allocates $80,883.10 for Indirect Medical Education (IME), which is paid to only hospitals, and $6,800.90 for Direct Medical Education (DGME), which is paid to reimburse hospitals and organizations for resident salaries.[263] This amounts to $87,684. Massachusetts may allot roughly $87,000 for Medicaid GME payments.

Limitations:

It is difficult to quantify Medicaid GME payments or monitor or track their efficacy due to the way payments are made.[264] Payments are made through Medicaid service rate increases. Under Medicaid law, there are no detailed provisions regarding payment requirements for hospital services. This grant states a large flexibility to develop standards and methods to determine the price to pay for Medicaid services. It is difficult for states to correspond Medicaid payments with GME program operations because funding is not limited to teaching hospitals or educational costs or measures. This is particularly difficult for programs that include training in non-hospital settings. Therefore, guaranteeing the efficacy of Medicaid GME payments is challenging. Further,

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[262] "Graduate Medical Education Expansion in New Mexico Five Year Strategic Plan." 2019. https://burrell.edu/wp-content/uploads/2020/10/HSDGME-StrategicPlan-Final2020.pdf.

[263] "Graduate Medical Education Expansion in New Mexico Five Year Strategic Plan."

[264] "Medicaid Program; Graduate Medical Education." 2007. Federal Register. May 23, 2007. https://www.federalregister.gov/documents/2007/05/23/07-2576/medicaid-program-graduate-medical-education.

under the current Medicaid statute, the federal government can only evaluate and monitor Medicaid spending for medical service rates, but not for GME. The benefits of Medicaid GME surpass these limitations. Medicaid GME will increase and maintain the physician population, which can then treat far more patients and result in decreased emergency department visits, hospitalizations, and surgeries. One study supports that 1 PCP per 10,000 individuals results in an 11% decrease in emergency department visits, 6% decrease in hospital inpatient admissions, and a 7% decrease in surgery.[265] Strengthening physician capacity and distribution through federal funding will undoubtedly strengthen the physician workforce and help contribute to decreases in cost and visits.

Implementation Logistics and Final Summary:

There is no current statutory authority for GME under federal law. Therefore, Medicaid programs are not obligated to pay for GME programs. However, most states can make payments under their fee-for-service programs. Under this program, the Medicaid agency pays healthcare professionals directly for each service they provide to a Medicaid beneficiary. This opposes the managed care program, where the state pays a managed care organization (MCO). There are no federal guidelines regulating state usage. Senate Bill 900 proposes that Medicaid GME payments follow the statutory regulations and methods of Medicare GME payments under Section 1886(h) of the Social Security Act, as implemented by 42 CFR 413.75 through 42 CFR 413.83.

III. Amend Bill S.900 to Increase the Allocation of Funding for Training Programs in Rural Areas.

[265] "Graduate Medical Education Expansion in New Mexico Five Year Strategic Plan."

Training programs for physicians are severely underfunded and lacking in rural areas in Massachusetts. Specifically, from 2002 to 2017, medical student graduates living in rural parts of the state decreased by 28%, leading to a significant shortage of qualified medical professionals in the region.[266] This decrease can be attributed to a variety of factors, including increased urbanization, with 81% of Massachusetts' cities increasing in population from 2003 to 2024, and decreased training options and job offers for working spouses in rural areas.[267] Thus, by increasing the residency programs available in rural areas of Massachusetts, the number of physicians in the region will also increase. This is because the place where a physician completes their residency is likely the place where they will practice medicine, with 58% of physicians currently practicing in the place where they completed their residency.[268]

Specifically, the Massachusetts Senate Bill 900 aims to accomplish this by directing funds towards graduate medical education, diverting funds from Medicaid to be used to enhance primary care education in the state.[269] However, there aren't many specific guidelines within this bill on how to use these funds in a particular manner to support graduate medical education to increase the number of primary care physicians within the state. Thus, by mirroring the existing AHEC program in North Carolina, which divided the state into 9 regions with 300 resident slots for PCPs annually, Massachusetts will be able to enhance the existing state-funded programs for graduate medical students effectively.

Background & Case Study:

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[266] "Number of medical students from rural areas down 28% over 15 years." 2019. American Hospital Association. https://www.aha.org/news/headline/2019-12-04-number-medical-students-rural-areas-down-28-over-15-years.

[267] Jaret, Peter. 2020. "Attracting the next generation of physicians to rural medicine." AAMC. https://www.aamc.org/news/attracting-next-generation-physicians-rural-medicine.

[268] Murphy, Brendan. 2024. "How training location, specialty affect where doctors go after GME." American Medical Association. https://www.ama-assn.org/medical-residents/transition-resident-attending/how-training-location-specialty-affect-where#:~:text=Resident%20retention%20by%20state,phases%20of%20the%20GME%20continuum.

[269] Oliveira, Jacob. 2025. "An Act to promote primary care through Medicaid graduate medical education funding." The 194th Court of the Commonwealth of Massachusetts. https://malegislature.gov/Bills/194/S900.

Residency programs are when medical students truly begin to see themselves as physicians, and rural areas often do not have the facilities to enable physicians from their region to remain there for their training. By addressing this issue, rural residents will have significantly more chances to remain and help in the areas where they want to live. This has been done previously in the state of North Carolina, which opened nine Area Health Education Centers (AHECs), which aimed to increase rural opportunities for residency and other medical training programs.[270] Currently, the North Carolina AHEC program maintains 19 residential programs for the state's medical students, covering family medicine, general surgery, psychiatry, internal medicine, pediatrics, and obstetrics and gynecology.[271] These programs take place both within AHECs across the state's 9 AHEC regions as well as within major universities in the state, such as the University of North Carolina-Chapel Hill and Duke University. As a result of these programs, retention rates for hospitals in western North Carolina, which contains the highest rural population of the state, increased to 90%. Compared to the national average retention rate of 25% in rural areas, the introduction of the AHECs significantly increased rural areas' physician populations within the state, combating the significant disparities that many previously experienced in the state. Thus, Massachusetts would similarly benefit from implementing increased training programs and options in rural areas across the state.

Estimated Costs of Policy:

Below is an itemized estimate of the costs for the creation of these programs, assuming that this policy enacts the development of 6 residency training centers similar to North Carolina's

[270] Klein, Sarah, and Patricia R. Schoenbrun. 2024. "An Enticing Offer: How Some Rural Communities Are Winning the Competition for New Clinicians." The Commonwealth Fund. https://www.commonwealthfund.org/publications/2024/dec/how-some-rural-communities-are-winning-new-clinicians#:~:text=While%20the%20program%20isn't,funding%20from%20a%20local%20philanthropy.

[271] "NC AHEC Residency Programs." n.d. NC AHEC. https://www.ncahec.net/graduate-medical-support/nc-ahec-residency-programs/.

AHECs, assuming that 50 residents will train at each center initially. This matches the 300 slots that North Carolina's AHECs offer for residents.[272]

Cost for maintaining residents

Avg. cost per medical resident inMassachusetts(2014)[273]: $42,111

Adjustment for inflation: $57,124[274] x 300 = $17,164,200

Salary cost

Avg. salary per medical resident in MA: $61,991[275] x 300 = $18,597,300

TOTAL COST: $35,761,500

Limitations:

Due to the enactment of the One Big Beautiful Bill in July 2025, Massachusetts stands to lose between 10-13% of its federal Medicaid funding in the next 10 years.[276] Since S.900 is based on being funded by Medicaid, this would possibly cause a financial strain in funding this recommendation. However, considering that North Carolina's AHEC residency programs offer a stipend of approximately $12,150 per resident, there is significant room to cut spending on resident salaries, because the effectiveness of North Carolina's program remained extremely high despite a much lower stipend. The current plan should account for a higher salary because Massachusetts is experiencing a severe staffing shortage, so the highest possible resident salary would be ideal.

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[272] Newton, Warren. 2018. "Memorandum on State AHEC Funding." North Carolina AHEC. https://webservices.ncleg.gov/ViewDocSiteFile/14984.

[273] Ben-Ari, Ron. 2014. "The Costs of Training Internal Medicine Residents in the United States." Alliance for Academic Internal Medicine. https://www.amjmed.com/article/S0002-9343(14)00596-8/pdf#:~:text=Overall%2C%20they%20calculated%20that%20the,%2C%20outpatient%20intensive%20programs)%20annually.

[274] "2014 to 2025." n.d. CPI Inflation Calculator. https://www.in2013dollars.com/us/inflation/2014?amount=42111.

[275] Jerkins, Michael. n.d. "Resident Physician Salary By State." Panacea Financial. Accessed August 11, 2025. https://panaceafinancial.com/resources/how-much-medical-residents-make/.

[276] "Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package." 2025. KFF. https://www.kff.org/medicaid/issue-brief/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/.

Amend and Enact Massachusetts Bill H.1289, An Act requiring reimbursement for the costs of providing competent interpreter services

I. Amend Bill H.1289 to Adopt the Workforce Framework from the Federal "Community Health Workers Act," to Include Non-Clinical Roles and a Combined Training Pipeline to support Healthcare Workers who Deliver Competent Interpretation Services

The Massachusetts State Legislature should adopt the framework from SB 58 to include non-clinical roles in H.1289. The bill currently prioritizes compensation for healthcare facilities that provide "competent interpreter services through sign and spoken language" to incentivize facilities to deliver healthcare services that reach patients from diverse cultural and linguistic backgrounds.[277] However, compensation is currently for "facilities licensed," which may or may not include rural CHCs, resulting in a prolonged divide between the growing need for linguistic and cultural competency in rural CHCs and the lack of appropriate healthcare. In addition, there is no standard for "competent interpreter services" without a proper certification process for interpretation services in place.

Amending H.1289 to include non-clinical roles would encourage new, linguistically and culturally competent community health center workers to practice in rural regions, where interpretation services are most needed.[278] Furthermore, to address the existing shortage of linguistically and culturally competent healthcare workers in rural CHCs, the incentives should

[277] "Massachusetts H1289 | 2025-2026 | 194th General Court," LegiScan, 2025, https://legiscan.com/MA/text/H1289/id/3169391.
[278] "Bridging the Gap: Remote Interpreting for Rural Communities," www.helloglobo.com, n.d., https://www.helloglobo.com/blog/remote-interpreting-for-rural-communities-bridging-the-gap.

be paired with a training pipeline to increase the number of bilingual healthcare workers and recruit interpreters from underserved communities in rural CHCs.

Background Research & Case Study:

New Mexico has a rich ancestry rooted in Native American culture, which has shaped its linguistic and cultural diversity. However, New Mexico faces notable health disparities: one in five women in the state experiences poverty, and a quarter of low-income residents report fair to poor health.[279] The New Mexico Community Health Worker program uses a combination of Medicaid funds, grants, and tax dollars to support community health workers in low-income areas and federally qualified health centers, which serve underserved populations.[280] Passed in 2014, SB 58, the Community Health Workers Act, along with its implementation through the New Mexico Administrative Code (NMAC) 7. 7.29.5.5, Certification of Community Health Workers, establishes screening procedures and comprehensive certification processes to recruit community healthcare workers who deliver competent interpretation services.[281]

For example, the One Hope Centro de Vida Health Center was established in the International District in East Central Albuquerque. Starting in the 1970s, the district experienced increased violence and prostitution, with poverty rates exceeding 50%. It is the most culturally diverse region in New Mexico, home to Hispanics, whites, Native Americans, African

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[279] Sarah Klein et al., "PROGRAM at a GLANCE CASE STUDY PRIMARY CARE for LOW-INCOME POPULATIONS How New Mexico's Community Health Workers Are Helping to Meet Patients' Needs Will Tackling Entrenched Problems like Poverty and Criminal Recidivism Improve Health? Consulting Writer and Editor the Commonwealth Fund Roosa Tikkanen," 2020, https://www.commonwealthfund.org/sites/default/files/2020-02/Klein_New_Mexico_community_hlt_workers_hotspotting_cs_v2.pdf.

[280] FQHC Associates, "What Is a Federally Qualified Health Center (FQHC)?," FQHC.org, 2024, https://www.fqhc.org/what-is-an-fqhc.

[281] "ACT RELATING to HEALTH CARE; ENACTING the COMMUNITY HEALTH WORKERS ACT; PROVIDING for DEPARTMENT of HEALTH CERTIFICATION of COMMUNITY HEALTH WORKERS; PROVIDING for RULEMAKING, FEES, CRIMINAL BACKGROUND SCREENING and DISCIPLINE RELATING to CERTIFIED COMMUNITY HEALTH WORKERS; CREATING a BOARD of CERTIFICATION of COMMUNITY HEALTH WORKERS. BE IT ENACTED by the LEGISLATURE of the STATE of NEW MEXICO," accessed July 20, 2025, https://www.nmlegis.gov/Sessions/14%20Regular/final/SB0058.pdf.

Americans, and Asians, and this cultural diversity adds complexity to providing healthcare services that are linguistically accessible.[282]

However, the One Hope Centro de Vida Health Center and its community healthcare workers addressed these barriers and provided services that extended beyond clinical treatment. The center developed tailored plans that consider patients' financial barriers to affording medications and screening tests.[283] Community health workers served vulnerable communities, many of whom came from low-income backgrounds themselves. They often faced the same socioeconomic barriers, ethnicities, languages, and economic backgrounds as their patients, making them well-suited to serve these populations. These workers helped bridge the linguistic and cultural gaps in healthcare access, addressing social aspects of health that can be overlooked in traditional clinical settings. Since 2005, 50,000 patients have been screened, and about one-third of those with social needs have received assistance. The NM Department of Health, Office of Community Health Workers (OCHW), developed training pathways and certification for specialized aspects of healthcare, reimbursing community health workers through state-level New Mexico Medicaid and grant funding from entities such as the CDC Health Disparities Grant.[284]

H.1289 should be amended to fully acknowledge and fund community health workers in rural CHCs who provide interpretation services. H.1289 refers to section 19 of Chapter 19 and Section 51 of Chapter 111, which typically include mental health facilities and general hospitals as institutions that should receive reimbursement for interpretation services. Funding is included in the state's MassHealth budget, and instead of creating a new funding source, the bill requires

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[282] Community Health Workers Act, SB 58 (N.M. 2014).
[283] Community Health Workers Act, SB 58 (N.M. 2014).
[284] "State Community Health Worker Policies: New Mexico - NASHP," NASHP, April 2, 2025, https://nashp.org/state-tracker/state-community-health-worker-policies/new-mexico/.

that MassHealth allocate its existing budget for interpretation reimbursement. The amendment would reallocate current MassHealth funds and dedicate a portion of its budget to non-clinical healthcare workers in rural CHCs who offer interpretation services.

Representative Plouffe of Brockton sponsors Bill H.1289 and has become a sponsor of the new draft H.4341; the bill advanced to the committee on Health Care Financing on July 31st, and Representative Murphy (D) could be a potential candidate for a co-sponsor, as he reported the bill favorably as Chair of the Joint Committee on Financial Services. Continued support from members of the Joint Committee on Financial Services will be helpful as the bill progresses through the House and Senate. Organizations, including the Massachusetts Coalition for Health Equity, an advocacy group that aims to streamline healthcare access throughout Massachusetts, and the Massachusetts Public Health Association (MPHA), which drives explicit policy changes to promote health equity.

H.1289 should first clearly identify the non-clinical roles in rural CHCs eligible for reimbursement when serving as interpreters. These include front-desk staff, wellness coordinators, patient advocates, health educators, and social workers.[285] These roles should be based at community health centers in Massachusetts' rural areas, as defined by the Health Resources and Services Administration (HRSA).[286]

Next, there should be procedures in place to ensure that these non-clinical workers can provide effective interpretation services. To create a strong training pipeline in rural Community Health Centers, Massachusetts could establish a certification program through the Massachusetts Association of Community Health Workers to recruit healthcare workers from rural parts of the

[285] "13 Non-Clinical Healthcare Jobs," Indeed Career Guide, 2024, https://www.indeed.com/career-advice/finding-a-job/non-clinical-healthcare-jobs.
[286] Health Resources & Services Administration, "MUA Find," Hrsa.gov, 2019, https://data.hrsa.gov/tools/shortage-area/mua-find.

state who demonstrate proficiency in interpretation. As part of the training pipeline, H.1289 should implement a certification process, involving a certification board and training pathway, with organizations including the Berkshire Area Health Education Center, which offers a Medical Interpreter Program aimed at reducing communication barriers between patients and healthcare providers in Massachusetts. This program allows bilingual individuals to train in providing interpretation services within a healthcare setting, and they must complete language assessments to receive certification.[287] In addition, the program is offered virtually twice a year to increase accessibility, and free tuition is offered for Massachusetts residents who are underemployed or unemployed.[288]

Cost/Benefit Analysis:

Shown below is an estimate of the proposed reimbursement rates based on the Medicaid and CHIP Reimbursement Models for Utah:[289]

1. **Person-to-person services**: $30-$48/hour (one-hour minimum)
2. **Virtual (telephonic/video):** $0.60-$1.10/minute (no time minimum)
3. **ASL services:** $57-$90/hour (2-hour minimum)

It is important to note that amending the language of H.1289 may prove difficult if strict regulations enforced by MassHealth limit how reimbursement can be granted; non-clinical roles may not comply with regulations, preventing healthcare workers in rural CHCs from receiving reimbursement for their interpretation services. Additionally, since MassHealth has already

[287] "Medical Interpreter Training – Berkshire Area Health Education Center," Berkshireahec.org, 2025, http://berkshireahec.org/medical-interpreter-training/.
[288] "Berkshire AHEC – Medical Interpreter Training," Massmedicalinterpreting.org, 2025, https://www.massmedicalinterpreting.org/training/fundamentals-training-schedule/berkshire-ahec-western-massachusetts/.
[289] Mara Youdelman, "Medicaid and CHIP Reimbursement Models for Language Services Medicaid and CHIP Reimbursement Models for Language Services 2024 Update Author," n.d., https://healthlaw.org/wp-content/uploads/2024/03/Medicaid-and-CHIP-Reimbursement-Models-FINAL-2024-1.pdf.

outlined a strategy for reimbursement of interpretation services in clinical settings, it may not have sufficient funding to divert existing funds to rural CHCs.

Nonetheless, by adopting a similar framework from SB 58 into H.1289, Massachusetts can take the crucial steps to not only increase the initiation of healthcare workers in rural CHCs but also boost the number of culturally and linguistically competent healthcare workers who can connect and best serve diverse communities.

Amend and Enact Massachusetts Bill H.283/S.1385, An Act expanding loan repayment assistance for primary care physicians

I. Amend Bill H.283/S.1385 to Bolster the Existing Incentives and Benefits for New Physicians and Medical Students.

The Massachusetts Department of Health should enhance the existing MA Repay program to more actively benefit new physicians by bolstering the current incentives outlined in Bills H.283/S.119. The current MA Repay program does have significant benefits, but it is not beneficial enough to convince many students to shift to Gateway Cities and rural areas. Specifically, the current average allotment of $100,000 for loan repayment per primary care professional should be increased to a maximum of $250,000, considering that the average tuition for medical school in Massachusetts is between $160,000 to almost $500,000, and students carry an average of $234,597 in debt following their graduation.[290,291] This can be coupled with increased requirements to receive the maximum loan payment, such as changing the service commitment from four full-time years to ten, with a minimum of 35 hours per week for 45 weeks

[290] "UMass Chan Medical School - Best Medical Schools." n.d. U.S. News & World Report. Accessed July 15, 2025. https://www.usnews.com/best-graduate-schools/top-medical-schools/umass-chan-medical-school-04049.
[291] Hanson, Melanie. 2024. "Average Medical School Debt [2024]: Student Loan Statistics." Education Data Initiative. https://educationdata.org/average-medical-school-debt.

a year. Furthermore, physicians who are multilingual should be given credits to incentivize them to move to Gateway Cities, where culturally competent care is in dire need of reinforcement. Specifically, such credits could include an annual stipend of $5,000 during the three years of residency for primary care physicians. It would also involve a verification process, including an oral and written exam, as well as a simulation of a patient visit to ensure the provider is fluent in their respective language. It could also include reimbursement of up to $2,500 for courses that PCPs choose to enroll in to diversify their linguistic capabilities.

Background Research & Case Study

The MA Repay program was established in 2022 to encourage recently graduated medical students to move to rural areas of the state to practice. In particular, the program prioritizes practitioners who tend to patients speaking languages other than English or living in a state-designated underserved area. It involves separate programs that have awarded more than 271 million dollars in aid collectively, with an average of approximately $45,000 repaid per student.[292] The program was extremely beneficial for such professions, with the average debt for employees in these fields after graduation from their respective professional programs ranging from around $30,000 to $50,000.[293] Thus, the average loan repayment of around $45,000 completely covers or almost covers their debt. This has benefitted areas experiencing staffing shortages, but physicians are unable to benefit as much from the current MA Repay program. Increasing the amount of repayment that students receive and implementing additional credits will be essential to enhancing MA Repay's effectiveness.

[292] Kumar, Brianna. 2025. "Impact."MassachusettsRepay. https://www.marepay.org/impact.
[293] "Here's the Average Student Loan Debt for Graduate School - Earnest." 2024. Earnest. https://www.earnest.com/blog/average-graduate-student-loan-debt/.

For example, in the state of Michigan, one of every five residents lives in a rural area.[294] Due to a similar shortage of medical professionals in these areas, Michigan established a similar program, entitled the Michigan State Loan Repayment Program (MSLRP). A study conducted by the Michigan Health Council in September 2023 found that while the program was effective, with 90% of the participants stating that they felt motivated to help the rural communities of their state and wanted to further their commitment to working in such places, the study's authors also found that the maximum repayment of $300,000 was not nearly enough for participants, due to rising medical school costs and high debt accumulation over the eight years of education required to become a physician.[295]

Estimated Costs of Policy:

Below is an itemized estimate of the costs for this expansion to the MA Repay program for 100 physicians, with 40 also being multilingual, correlating with the 39.7% of Massachusetts physicians that speak a language other than English, and 20 taking advantage of the language course funding:[296]

1. **Loan repayment**
    a. $250,000 x 100 physicians = $25,000,000
2. **Stipends**
    a. Assuming 40 physicians are multilingual,

        $5,000/year of residency x 3 years of residency for PCPs x 40 = $600,000

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[294] "Much of Michigan is rural. What will it take for small towns to thrive?" 2022. Bridge Michigan. https://www.bridgemi.com/business-watch/much-michigan-rural-what-will-it-take-small-towns-thrive.

[295] Friednen, Katherine. 2023. "Is Loan Repayment an Effective Recruitment and Retention Strategy for Healthcare Professionals?" Michigan Health Council. https://www.mhc.org/post/is-loan-repayment-an-effective-recruitment-and-retention-strategy-for-healthcare-professionals#:~:text=SERVICE%20OBLIGATION%20&%20RETENTION,(2020%2D2022%20Report).

[296] Cristantiello, Ross. 2024. "Mass. needs doctors. Foreign-trained ones want to work. A new law looks to address both problems." Boston.com. https://www.boston.com/news/health/2024/12/03/mass-needs-doctors-foreign-trained-ones-want-to-work-a-new-law-looks-to-address-both-problems/.

3. **Course reimbursement**

    a. Assuming 20 physicians participate in the courses,

    $2,500/physician x 20 = $50,000

    Thus, the total sum would be:

    $25,000,000 + $600,000 + $50,000 = $25,650,000 for 100 physicians

    TOTAL RECOMMENDED: $25,650,000

Limitations:

The $250,000 loan repayment may not be enough to cover the entire cost of medical school for some students, which may make this option unattractive. However, considering that the average debt of a medical student in the state is around $234,000, the $250,000 repayment should be a reasonably effective mitigation in managing students' debt and in attracting them to rural areas and Gateway Cities within Massachusetts.

Amend and Enact Massachusetts Bill S.301/H.489, An Act providing affordable and accessible high-quality early education and care to promote child development and well-being and support the economy in the Commonwealth

I. **Amend Bill S.301/H.489 to Include Specific Childcare Support For Healthcare Professionals.**

Bill 301 is an act providing affordable and accessible high-quality early education and care to promote child development and well-being and support the economy in the Commonwealth. This bill amends Section 2 of chapter 15D of the General Laws by initiating (1) a rate structure for voucher and contracted payments to early education and care providers who

accept children receiving child care financial assistance, in conformity with federal and state law, and (2) a sliding fee scale for families receiving child care financial assistance which is updated at least every 5 years to reflect affordability standards for participating families.[297]

The goal is to adopt provisions inspired by the federal Essential Skills and Child Care for Health Professions Act (H.R.4781 in 2023, introduced by Rep. Judy Chu) to guarantee that child care is "available and affordable" for healthcare workers who need it. In practice, this means requiring that health sector employers or programs provide childcare assistance through measures such as: (i) helping employees secure subsidized child care placements (referrals and application assistance), (ii) directly paying a portion of childcare costs if no subsidy slot is open, and (iii) covering copayments or fees to reduce out-of-pocket costs.[298]

Background Information & Case Study

We propose implementing a *Tri-Share* model in partnership with the Massachusetts League of Community Health Centers: under this model, the cost of child care would be split three ways – the employer (e.g. a community health center or hospital) pays part, the employee pays an affordable part, and the state (possibly through a grant or subsidy expansion) pays the remaining share. This public-private partnership model has been tested in states like Michigan with success, and Massachusetts' own Early Education and Care Workforce Council has recently discussed piloting tri-share arrangements involving employers, given the urgent need to engage the business community in child care solutions. By embedding a tri-share child care program or similar benefit into Bill 301, Massachusetts would specifically support healthcare workers (who

[297] "Bill S.301," Malegislature.gov, 2023, https://malegislature.gov/Bills/193/S301.
[298] Chu, Judy "Text - H.R.4781 - 118th Congress (2023-2024): Essential Skills and Child Care for Health Professions Act," Congress.gov, 2023, https://www.congress.gov/bill/118th-congress/house-bill/4781/text.

have 24/7 schedules and critical roles) in balancing work and family, thereby improving retention in these high-need jobs.

A trishare model of childcare could distribute the costs to the state, employer, and parents.[299] In 2019, Grand Rapids, Michigan, piloted the nation's first Tri-Share childcare program, which later emerged as a national model for affordable childcare during the COVID-19 pandemic. Officially launched statewide in 2021, the MI Tri-Share model encourages the division of childcare costs equally among three parties: the employer, the employee, and the State of Michigan. A regional facilitator hub coordinates this three-way cost-sharing arrangement, serving as an intermediary between stakeholders. The program has demonstrated significant success. Participating families saw average monthly childcare costs drop from $716 (≈15% of income) to $252 (≈5% of income), representing a 66% reduction.[300] In pilot regions, employers reported up to an 80% reduction in turnover among participating staff, including one mid-sized manufacturer that virtually eliminated turnover using Tri-Share. As a result, after its pilot phase with initial funding of around $1 million, the program received an additional $2.5 million in Michigan's FY2022 budget to scale up facilitator hubs and expand service areas.[301]By

[299] Rassoul, Elijah. 2024. "Cost-Sharing for Child Care: Looking at the Tri-Share Model | CLASP." CLASP. August 22, 2024. https://www.clasp.org/blog/cost-sharing-for-child-care-looking-at-the-tri-share-model/.
[300] Rachel Cohen, "This Workplace Benefit Is Helping Parents — and Boosting Businesses. Could It Backfire?," Vox, February 26, 2025, https://www.vox.com/child-care/401260/child-care-daycare-employer-ceo-kindercare-bright-horizons-pittsburgh.
[301] Public Sector Consultants, "MI Tri-Share Pilot Evaluation Final Report," 2022, https://www.michigan.gov/mileap/-/media/Project/Websites/mwc/Tri-Share/MI-Tri-Share-Pilot-Evaluation-Report-FINAL.pdf?rev=b22e11e8ff544f4ba7666644447647fd.

mid-2025, Tri-Share was available statewide, serving over 800 families and nearly 1,000 children across more than 250 employers; total family savings exceeded $8.6 million.[302] Further, as of May 2025, enrollment eligibility was broadened from households earning up to 325% of the Federal Poverty Level (FPL) to those up to 400% FPL—roughly $128,600 for a family of four—making the benefit accessible to more middle-income households.[303]

In Massachusetts, this model can be enacted through the League of Community Health Centers, founded in 1972, a primary care association that oversees 50 health centers by providing services such as training, technical assistance, advocacy guidance, and more.[304] Serving over a million patients across 98% of Massachusetts zip codes, these centers have been at the forefront of implementing health policy to expand medical centers. Coordinating childcare services could be an extension of the services it already provides to rural healthcare workers and their communities.

Massachusetts can leverage existing structures to execute this: for example, EEC (the Department of Early Education and Care) could administer a pilot program in coordination with health care employers. An initial pilot or grant program may be advisable given the novelty of the strategy, although Massachusetts has been actively studying innovative child care financing models, and the Early Education and Care Workforce Council in 2025 discussed using state funds to match employer contributions for child care.[305] Therefore, our recommendation to

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[302] Peng, Michelle. "Inside Michigan's New Model for Addressing the Child-Care Crisis." Time, April 30, 2023. https://time.com/charter/6276140/tri-share.

[303] Michigan Department of Lifelong Education, Advancement, and Potential, "PRESS RELEASE: MiLEAP Expands MI Tri-Share Child Care Program to Support More Working Families," Michigan.gov, 2025, https://www.michigan.gov/mileap/press-releases/2025/06/03/mileap-expands-mi-tri-share-child-care-program-to-support-more-working-families.

[304] Massachusetts League of Community Health Centers. "About - Massachusetts League of Community Health Centers," January 8, 2025. https://www.massleague.org/about/.

[305] Department of Early Education and Care, "Board of Early Education and Care Vote Improves Access to Child Care Financial Assistance," Mass.gov, 2025, https://www.mass.gov/news/board-of-early-education-and-care-vote-improves-access-to-child-care-financial-assistance.

incorporate a tri-share model for health workers is consistent with the direction of current policy discussions. Legally, appropriating state funds or requiring certain employers to provide child care support would need clear legislative authorization; doing so through the amendment to Bill 301 ensures it's part of the Commonwealth's formal early education reform efforts. Expanding child care benefits for a specific workforce (health professionals) is permissible under Massachusetts law, though it will require legislative action to establish the funding and framework. Massachusetts General Laws Chapter 15D, which governs the Department of Early Education and Care, does not explicitly forbid targeted subsidy programs or employer partnerships;[306] Bill 301 itself is designed to redesign funding and access models for child care across the state. The amendment would append a section to focus on health care workers as a priority group for child care support, in line with the bill's general aim of making care more affordable by specifying the tri-share/employer-supported model.

Both healthcare and childcare stakeholders should champion this amendment. In the legislature, the Joint Committee on Education (which oversaw S.301) involves Senator Jason Lewis, the lead sponsor of S.301, who has demonstrated bipartisan commitment to child care access.[307] Additionally, members of the Joint Committee on Public Health or Health Care Financing might support this idea, since it addresses healthcare workforce stability, and lobbying can be directed towards legislators who have worked on nursing or clinician workforce issues could co-sponsor the amendment. On the organizational side, the Massachusetts League of Community Health Centers is a key partner; they can coordinate among community health center employers statewide and possibly serve as an administrative "hub" for a tri-share program. Child care advocacy groups and early education leaders in Massachusetts, such as Strategies for

[306] "Chapter 15D," malegislature.gov, n.d., https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter15D.
[307] "Bill S.301," Malegislature.gov, 2023, https://malegislature.gov/Bills/193/S301.

Children, the Massachusetts Association for the Education of Young Children, and the Massachusetts Business Coalition for Early Childhood Education, would likely support any expansion of child care assistance funding, and they can provide data on how child care costs impact the workforce. We should also seek support from healthcare workforce advocates, the Massachusetts Nurses Association, and unions representing health workers.

Amend and Enact Massachusetts Bill. H.1410/S.891, An Act relative to the primary care workforce development and loan repayment grant program at community health centers

I. Amend Bill H.1410/S.891 to Subsidize Monthly Retention Benefits for Primary Care Physicians Practicing in Rural and Understaffed Community Healthcare Centers for Five Years Following Massachusetts Loan Repayment Program Completion.

Bill H.1410/S.891 should be amended to include a provision that grants a monthly bonus of $150 for PCPs who continue to work at understaffed rural CHCs after fulfilling the obligations set by their LRP.[308] This monthly figure should increase incrementally by $175 per year until $850/month is reached by the 5th year. Final payment amounts are subject to change and should be configured by considering existing Massachusetts salary rates adjusted for inflation.

The decision process for choosing eligible CHCs should be need-based. Based on reporting from the Health Resources & Services Administration (HRSA), subsidized bonuses should be piloted in the following six health professional shortage areas: Community Health Center of Franklin County, Community Health Programs Incorporated, Island Health,

[308] Roger A. Rosenblatt et al., "Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion," *JAMA: The Journal of the American Medical Association* 295, no. 9 (2006): 1042-1049, https://doi.org/10.1001/jama.295.9.1042.

Wampanoag Health Service, East Mountain Medical, Williamstown Medical, and Williamstown Medical at North Adams.[309] To affirm the accuracy of these locations' rural health center (RHC) and CHC statuses, the Massachusetts legislature should communicate with the Massachusetts Department of Public Health's Primary Care office.

Background Research & Case Study:

Currently, Bill H.1410/S.891 promises $198,650,000 in funding for an LRP at community healthcare centers (CHCs) to improve primary physician, general clinician, and other staff retention rates.[310,311] Approximately 44.5% of rural Massachusetts CHC staff are already enrolled in an LRP at either the federal or state level. This figure is nearly double the enrollment rates of healthcare staff within urban health centers.[312]

By either redistributing existing funding or apportioning additional funds for retention payments, healthcare workers will be more likely to continue at a rural CHC past the duration of the typical two-year LRP requirement.[313] Payments should be piloted until five years after LRP completion, as the number of physicians who remain in CHCs begins to drop significantly after that duration. A study of PCPs working at CHCs found the median tenure to be approximately 3 years, with the average risk of leaving after two years reaching 11%.[314]

Addressing the PCP shortage is a targeted and efficient avenue to begin tackling the larger health professional shortage in Massachusetts. PCPs address a majority of health needs, making them central to improving healthcare access in rural areas, where low population density

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309 "HPSA Find," Health Resources & Services Administration, accessed August 2, 2025, https://data.hrsa.gov/tools/shortage-area/hpsa-find.
310 "Bill H.1410," Malegislature.gov, 2025, https://malegislature.gov/Bills/194/H1410.
311 "Bill H.4269," Malegislature.gov, 2021, https://malegislature.gov/Bills/192/H4269.
312 Rosenblatt, "Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion," 1044.
313 "Massachusetts Loan Repayment Program (MLRP) for Health Professionals," Mass.gov, accessed July 14, 2025, https://www.mass.gov/info-details/massachusetts-loan-repayment-program-mlrp-for-health-professionals.
314 Judith D. Singer et al., "Physician Retention in Community and Migrant Health Centers: Who Stays and for How Long?" *Medical Care: Office Journal of the Medical Care Section, American Public Health Association* 36, no. 8 (1998): 1198-1213.

is unable to support various specialty care providers. The need for more PCPs is evidenced by predictions estimating an increase in office visits from 773,606 to 893,098 between 2020 and 2040.[315]

In accordance with the findings that the patient-to-PCP ratio in rural areas is only 39.8 physicians per 100,000 people, the rural population in Massachusetts is approximately 635,104, and the average RHC serves 7,077 patients per year, PCP estimates per rural Massachusetts CHC come to around 2.816.[316,317,318] Considering the proposed year-by-year increases to retention bonuses, the Massachusetts state legislature should expect to apportion $182,700 for the six pilot CHCs (year 1: $2,700, year 2: $5,850, year 3: $9,000, year 4: $12,150, and year 5: $15,300).To avoid improperly calculating funding, the Massachusetts state legislature should communicate with all six CHCs to confirm PCP counts before amending H.1410.

If payments are promptly and consistently delivered, Massachusetts CHCs can expect to experience an increased retention of PCPs. One experiment of Chinese general practitioners provided monthly bonuses of around $140 up to $836 to general practitioners (GPs) in rural and partially rural CHCs, equating to a 48-52% bonus. Results found that from 2014 to 2016, the GP population increased by an average of 6.83% and 14.28% yearly, which was 4.54-5.82% higher than before implementation.[319] In 2014, total funding for this program was approximately $7 million and reached over $15.2 million by 2017.[320]

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[315] Andrew W. Bazemore et al., "U.S. Primary Care Workforce Growth: A Decade of Limited Progress, and Projected Needs Through 2040," *Journal of General Internal Medicine* 40, (2025): 339-346, https://doi.org/10.1007/s11606-024-09121-x.
[316] Esther Hing and Chun-Ju Hsiao, "State Variability in Supply of Office-based Primary Care Providers: United States, 2012," *NCHS Data Brief*, no. 151 (2014).
[317] "Survey Emphasized Scale and Significance of the RHC Program," National Association of Rural Health Clinics, accessed August 2, 2025, https://www.narhc.org/News/30432/Survey-Emphasizes-Scale-and-Significance-of-the-RHC-Program.
[318] "Rural Population in Massachusetts," America's Health Rankings, accessed August 2, 2025, https://www.americashealthrankings.org/explore/measures/pct_rural_b/MA.
[319] Limei Jing et al., "Health personnel recruitment and retention target policy for health care providers in the rural communities: A retrospective investigation at Pudong New Area of Shanghai in China," *The International Journal of Health Planning and Management* 34, no.1 (2018): 157-167, https://doi.org/10.1002/hpm.2618.
[320] Jing, "Health personnel recruitment and retention," 159.

Another study of U.S. physician programs found that in addition to the 66% of loan repayment recipients who remained in their rural service site 8 years after starting work there, the retention rate for direct financial incentive recipients was around 55%; these two programs showed the largest success of those examined.[321] In combining both existing LRPs offered by organizations like the Massachusetts League of Community Health Centers (MLCHC) and MA Repay's monthly bonuses, PCP retention rates should be expected to increase over the next five years.

Over time, CHCs and RHCs will begin to see community and financial benefits as well. Assuming that Massachusetts experiences PCP population growth similar to Jing and peers' study, the average number of PCPs per CHC/RHC should increase to anywhere from 3-3.218. This growth improves the number of PCPs per 100,000 patients by approximately 5.671, fulfilling over half of the 10 PCP increase per 100,000 patients found to be associated with "a substantial increase in life expectancy (51.5 days)."[322] Additionally, accounting just for basic office visits, PCPs will bring in sustained amounts of $80-100 per additional patient visit, reducing the gap between clinic spending and reimbursement.[323]

While studies have found year-to-year bonuses as a successful retention mechanism, the longevity of these results is unknown. Due to a lack of longitudinal research, only 1-to 2-year benefits can be guaranteed. However, this policy proposal should not be ignored on the basis of uncertainty. Increasing PCP retention is vital to alleviate existing strain on Massachusetts's rural CHC population, which retention bonuses have been proven to do. By focusing on a few, yet

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[321] Donald E. Pathman et al., "Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians," *Medical Care* 42, no. 6 (2004): 560-568, https://doi.org/10.1097/01.mlr.0000128003.81622.ef.
[322] "State of the Primary Care Workforce, 2024," Health Resources & Services Administration, accessed August 2, 2025, https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-primary-care-workforce-report-2024.pdf.
[323] "Consumer Guide to Understanding Health Insurance," Mass.gov, accessed August 2, 2025, https://www.mass.gov/info-details/consumer-guide-to-understanding-health-insurance.

high-impact locations, this policy will reduce tensions while also proving whether retention bonuses are a sustainable long-term solution or if they are short-term fixes that require supplementary support.

II. Amend Bill H.1410/S.891 to Fill Financial Requirements To Support Increased Rural Residency Training Available By Applying the Rural Training Track Model Within Rural Teaching Health Centers.

CHCs established as and seeking to become rural THCs should implement the RTT model to increase their access to qualified physicians, medical equipment, rotational opportunities, and funding. An RTT involves a partnership between rural and urban sites, allowing participating residents and fellows to train in both areas. To be recognized by the Accreditation Council for Graduate Medical Education, at least 50% of medical training must be completed in rural areas.[324]

Within these RTT partnerships, urban centers should cover the financial discrepancy between urban and rural training costs while the state subsidizes the remainder of residency training finances. The MLCHC should publish an initiative to foster these connections among state CHCs, specifically in rural and underserved areas. This program could be integrated into the existing Clinical Leadership Networks, which provide networking and communication opportunities between clinicians.[325]

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[324] "Rural Track Program Designation," Accreditation Council for Graduate Medical Education, accessed August 4, 2025, https://www.acgme.org/initiatives/medically-underserved-areas-and-populations/rural-tracks/#:~:text=An%20ACGME%20Rural%20Track%20Program,urban%20Core%2DBased%20Statistical%20Area.

[325] "Clinic Quality Initiatives," Massachusetts League of Community Health Centers, accessed July 28, 2025, https://www.massleague.org/programs-initiatives/clinical-quality-initiatives/.

Beginning as a pilot initiative, 5-10 urban-rural partnerships should be fostered with 10 new residency training openings per rural THC-designated CHC. Although there are only seven THCGME-recognized sites, partnership offers should be extended to THCs without federal accreditation, which can be accomplished through collaboration with the state government. Still, the exact nature of these partnerships may be determined on a case-by-case basis. This intervention would ensure that rural THCs are not forced to shut down or discouraged from beginning due to technical blockades, allowing for increased retention of incoming physicians.

Background Research & Case Study:

A study of Massachusetts physicians found that those most likely to continue practicing in CHC settings were also more likely to report feeling very prepared to do so by the end of their residency training.[326] One specific federally-funded program is the Teaching Health Center Graduate Medical Education program (THCGME), which operates through THC residency sponsors that provide training experience in community-based rural and underserved settings.[327] Beyond higher recruitment rates, THC graduates were found to be more likely to stay in rural or underserved settings, with 56% of prior year program completers actively practicing in those regions during 2018-2019.[328,329] However, only 20% of these programs are located in rural areas.[330] Of Massachusetts' seven THCGME-recognized training sites, only two are considered

[326] Judith A. Savageau, "Recruitment and Retention of Primary Care Physicians at Community Health Centers: A Survey of Massachusetts Physicians," 827.
[327] Julia H. Strasser et al., "A Mixed-Methods Study of Teaching Health Center Residents' Experiences of Mentorship, Career Planning, and Postresidency Practice Environments," *Academic Medicine* 97, no. 1 (2022): 129-135. https://doi.org/10.1097/ACM.0000000000004419.
[328] Strasser, "A Mixed-Methods Study of Teaching Health Center Residents' Experiences," 133.
[329] "Teaching Health Center Graduate Medical Education Program," Health Resources & Services Administration, accessed July 15, 2025, https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/teaching-health-center-graduate-medical-education-annual-report-2021-2022.pdf.
[330] Marshala Lee et al., "The Benefits of Physician Training Programs for Rural Communities: Lessons Learned from the Teaching Health Center Graduate Medical Education Program," *Journal of Health Care for the Poor and Underserved* 27, no. 4 (2016): 83-90. https://doi.org/10.1353/hpu.2016.0184.

rural rotation sites: UMass Chan with less than 50% training time in a rural setting, and Baystate Franklin Medical Center Program with over 50% rural training time.[331,332]

This deficiency is in part due to the multi-year effort required to receive accreditation. Rural THCs already manage on small profit amounts, meaning they need outside help to recruit faculty and strong training partnerships to meet subspecialty accreditation requirements. Additionally, technical assistance is crucial to support initial growth.[333] By introducing the RTT model to existing and emerging rural THCs, centers can partner with urban training sites that have greater funding, staffing, panel size, and rotational opportunities.[334] A previous study of a rural general surgery training track found that rotation quality, and by extension participants' future employment decisions, were reliant on available faculty, emphasizing the need for rural-urban THC partnerships.[335]

Partnership costs will be unique to each THC pairing. However, previous research found the median cost for training a resident at a rural THC totaled $169,161. In comparison, non-rural THCs spend a median of $159,311 per resident, almost $10,000 less.[336] Additionally, urban programs receive greater reimbursement, with 99% of Medicare spending for GME programs going to urban areas.[337] To address the gap in residency training costs, urban centers within the

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[331] Health Center Training Sites," THCGME.org, accessed August 4, 2025, https://www.thcgme.org/health-center-training-sites.
[332] "Rural Residency Programs and Rural Rotation Sites," RuralGME.org, accessed August 2, 2025, https://www.ruralgme.org/rural-programs.
[333] Emily M. Hawes et al., "Evaluating Teaching Health Center Planning and Development: Unlocking and Sustaining the Full Potential of the Teaching Health Center Program," *Diversity, Equity, Inclusion, and Justice* 17, no. 3 (2025): https://doi.org/10.4300/JGME-D-24-00593.1.
[334] Lee, "The Benefits of Physician Training Programs for Rural Communities," 87.
[335] Jude C. Barber et al., "Effectiveness of a Dedicated Rural General Surgery Residency Track: A 13-Year Analysis of the First ACGME Designated Rural Track," *Northern Plains Rural Surgical Society* 91, no. 8 (2025): 1298-1302.
[336] U.S. Department of Health and Human Services Health Resources and Services Administration, *Teaching Health Center Graduate Medical Education Direct and Indirect Training Expenses Report,* https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/about-us/reports-to-congress/report-to-congress-thcgme-2019.pdf (accessed August 2, 2025).
[337] Emily M. Hawes et al., "Rural Residency Training as a Strategy to Address Rural Health Disparities: Barriers to Expansion and Possible Solutions," *Journal of Graduate Medical Education* 13, no. 4 (2021): 461-465: https://doi.org/10.4300/JGME-D-21-00274.1.

partnerships should fulfill a material equivalent of $10,000 for their rural THC (e.g., through faculty, rotations, etc.). This contribution should be apportioned amongst each cluster of 10 rural residency trainees, in accordance with the 2024 HRSA report.[338] The Massachusetts state government should subsidize the remaining $1,591,610 per partnership via H.1410/S.891. In the case that certain urban centers are unable to apportion $10,000 worth of materials, Massachusetts state should set aside an extra $50,000 to be used across all 10 partnerships to support urban THC faculty and staff, allowing them to take shifts at rural THCs.

In total, each urban THC is expected to apportion $10,000 per partnership, totalling around $50,000-100,000 in support for 50-100 new rural resident positions. Additionally, the Massachusetts state legislature will subsidize a total of $8,008,050-15,966,110. Assuming 56% of trainees remain in rural areas and that each physician sees an average of 20.2 patients per day, the number of patients seen in rural Massachusetts from one partnership alone would be 113.12.[339,340] Collectively, from these 5-10 partnerships, the number of patients seen would increase by 566-1,132.

Even with subsidies from the state government, urban THCs still may feel strained or take time to adjust to the nature of their partnerships, impacting their performance as well. Moreover, it is expected that CEOs, board members, and donors may be against forming these partnerships to begin with. However, concerns and resistance should be manageable through communication fostered by far-reaching organizations like the MLCHC and outside support from the state budget.

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[338] "State of the Primary Care Workforce, 2024."

[339] Merritt Hawkins, *2018 Survey of America's Physicians: Practice Patterns & Perspectives*, U.S.: The Physicians Foundation, 2018.

[340] "Teaching Health Center Graduate Medical Education Program."

Enact Massachusetts Bill S.711/H.1096, An Act relative to rate equity for community health centers.

I. Enact Massachusetts Bill S.711/H.1096, An Act relative to rate equity for community health centers.

The Massachusetts Legislature should pass S.711/H.1096, "An Act relative to rate equity for community health centers," to require commercial insurers to reimburse CHCs at a rate no less than MassHealth Medicaid pays under the federally mandated prospective payment system (PPS).[341] In effect, although different from the all-payer system cited in the case study, it creates a similar floor through which private and public insurers both pay the same cost for services, while lacking the hospital price bargaining that exists in Maryland.

Background Research:

Underpayments by private insurance providers have hampered CHC financial stability and impacted their services for residents. In 2025, Statewide operating margins were negative 0.7% and 55% of Massachusetts hospitals ran negative operating margins during Q1. As budget shortfalls increase, CHCs are facing difficulty recruiting and retaining staff. This issue isn't unique to CHCs, given that Massachusetts currently has the lowest share of physicians working in primary care.[342] In an environment where few new graduates are entering family medicine, CHCs are struggling to attract them as they pay lower salaries than academic or private hospitals. A driving cause of these patient issues can be seen through staffing shortages. Nationwide, 70% of CHCs have experienced shortages of physicians, nurses, or other specialties. It is no different in Massachusetts, where Damian Archer, the chief executive officer of Outer Cape Health

[341] Massachusetts General Court. "Bill S.711: An Act Relative to Rate Equity for Community Health Centers." *The 194th General Court of the Commonwealth of Massachusetts*. Accessed August 8, 2025. https://malegislature.gov/Bills/194/S711.
[342] Kuznitz, Alison, "Mass. Health Care Regulators Recommend Fixes for Strained Primary Care System," *WBUR*, January 17, 2025, https://www.wbur.org/news/2025/01/17/primary-care-massachusetts-staff-wait-times.

Services, a federally funded community health center, said that since COVID-19, staff turnover has increased, and with "no affordable housing" in the area, it is "almost impossible" for new staff to find a place to live."[343]

As a result, 74% of Massachusetts CHCs have a waitlist for primary care services, 84% have a waitlist for behavioral health services, and 82% that have a dental program have a waitlist for new dental patients.[344] According to the Massachusetts League of Community Health Centers, existing patients must wait an average of 44 days for a routine exam, and new patients average 80 days to be seen by a primary care provider.

Part of the issue with the budget deficits that CHCs are facing is the underpayment by commercial insurers.[345] Even though Medicaid and Medicare typically do not reimburse the full cost for treatment, Federally Qualified Health Centers (FQHC) now receive the full cost of treatment reimbursed due to the Affordable Care Act.[346] As a result, one of the remaining barriers to financial solvency for CHCs is ensuring that commercial insurers pay less to CHCs than academic center hospitals. As a result, community health centers are receiving less reimbursement than public hospitals for the same operation.

Case Study:

Maryland's health care system offers unique examples of how a health care system can ensure that private and public insurance providers both pay the same rate. In Maryland, the state employs a unique all-payer rate-setting system that ensures that all third parties end up paying

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343 Berger, Ava. 2025. "Rural Community Health Centers Face Workforce, Patient Population Challenges." *Boston Business Journal,* January 1, 2025. https://www.bizjournals.com/boston/news/2025/01/01/rural-community-health-centers.html.

344 Mohammed, Zeina. "Community Health Centers Push for State Support amid Workforce Shortages." *The Boston Globe*, June 20, 2023, https://www.bostonglobe.com/2023/06/20/metro/community-health-centers-push-state-support-amid-workforce-shortages/

345 Lee, Thomas, "Among Massachusetts Hospitals, the Gap Between Rich and Poor Widens," *The Boston Globe*, August 7, 2024, https://www.bostonglobe.com/2024/08/07/business/hospitals-insurance-community-systems-health-care/h

346 "Federally Qualified Health Center PPS," *CMS.gov*, last modified June 26, 2025, https://www.cms.gov/medicare/payment/prospective-payment-systems/fqhc_pps

the same rate. This is made possible by a 36-year-old Medicare waiver that exempts Maryland from the Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS). As a result, the state can set its own rates and has improved results for patients and hospitals—especially applicable for Massachusetts CHCs that suffer from lower reimbursements from private insurance providers.

An all-payer system requires hospitals to charge the same price for each service to each insurance, as seen in countries such as Germany.[347] In Germany, all insurers and the representatives of hospitals negotiate a binding rate that all health insurance and all health systems accept. However, in Maryland, instead of an insurance and hospital negotiation, the rates are set by the Health Services Cost Review Commission, and rates are not nationwide, but instead each hospital sets the same rates for all the insurance providers.[348] Part of the requirement that resulted between Maryland officials and federal officials for the five-year program was that a comprehensive plan was to be developed for Maryland to address the needs of all Medicare beneficiaries.

The first model of Maryland's contract, known as the "Maryland All-Payer Medicare Model Contract," was a five-year pilot program that proved successful with the $300 million in cost reduction.[349] That is the model most likely directly applicable to CHCs in Massachusetts right now, as the second stage of Maryland's model, known as the Total Cost of Care Model, is much more comprehensive and requires more in-depth planning by administrators and government coordination.[350]

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[347] Barlow, Rich, "You've Heard of Single-Payer. What about All-Payer Health Care?" *BU Today*, March 19, 2018, https://www.bu.edu/articles/2018/single-payer-vs-all-payer-health-care/.

[348] Gerard Anderson and Bradley Herring, "The All-Payer Rate Setting Model for Pricing Medical Services and Drugs," *AMA Journal of Ethics* 17, no. 8 (August 2015): 770–775, https://doi.org/10.1001/journalofethics.2015.17.8.pfor1-1508.

[349] "Maryland's Total Cost of Care Model." *Maryland.gov*. https://hscrc.maryland.gov/Pages/tcoc.aspx.

[350] "Maryland's Total Cost of Care Model: Background and Summary," *Maryland Health Services Cost Review Commission,* https://hscrc.maryland.gov/Documents/Modernization/TCOC%20Background%20and%20Summary%20_5_23_18%20.pdf.

Cost-Benefit Analysis:

The average medical PPS rate provided by the Massachusetts Medicaid State Plan at $216. At an FQHC, that should cover the full cost of treatment. The underpayment gap for each commercial insurance use compared to Medicaid reimbursement is $38.88 per visit. As a result, with 3.44 million visits to Massachusetts CHCs a year and around 25% of CHC visitors with commercial insurance, the result is 920,000 visits relying on commercial insurance.[351] If those 920,000 visits were to pay $38.88 extra per visit—bringing their reimbursement to PPS parity—the annual cost to commercial insurers would be $33,436,800.

Enact Massachusetts Bill H.2393, An Act authorizing Massachusetts entry into the interstate medical licensure compact

I. Enact Massachusetts Bill H.2393, An Act authorizing Massachusetts entry into the interstate medical licensure compact

An Act Authorizing Massachusetts Entry into the Interstate Medical Licensure Compact (Bill H.2393) amends the Massachusetts General Laws by inserting Chapter 112B, which outlines the full text of the Interstate Medical Licensure Compact (IMLC). In section 1 of Chapter 112B, it is stated that "the member states of the Interstate Medical Licensure Compact have allied in common purpose to develop a comprehensive process that… provides a streamlined process that allows physicians to become licensed in multiple states."[352] Depending on the needs of Massachusetts hospitals and community health centers, this bill would allow

[351] "The Value and Impact of Massachusetts Community Health Centers", *Capital Link,* 2022, https://www.massleague.org/wp-content/uploads/MassachusettsEIA.pdf.

[352] 194th General Court of the Commonwealth of Massachusetts. "An Act Authorizing Massachusetts Entry into the Interstate Medical Licensure Compact, Bill H.2393." Malegislature.gov, 2025. https://malegislature.gov/Bills/194/H2393/BillHistory.

physicians from other states to provide in-person or telehealth services in Massachusetts, while also permitting Massachusetts-licensed physicians to practice across state lines.

Background Research, Case Study, & Cost/Benefit Analysis:

Similar to the Interstate Medical Licensure Compact (IMLC), the Nurse Licensure Compact (NLC) streamlines the process of nurses becoming licensed in multiple states. In a 2024 study by the *Journal of Nursing Regulation,* nurses in five NLC-participating states—Alaska, Kansas, Minnesota, Nevada, and Vermont—were surveyed to gauge their opinions on the benefits and drawbacks of the NLC. Comparable to the IMLC, the NLC confers several benefits to healthcare providers: easier provision of in-person and virtual care across state borders, simplified processes for obtaining multistate licenses, and increased health equity for patients. Due to the NLC, the number of nurses providing services—whether in-person or via telehealth—in multiple states increased by 10% since the most recent survey.[353] In addition, the number of nurses who held licenses in at least two states increased by 6%, and 96% of nurses viewed the multistate license offered through the NLC as enhancing their work experience.[354] With the entry of states into the NLC, healthcare workers are instantly witnessing the benefits of this program, allowing them to provide care to diverse populations in different states and regions.

Complementing these results, a 2020 study revealed that states participating in the IMLC witnessed a 50% increase in telehealth visits compared to 2019, demonstrating the capacity of the IMLC to scale telehealth services to meet patient demand.[355] Additionally, in a separate study, it was reported that 30% of physicians leverage the IMLC to provide care to underserved

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[353] Zhong, Elizabeth H, et al. "Highlights of the Nurse Licensure Compact Survey Findings: Nurses' Needs, Experiences, and Views." Journal of Nursing Regulation 15, no. 2 (2024): 38–44. https://doi.org/10.1016/s2155-8256(24)00054-1.

[354] Zhong, EH., et al., *Highlights of the Nurse Licensure Compact.*

[355] Deyo, Darwyyn, Sriparna Ghosh, and Alicia Plemmons. "Access to Care and Physician-Practice Growth after the Interstate Medical Licensure Compact." Social Science Research Network, January 1, 2023. https://doi.org/10.2139/ssrn.4629647.

areas, such as rural ones.[356] Massachusetts' participation in compacts such as the NLC and IMLC would enable providers from other states to fill in staffing shortages in rural CHCs via telehealth and in-person services. In addition, entry into the compact would grant healthcare workers the freedom and flexibility to provide care to patients in other states without the burden of excessive paperwork. These added resources could increase access to mentorship and professional opportunities, reduce burnout for clinical staff, and enhance overall job satisfaction, supporting employee retention.

According to a 2023 study, it was found that states that joined the IMLC experienced between a 10% and 15% increase in the number of licensed physicians, who provide both in-person and telehealth services.[357] Considering that the total number of licensed physicians in Massachusetts is currently approximately 37,000 and each Massachusetts physician licensing fee costs $600, the increase in total licensing revenue is expected to be between $2,220,000 and $3,330,000.[358,359] To aid with the additional paperwork required to confirm physician eligibility when applying to the IMLC, it may be beneficial to hire a full-time licensing analyst. In Massachusetts, the average salary for a licensing analyst is $90,000.[360] The true cost for the full-time employee—accounting for payroll taxes and benefits—would be approximately $119,250, which is 1.325 times greater than the base salary. The factor of 1.325, calculated as the average

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[356] Interstate Medical Licensure Compact Commission, "IMLCC Data Study Year 6 - Information Release," 2023, https://imlcc.com/wp-content/uploads/2023/06/IMLCC__Year6_DataStudy-For-Publication-6-6-2023.pdf.

[357] Nguyen, Ann M., and Schaler-Haynes, Magda. "Can Interstate Licensure Compacts Enhance the Health Care Workforce?" Milbank Memorial Fund, April 11, 2023. https://www.milbank.org/2023/04/can-interstate-licensure-compacts-enhance-the-health-care-workforce/.

[358] KFF. "Professionally Active Physicians," May 20, 2020. https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22.

[359] Massachusetts Department of Public Health. "Physician Licensing Fees and Eligibility Requirements." Mass.gov, 2024. https://www.mass.gov/info-details/physician-licensing-fees-and-eligibility-requirements.

[360] ERI Economic Research Institute. "Licensing Analyst Salary in Massachusetts, United States," 2025. https://www.erieri.com/salary/job/licensing-analyst/united-states/massachusetts?utm_source.

of the range from 1.25 to 1.4 provided in a study, is the multiplier applied to the base salary to determine the true cost of employment.[361]

In addition, entry into the IMLC would likely require an information technology (IT) update to ensure the accurate processing of physician information and smooth communication among states and with the IMLC Commission (IMLCC). For instance, part of the process of expediting licensure is the issuance of a Letter of Qualification (LOQ) to physicians from their State of Principal License, where each physician holds an active, unrestricted license to practice medicine. Because the LOQ can be issued only once certain eligibility requirements have been met, an updated IT system would allow states to more efficiently track and exchange licensure information.[362] According to a Minnesota fiscal note on the Physical Therapy Interstate Licensure Compact, the IT-related costs as a member of the compact were $65,000.[363]

Assuming that Massachusetts adopts updates similar to those of Minnesota, it is reasonable to estimate that the associated costs for Massachusetts would be comparable. The IMLCC meets at least once a year, and each member state must send representatives, known as commissioners, to attend the meetings. However, because there is the option to participate virtually, these meetings do not have to incur additional expenses.[364] The last expenditure to consider would be the cost of notifying physicians and relevant individuals regarding changes to the system and educational materials, which is projected to be approximately $1,000.[365] Overall, the costs of entry into the IMLC are expected to be $185,250. With the revenue being between

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[361] Hadzima, Joe. "How Much Does an Employee Cost." Mit.edu, 2019. https://web.mit.edu/e-club/hadzima/how-much-does-an-employee-cost.html.
[362] Interstate Medical Licensure Compact. "States Information | Interstate Medical Licensure Compact," April 17, 2023. https://imlcc.com/information-for-states/.
[363] "State Cost (Savings) Biennium Biennium Dollars in Thousands," 2024. https://www.lrl.mn.gov/archive/minutes/senate/2024/jud/20240412/Jud_20240412_SF1322-fiscal-note.pdf.
[364] "Interstate Medical Licensure Compact Bylaws." Accessed August 3, 2025. https://imlcc.com/wp-content/uploads/2020/02/IMLC-Bylaws-Article-VI-Meetings-of-the-Commission.pdf.
[365] *State Cost (Savings) Biennium Biennium Dollars in Thousands.* 2024.

$2,220,000 and $3,330,000, the calculated profit ranges from $2,034,750 to $3,144,750. Although the increase in physicians would require greater physician investment, these costs would be partially offset by the corresponding increase in patients served.

To support the expenditures necessitated by entry into the IMLC, the Massachusetts Board of Registration in Medicine (BORIM) Trust Fund should allocate funds to cover operational costs incurred by the IMLC. Currently, the trust fund covers the BORIM's administration and operations, which are primarily focused on physician licensing.[366,367] If Massachusetts enters the IMLC, the BORIM should allocate the revenue from increased licensing applications to cover the additional costs. These efforts would help ensure that the IMLC effectively decreases physician shortages in rural CHCs without increasing the financial burden on these centers. By providing greater job flexibility and enabling physicians from other states to fill in staffing shortages, the IMLC—coupled with continuous funding—would increase job satisfaction and reduce clinician burnout, ensuring higher physician retention in rural CHCs.

Through the IMLC, physicians from other states could provide care to Massachusetts residents via telehealth; however, this solution introduces other challenges, namely the digital divide, which is the unequal access to technology and is particularly prominent in rural areas. According to studies, patients from rural areas are 8.3 percentage points less likely to use telehealth services than those from urban areas due to disparities in technology access and digital literacy skills.[368] Thus, the widespread use of telehealth must be coupled with efforts to bridge the digital divide, maximizing both the availability of qualified healthcare professionals and the

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[366] Malegislature.gov. "General Law - Part I, Title II, Chapter 10, Section 35M," 2025. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter10/Section35M.

[367] Massachusetts Department of Public Health. "Board of Registration in Medicine | Mass.gov." www.mass.gov, 2025. https://www.mass.gov/orgs/board-of-registration-in-medicine.

[368] Commonwealth of Massachusetts-Health Policy Commission. "Telehealth Use in the Commonwealth and Policy Recommendations." Masshpc.gov. January 2023. https://masshpc.gov/sites/default/files/2023-04/Telehealth%20Use%20in%20the%20Commonwealth%20and%20Policy%20Recommendations_0.pdf.

efficiency of remotely delivering healthcare services everywhere. The Federally Qualified Health Center (FQHC) Telehealth Consortium is engaging in crucial work to bridge the digital divide, ensuring that telehealth is accessible to patients in underserved areas. Leveraging the funds of the FQHC Telehealth Consortium and additional subsidies from the state, FQHCs and CHCs must help to distribute technological resources and support to patients, enabling them to take full advantage of telehealth services.[369]

Enact Legislation Modifying the Massachusetts General Laws or Creating Novel Programs

Amend Massachusetts General Laws, Part I, Title IX, Chapter 62, Section 6

I. Amend Massachusetts General Law, Part I, Title IX, Chapter 62, Section 6 to Establish a Combination of Tax Credits, One Providing a Financial Incentive to Licensed Primary Care Physicians Who Reside and Practice in Designated Rural Counties Classified as Healthcare Professional Shortage Areas, and Another Granting a Credit to Individual and Corporate Taxpayers Who Donate a Portion of Their Income to Qualified Rural Hospitals in Those Same Areas.

The Massachusetts Health & Hospital Association (MHA) should partner with the National Rural Health Association (NRHA) to lobby the Massachusetts Legislature for the adoption of an article establishing tax credits for healthcare professionals who reside and actively practice in Healthcare Professional Shortage Areas (HPSAs), as well as for individuals and corporations that contribute funds to qualified rural hospitals in those areas. The article could be added to the Massachusetts General Law, Part I, Title IX, Chapter 62, Section 6 (Credits), as this section already includes various tax credits/bonuses designed to incentivize actions that serve the

[369] FQHC Telehealth Consortium, "Our Work – FQHC Telehealth Consortium," Fqhctelehealth.org, 2020, https://fqhctelehealth.org/our-work/.

public good—such as those for renewable energy installations—making the proposed addition consistent with its existing purpose.[370]

Background Research & Case Study:

Several precedents exist for rural physician tax credits, with states such as Alabama, Georgia, Louisiana, New Mexico, and Oregon having enacted programs to incentivize physicians to practice in underserved areas in the past.[371] Additionally, a federal effort to establish a similar tax credit program was also made back in 2007 with the introduction of the Rural Physician Relief Act.[372] Comprehensive case studies on the effectiveness of such tax credit programs remain limited. However, in Georgia, data from 2010 projected that by 2025, approximately 1,655 additional primary care physicians would be needed to adequately serve the state's Healthcare Professional Shortage Areas (HPSAs).[373] Today, that number has decreased significantly, with only about 596 primary care physicians reportedly needed to eliminate HPSA designations in the state.[374] Although multiple factors likely contributed to this change, one significant reason could be the implementation of the Rural Physician Tax Credit in Georgia, which took effect on May 15, 2024, and provided a tax credit of $5,000, which aligns with

[370] The 194th General Court of the Commonwealth of Massachusetts. (n.d.). General Law - Part I, Title IX, Chapter 62, Section 6. Retrieved from malegislature.gov website: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleIX/Chapter62/Section6.
[371] Kulka, A., & McWeeny, D. (2019, December 12). Rural Physician Shortages and Policy Intervention. Retrieved from papers.ssrn.com website: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3481777
[372] Murkowski Reintroduces Rural Physicians Relief Act | U.S. Senator Lisa Murkowski of Alaska. (2007, January 12). Retrieved August 11, 2025, from Senate.gov website: https://www.murkowski.senate.gov/press/release/murkowski-reintroduces-rural-physicians-relief-act
[373] Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, health, and Cost. *Health Affairs (Project Hope)*, *27*(3), 759–769. https://doi.org/10.1377/hlthaff.27.3.759.
[374] Bureau of Health Workforce Health Resources and Services Administration (HRSA) U.S. Department of Health & Human Services. (2025). Designated Health Professional Shortage Areas Statistics. Retrieved from HRSA Data website: https://data.hrsa.gov/default/generatehpsaquarterlyreport.

typical amounts seen in similar programs, for each qualifying rural physician as of the tax credit's implementation date.[375,376]

A rural physician tax credit can help increase recruitment of physicians to underserved rural areas, but its long-term effectiveness remains uncertain. To complement this, a tax credit for taxpayers who contribute funds to rural hospitals could provide additional, sustained financial support to these critical healthcare institutions. Georgia provides a good example of such a tax credit with their Georgia Rural Hospital Tax Credit Program, instituted in 2016 and effective starting January 1st of 2017. The code stated that individuals willing to make financial contributions to rural hospital organizations would qualify for a tax credit for a specific amount.[377] A longitudinal cross-sectional case study done using hospital financial data from the Centers for Medicare and Medicaid Services was conducted to compare the financial health of rural hospitals before and after implementation of the program. This study revealed that two years after implementation of the program, there was a clear improvement in financial health in participating rural hospitals, numbers showing an approximate 23% increased probability of hospitals having good or excellent financial health.[378] This policy significantly improved hospital profitability and financial stability. With greater financial security, hospitals were then able to

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[375] Office of Governmental Affairs and Trial Court Liaison of the Judicial Council of Georgia/ Administrative Office of the Courts. (2024). Summary of Enacted Legislation 2024. Retrieved from https://georgiacourts.gov/wp-content/uploads/2024/06/2024-Enacted-legislationv2.pdf.

[376] Georgia Department of Revenue. (2025). Tax Credits. Retrieved from https://dor.georgia.gov/document/document/tax-credit-summary-12-9-20pdf/download.

[377] 2024 CODE OF GEORGIA :: Title 48 - REVENUE AND TAXATION (§§ 48-1-1 — 48-18-1) :: Chapter 7 - INCOME TAXES (§§ 48-7-1 — 48-7-170) :: Article 2 - IMPOSITION, RATE, AND COMPUTATION; EXEMPTIONS (§§ 48-7-20 — 48-7-42) :: Section 48-7-29.20 - [Repealed and Reserved Effective 12/31/2029] Tax credits for contributions to rural hospital organizations. (2024). Retrieved August 11, 2025, from Justia Law website: https://law.justia.com/codes/georgia/title-48/chapter-7/article-2/section-48-7-29-20/.

[378] Apenteng, B. A., Opoku, S. T., Owens, C., Akowuah, E., Kimsey, L., & Peden, A. (2021). Assessment of the Financial Health of Rural Hospitals After Implementation of the Georgia Rural Hospital Tax Credit Program. JAMA network open, 4(7), e2117791. https://doi.org/10.1001/jamanetworkopen.2021.17791

allocate resources toward retaining healthcare workers by addressing the issue of non-competitive wages directly.

Estimated Cost of Implementation:

As a tax credit, the cost of implementing such a policy could be funded directly from the Massachusetts General Fund. This could be achieved by reallocating a portion of funds within MassHealth, particularly given that the Massachusetts Senate recently approved a $3.7 billion budget increase, with the majority of that increase directed toward MassHealth.[379] The Massachusetts Legislature could also consider increasing taxes on certain commodities, such as cigarettes or alcohol, both to encourage healthier behaviors and to help offset the costs of the proposed tax credits.

Rural Physician Tax Credit	Annual Cost
A $5,000 tax credit to ≈1,500 primary care providers in designated HPSAs[380,381]	$7,500,000
Administration Costs (to Department of Revenue Administration, coordination with rural health agencies, legislative drafting, etc.)	$200,000

Rural Hospital Tax Credit	Annual Cost

[379] Press Room. (2025). Retrieved August 11, 2025, from Malegislature.gov website: https://malegislature.gov/PressRoom/Detail?pressReleaseId=201.
[380] Kulka, A., & McWeeny, D. (2019, December 12). Rural Physician Shortages and Policy Intervention. Retrieved from papers.ssrn.com website: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3481777.
[381] Massachusetts Health Policy Commission. (n.d.). A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action. Retrieved from https://masshpc.gov/sites/default/files/HPC%20Chartpack_A%20Dire%20Diagnosis%20-%20The%20Declining%20Health%20of%20Primary%20Care%20in%20MA_1.pdf.

Based on expenditures by Georgia on the Rural Hospital Tax Credit over the past years (and considering that Georgia has approximately ten times the number of rural healthcare facilities in Massachusetts)[382,383,384]	≈$6,000,000
Administration Costs (to Department of Revenue Administration, coordination with rural health agencies, legislative drafting, etc)	$200,000

Amend Massachusetts General Laws, Chapter 112

I. Amend Massachusetts General Laws, Chapter 112, by Adopting Associate Physician Licensure as a Path to Residency at Rural and Underserved Health Centers.

Chapter 112 of the Massachusetts General Laws describes the scope of practice for practitioners in the state. Legislators should pass a law that allows medical school graduates who were not accepted into residencies to work in rural CHCs, completing primary care services under the supervision of a licensed collaborating physician. After completion of the 2-year program, the individual's application will get priority review for residencies at approved clinics in underserved areas, along with benefits like a recommendation or a secured interview, depending on the center and clinic. Importantly, health professionals who gain exposure to these communities are more likely to continue working in them, thereby increasing retention in rural CHCs.[385]

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[382] Rural Hospital Tax Credit - Related Files Archive. (2017). Retrieved August 11, 2025, from Georgia Department of Community Health website: https://dch.georgia.gov/programs/rural-hospital-tax-credit/rhtc-archive.

[383] Rural health for Georgia Introduction - Rural Health Information Hub. (2018). Retrieved from Ruralhealthinfo.org website: https://www.ruralhealthinfo.org/states/georgia.

[384] Rural health for Massachusetts Overview - Rural Health Information Hub. (n.d.). Retrieved from www.ruralhealthinfo.org website: https://www.ruralhealthinfo.org/states/massachusetts

[385] Supakorn Kueakomoldej et al, "Recruitment and Retention of Primary Care Nurse Practitioners in Underserved Areas: A Scoping Review," *Nurs Outlook* 70, no.3 (2022): 401-416, https://doi.org/10.1016/j.outlook.2021.12.008.

Background Research & Case Study:

A form of Associate Physician (AP) licensing has been implemented in 11 states, and Missouri is among the first. In the first year of Missouri's program, only 25.5% of the APs had secured a collaborative agreement, and 80.0% of that group was working in a federally designated professional shortage area. In regard to USMLE performance rates, APs had lower scores for all 4 Step exams compared to the U.S. medical graduates and for 3 Step exams compared to international medical graduates.[386] The first year of a new development is expected to encounter some gaps and challenges, and many amendments to the Missouri Licensure program have been made since.[387] By February of 2023, Missouri had licensed 292 APs, which was projected to increase the primary care physician population by 3%.[388] Massachusetts' legislation should enforce guidance for APs in first establishing a relationship with a collaborative physician, as well as practice in clinical experience prior to Step 3 of the USMLE. Given the present shortage of workers in community health centers, this pathway would expose young physicians to healthcare in rural and underserved areas, as well as allow them the opportunity to offer their knowledge and experience to the medical field while continuing to apply for residency.

Additionally, the results of a study by Nursing Outlook found that after gaining clinical experience in a rural setting, nurse practitioners were 2.7 times more likely to choose a rural setting over an urban setting as their first practice location. Training location was the only variable that significantly predicted practice in underserved areas, while other variables like age,

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[386] Grant S. Hoekzema and James J. Stevermer, "Characterization of Licensees During the First Year of Missouri's Assistant Physician Licensure Program," *JAMA* 320, no. 16 (2018): 1706–1707, https://doi.org/10.1001/jama.2018.11191.
[387] "States with Enacted and Proposed Associate Physician Legislation," Federation of State Medical Boards, last updated April 2025, https://www.fsmb.org/siteassets/advocacy/policies/associate-physician-legislation-by-state-key-issue-chart.pdf.
[388] Jeffrey Singer and Spencer Pratt. "Expand Access to Primary Care: Remove Barriers to Assistant Physicians." *CATO Institute*, April 2023, https://www.cato.org/briefing-paper/expand-access-primary-care-remove-barriers-assistant-physicians.

sex, or marital status did not.[389] Receiving additional aid and support from APs can help with burnout, one of the leading reasons why workers leave safety-net centers or the healthcare field entirely.[390] Recognizing the lower exam performance rates of APs, the Massachusetts model should emphasize the outcomes of the AP program as a bridge to residency rather than suggesting a substitution of residency as Missouri's legislation does.

Cost-Benefit Analysis and Limitations

In Alabama, the cost to apply for Bridge Year Graduate Physician Licensing (along with a background check) is $265, and every subsequent year for renewal costs $100.[391] In British Columbia, Associate Physician registration costs $247.11 USD and $681.37 annually for licensure.[392] Similar costs can be expected for the Massachusetts program. In Berkshire County, MA, the average wage for a full-time AP would be about $100,000 a year. Amendment of General Law Chapter 118E through Bill SD.1526 called upon MassHealth to make graduate medical education payments for training in community-based primary care, behavioral health, and other areas of physician or provider shortage in community-based healthcare settings in the Commonwealth. Associate physicians would fall under this category. The costs of organizing, setting standards, and hiring associate physicians may mean the benefits take several years to be made apparent. Especially since residency would still be necessary for medical graduates to become fully licensed physicians, it could take several years to see more medical workers working in rural or underserved health centers.

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[389] Kueakomoldej et al, "Recruitment and Retention of Primary Care Nurse Practitioners in Underserved Areas: A Scoping Review."

[390] Zaher M. Kmail et al., "Burnout Predictors Among Direct Clinical Services Health Care Professionals in Community Health Centers: A Cross-Sectional Study," *American Journal of Health Promotion,* 1 Jun 2025, https://doi.org/10.1177/08901171251348220.

[391] "Bridge Year Graduate," *Alabama Board of Medical Examiners and Medical Licensure Commission*, https://www.albme.gov/licensing/md-do/registrations/bridge-year-graduate.

[392] "Health Professionals Act," *BC Laws,* January 2, 2024. https://www.bclaws.gov.bc.ca/civix/document/id/mo/hmo/m0389_2023.

Creating Housing Subsidies

I. Enact a Bill to Implement Housing Subsidies for Community Healthcare Workers.

Massachusetts should consider a bill modeled after California's Bringing Health Care into Communities Act of 2023 (AB 2123) to provide housing subsidies for healthcare workers in underserved areas. Under California's AB 2123, eligible health professionals (primary care physicians, dentists, nurse practitioners, pharmacists, mental health and behavioral health providers) can receive housing grants for up to 5 years to assist with mortgage payments on a home in a federally-designated Health Professional Shortage Area (HPSA).[393] The intent is to integrate healthcare providers into the communities they serve, especially rural and underserved areas. In California, the program is administered by the Housing Finance Agency; similarly, in Massachusetts, the quasi-public MassHousing agency could oversee financing and grants for this initiative. The ultimate goal is to attract and retain healthcare workers in rural and high-need areas by offsetting housing costs, thereby improving local access to care and reducing the economic burdens of health.

Background, Case Study, and Cost-Benefit Analysis:

A useful case study comes from the Richmond/Henrico Health District in Virginia, where Community Health Workers (CHWs) were embedded in low-income housing communities from 2013 to 2020. The Community Health Workers (CHW) program in the Richmond/Henrico Health District of the Virginia Department of Health (VDH) established resource center offices from which CHWs worked. The Richmond Henrico health district is one of Virginia's most

[393] Carlos Villapudua, "Brining Health Care into Communities Act of 2023," *California State Board of Behavioral Sciences Bill Analysis*, April 7, 2022, https://www.bbs.ca.gov/pdf/agen_notice/2022/20220420_pa_ix.pdf.

populous districts and consists of a mixture of suburban, rural, and urban communities.[394] In a 2024 survey of the district's residents, 24.8% of respondents reported difficulties accessing healthcare services, emphasizing the need for improved access and affordability.[395] In the CHW program, public health staff worked out of on-site resource centers within housing complexes, focusing on outreach, preventive care, and linking residents to services.

A longitudinal review of this 7-year program demonstrated several key benefits. First, investing in CHWs has proven to be a cost-effective strategy. Studies show that CHWs help reduce the use of more expensive interventions (like emergency room visits and hospitalization) by focusing on prevention and early intervention.[396] In the Virginia program, CHWs emphasized primary care and preventive services, likely averting costly acute episodes. In fact, research indicates that every dollar Medicaid spent on patients receiving support from Penn Medicine's community health worker (CHW) program resulted in an annual return on investment of $2.47.[397] A Patient-Centered Outcomes Research Institute study found patients who had CHW support experienced 29% fewer hospital stays than those without CHW assistance.[398] By helping patients manage conditions in outpatient settings and navigate resources (instead of defaulting to the ER for non-emergencies), CHWs generate significant healthcare cost savings. Community health centers facilitate economic growth in the neighborhoods they serve, generating over $85

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[394] Obasanjo, Iyabo, Monica Griffin, Alison Scott, Sarena Oberoi, Charles Westhoff, Patrice Shelton, and Stephanie Toney. 2022. "A Case Study of a Community Health Worker Program Located in Low-Income Housing in Richmond, Virginia." *Journal of Community Health* 47 (2): 316–23. https://doi.org/10.1007/s10900-021-01057-1.

[395] "Community Health Assessment (CHA) - Richmond City Health Department." 2024. Richmond City Health Department. October 11, 2024. https://www.vdh.virginia.gov/richmond-city/cha/.

[396] Obasanjo, Iyabo, Monica Griffin, Alison Scott, Sarena Oberoi, Charles Westhoff, Patrice Shelton, and Stephanie Toney. 2022. "A Case Study of a Community Health Worker Program Located in Low-Income Housing in Richmond, Virginia." *Journal of Community Health* 47 (2): 316–23. https://doi.org/10.1007/s10900-021-01057-1.

[397] "Penn's Community Health Worker Program Yields $2.47 for Every $1 Invested Annually by Medicaid | Penn Today," Penn Today, February 17, 2020, https://penntoday.upenn.edu/news/penns-community-health-worker-program-yields-247-every-1-invested-annually-medicaid.

[398] Shanteny Jackson, "CHWs Are Making an Impact in Virginia. Let's Find Sustainable Funding for Their Future," Virginiamercury.com, September 18, 2024, https://virginiamercury.com/2024/09/18/chws-are-making-an-impact-in-virginia-lets-find-sustainable-funding-for-their-future/.

billion on average and employing nearly 300,000 employees in the United States.[399] For example, one analysis in Virginia estimated that avoidable ER visits for conditions like UTIs or asthma cost over $75 million in a year, whereas treating those issues in primary care would cost only around $8 million, which highlights the huge savings potential when communities have proper access to care. Because CHWs often come from the communities they serve, they build strong rapport and trust with residents. In Richmond/Henrico, all the CHWs were women from minority backgrounds serving predominantly minority, low-income housing communities. In the Richmond/Henrico case, the CHW program provided jobs and likely reduced productivity losses due to illness by keeping people healthier. By embedding health services within housing, the program also improved residents' stability, helping them maintain housing and jobs through better health and resource access. CHWs are a cost-effective strategy, reducing the use of more expensive interventions like emergency rooms and costly medical devices. Further, this approach encourages mutual trust and understanding between community residents and health workers since the CHWs would understand and use the appropriate messaging to enable rural communities to adopt health-promoting practices.[400]

Implementing a housing subsidy program in a rural area can take different forms. One approach is to directly develop a cluster of housing units designated for healthcare workers (with subsidized rent or mortgage). Building 20 moderate-density housing units for healthcare workers in rural Massachusetts would require an estimated $5–6 million in upfront capital, covering site preparation, construction, design, and administration. Using state-owned or low-cost rural land can keep acquisition expenses minimal, and per-unit costs would remain below many urban

[399] NACHC. "What Is a Community Health Center? - NACHC," January 6, 2025. https://www.nachc.org/community-health-centers/what-is-a-health-center/.
[400] Ford, Eric. 2024. "The Role of Healthcare Systems in Workforce Housing: An Urban and Rural Imperative." Ache.org. 2024. https://www.ache.org/blog/2025/the-role-of-healthcare-systems-in-workforce-housing.

affordable housing projects. The goal is to attract and retain providers in Health Professional Shortage Areas (HPSAs), similar to California's AB 2123 housing grant program. Evidence from Virginia's Richmond/Henrico CHW initiative shows that embedding healthcare workers in the communities they serve leads to better preventive care access, reduced emergency room use, and stronger trust between providers and residents. Studies of CHW models suggest an ROI of roughly $2.47 saved for every $1 invested, largely from reduced hospitalizations and avoidable ER visits, making it likely the program could recoup its costs within a few years through healthcare savings alone.[401]

MassHousing, the state's housing finance agency, has broad authority to administer affordable housing programs and to make loans or grants as authorized by its statute. While MassHousing's typical focus is on financing developments and homeownership, it can administer targeted programs on the Commonwealth's behalf. Its charter allows running home improvement or rehabilitation grant programs for specific populations.[402] A new CHW housing stipend program could be structured similarly, perhaps as a pilot within an existing workforce housing initiative, without conflicting with current law. The key would be legislative authorization directing MassHousing (or another agency) to provide rental or mortgage assistance to CHWs in rural or high-need areas. To enact this, a coalition of Massachusetts-based organizations and agencies would rally behind the bill, involving the Massachusetts League of Community Health Centers and the Massachusetts Association of Community Health Workers (MACHW). State health agencies like MassHealth (Medicaid), which is investing in CHW

[401] Frank Marsh, "How Much Does It Cost to Build an Apartment Building in 2024?," SMA Estimating LLC, May 31, 2024, https://www.smaestimating.com/how-much-does-it-cost-to-build-an-apartment-building/.
[402] An Act Further Regulating the Massachusetts Housing Finance Agency. 1997. "Session Law - Acts of 1998 Chapter 239." Malegislature.gov. August 17, 1997. https://malegislature.gov/Laws/SessionLaws/Acts/1998/Chapter239.

workforce development under its waiver, and the Department of Public Health's Office of CHWs could offer expert support, ensuring the program aligns with health equity goals.

Executive Office Actions and Ancillary Statewide Programs

Executive Office of Health and Human Services

I. Expand the Massachusetts HIway Connection Requirement as Detailed in Mass. Gen. Laws Ann. Ch. 118I, § 7.

In 2017, the Massachusetts Executive Office of Health and Human Services (EOHHS) implemented the "Mass HIway Regulations," which are a series of regulations encouraging the adoption of the HEI in settings across the state. Pursuant to the Mass HIway regulations, specific healthcare providers, including both "Large and Small" CHCs, must connect to the Mass HIway and fulfill use requirements by sending and receiving messages through the system in a 4-year phased approach.[403] These regulations do not, however, require individual providers to adopt the system, nor do they require that healthcare settings use the system beyond a single documented "use case" in the provider-provider (communication between different provider organizations) category.[404] In order to encourage the more rapid adoption of this system and therefore reduce the administrative burdens associated with coordinating healthcare services across multiple providers, the Massachusetts EOHHS and the Health Information Technology Council (which is composed of many experts and shapes the implementation of the system) should modify the Mass HIway Connection Requirement. Within the basic regulatory framework and using the

[403] Massachusetts Executive Office of Health & Human Services, 2019, "101 CMR: EXECUTIVE OFFICE of HEALTH and HUMAN SERVICES 101 CMR 20.00: Health Information Exchange," October 4, 2019, https://www.mass.gov/files/documents/2019/10/03/101-cmr-20.pdf.
[404] Massachusetts Executive Office of Health & Human Services, "101 CMR: EXECUTIVE OFFICE of HEALTH and HUMAN SERVICES 101 CMR 20.00."

authority granted to them under Section 5, Chapter 1181 of Massachusetts General Laws, the EOHHS could require CHCs to document at least 10 use cases annually and require that individual providers in these settings each document at least one use case annually.

Background and Case Study:

Created in 2012, the Massachusetts Health Information Highway (HIway) is a state-sponsored health information exchange service that facilitates communication between healthcare providers in the Commonwealth.[405] The system allows healthcare providers to exchange health information with each other regarding a patient's care (though HIway does not itself store patient records), report public health information, and avoid excess paperwork associated with administrative tasks.[406]

One case study that demonstrates the potential impact of Mass HIway Expansion is the implementation of the MHS Genesis health records system in the military health system. In 2024, the Department of Defense finished the nearly decade-long implementation of the MHS Genesis system. The electronic health records (EHR) system, which standardizes patient records for service members and their families and compiles all medical records (inpatient, outpatient, those from military and civilian hospitals, and other medical information) into a single online system, now supports more than 9.5 million beneficiaries.[407] The system has been praised by military officials for improving the accessibility of records, improving patient care and safety, and improving physician workflows.[408] The data on the efficacy of the MHS Genesis in

[405] Commonwealth of Massachusetts, "Massachusetts Health Information HIway - HOME | MASSHIWAY Target," n.d, www.masshiway.net. https://www.masshiway.net/.
[406] Commonwealth of Massachusetts, "Massachusetts Health Information HIway - Information for Patients| MASSHIWAY Target," n.d, www.masshiway.net/index.php/About/Information_For_ Patients.
[407] Cornwell, Ken, 2024, "MHS GENESIS Leader Reflects on Challenges, Successes as He Prepares to Pass the Torch," Military Health System, Health.mil, August 10, 2024, https://www.health.mil/News/Dvids-Articles/2024/08/10/news478249.
[408] "MHS GENESIS: The Electronic Health Record," n.d, Military Health System, https://health.mil/Military-Health-Topics/Technology/MHS-GENESIS.

improving patient care is mixed but gives reason for optimism. When the DOD first collected data in 2022, just 24% of system users said that "the electronic health record enables me to deliver high quality care," however, when asked the same question just 12 months later 5% more people responded in the affirmative.[409] That pattern of growth holds on the statement "the electronic health record allows me to deliver patient-centered care," which jumped from 35% to 39% in the same time frame.[410] This data is encouraging in that it demonstrates the growing popularity of the system and the potential to improve patient care, but policy-makers must also be wary to explicitly incorporate physician feedback because these statistics still lag behind legacy system approval ratings.[411]

MassHealth

I. Modify Clinical Tier Requirements within the MassHealth Primary Care Sub-Capitation Program in Response to Medicaid Cuts

In 2023, of the $520 million paid to practices through the Primary Care Sub-Capitiation Program, about $100 million was paid through the Clinical Tier Enhanced Payment program.[412] This program creates three specific tiers of advanced services that qualify a practice for a higher sub-capitation rate.[413] While this system is an excellent way to ensure that centers offering more and better care are rewarded, it is imperative that it adopts provisions to include providers that

[409] "ELECTRONIC HEALTH RECORDS DOD Has Deployed New System but Challenges Remain Report to Congressional Committees United States Government Accountability Office," 2024, *Government Accountability Office*, https://www.gao.gov/assets/gao-24-106187.pdf.
[410] Government Accountability Office, "ELECTRONIC HEALTH RECORDS DOD Has Deployed New System but Challenges Remain Report to Congressional Committees"
[411] Government Accountability Office, "ELECTRONIC HEALTH RECORDS DOD Has Deployed New System but Challenges Remain Report to Congressional Committees"
[412] Commonwealth of Massachusetts, 2024, "MassHealth Primary Care Sub-Capitation: Care Delivery Transformation," Mass.gov, 2024, https://www.mass.gov/info-details/masshealth- primary-care-sub-capitation-care-delivery-transformation.
[413] Commonwealth of Massachusetts, "MassHealth Primary Care Sub-Capitation: Program Overview."

are serving populations left underinsured by recent Medicaid cuts. Predictions estimate that these cuts will cause 326,000 Massachusetts residents to lose their care, which represents an impending disaster for the state's primary care providers.[414] In order to counteract what will be a dramatic reduction in coverage for patients utilizing CHCs and an increase in the already intense financial strain placed on these institutions, MassHealth should modify the terms and conditions of the sub-capitation program (which is permissible under current statute) to add an enhanced payment tier specifically for providers serving underinsured populations. This provision would enable CHCs to continue serving these populations without having to lower already non-competitive salaries. The framework for this adjustment already exists within the current tier system's inclusion of "Population-Specific Requirements" for each of the three tiers, including screening for SNAP and WIC eligibility and on-site staff with children and family experience, among other care requirements.[415] Mirroring this structure, the rapid addition of a payment rate increase for those serving the populations most impacted by coverage cuts would be a critical step towards ensuring the long-term health of both thousands of Massachusetts residents and the CHCs that serve.

Background & Case Study:

Currently, MassHealth operates a state-wide incentive program aimed at rewarding quality primary care providers and remedying the pay inequities between specialty providers and primary care physicians.[416] Any primary care practice that participates in one of MassHealth's Accountable Care Organizations is eligible to receive a fixed per-member, per-month payment in

[414] Boston Globe Editorial Board, 2016, "One Big Disaster for Massachusetts Health Care," BostonGlobe.com, 2016, https://www.bostonglobe.com/2025/07/17/opinion/obbba-masshealth -medicaid-cuts/.
[415] Commonwealth of Massachusetts, "MassHealth Primary Care Sub-Capitation: Care Delivery Transformation."
[416] Commonwealth of Massachusetts, "MassHealth Primary Care Sub-Capitation Program," 2025, Mass.gov, 2025, https://www.mass.gov/masshealth-primary-care-sub-capitation-program.

exchange for providing a set of basic primary care services.[417] The program, which was implemented state-wide in 2023, moves away from fee-for-service reimbursement and is specifically designed to improve investment in primary care across the state.[418] The program has shown to be immensely popular with over 75% of primary care practices that accept MassHealth participating.[419]

Studies of the nation-wide Primary Care Incentive Program, which can serve as a case study for the Massachusetts Sub-Capitiation program, conclude that it contributed to significant long-term increases in Medicare providers. According to a study conducted between 2005 and 2011, in counties across the country, there was a nearly 19% increase in providers per county who were PCIP bonus eligible and submitted at least one claim.[420] This data held true in Physician Shortage Areas (often rural), where PCIP bonus-eligible providers increased by 1 during the studied period.[421] Further, in 2009, the Rural Policy Research Institute (RUPRI) produced research on the effects and influence of the Medicare PCIP in rural areas.[422] The researchers surveyed more than 1000 rural healthcare settings and found that 75% of rural primary care practitioners qualified for the program.[423] They also found that the average physician brought in $8000 in extra Medicare revenue annually. Importantly, RUPRI concluded that the 60% Medicare threshold to qualify for the PCIP bonus was appropriate for rural

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[417] Commonwealth of Massachusetts, "MassHealth Primary Care Sub-Capitation Program."
[418] Commonwealth of Massachusetts, "MassHealth Primary Care Sub-Capitation: Program Overview."
[419] Commonwealth of Massachusetts, "MassHealth Primary Care Sub-Capitation: Program Overview."
[420] The Lewin Group, 2014, "Health Practitioner Bonuses and Their Impact on the Availability and Utilization of Primary Care Services," Office of the Assistant Secretary for Planning and Evaluation, December 21, 2014, https://aspe.hhs.gov/reports/health-practitioner-bonuses-their-impact-availability-utilization-primary-care-services-0.
[421] The Lewin Group, "Health Practitioner Bonuses and Their Impact on the Availability and Utilization of Primary Care Services."
[422] Shane, Dan, A Clinton MacKinney, Fred Ullrich, Keith J Mueller, Paula Weigel, Rural Health Research & Policy Centers, and RUPRI Center for Rural Health Policy Analysis, University of Iowa College of Public Health, Department of Health Management and Policy. 2013. "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program." *Rural Policy Brief*, no. 2013 16 (January): 1–6. https://pubmed.ncbi.nlm.nih.gov/25399465/.
[423] RUPRI Center for Rural Health Policy Analysis, "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program."

settings.[424] Of the 25% of practices that didn't qualify for the PCIP bonus, the average share of primary care provided was just 29%.[425] That percentage indicates that the qualifications implemented under the original system were effective in identifying rural practices that were underfunded because of low primary care reimbursement rates. One drawback of the PCIP system is that it benefited larger practices more than it did smaller settings.[426] In an office with 15 primary care physicians and 7 non-physician practitioners, the PCIP would result in $141,000 extra in revenue annually.[427] However, in small settings, like many CHCs in Massachusetts, the bonus payments typically didn't allow for practices to hire additional staff.[428] In order to ensure that Massachusetts's CHCs are able to take advantage of a new PCIP, bonuses should be scaled to meet the needs of small centers.

Massachusetts Loan Repayment Program

I. Expand the Massachusetts Loan Repayment Program by Adding on a Medical Rural Bonded Scholarship Scheme that Provides Full Tuition to a Massachusetts Medical School for Students Who Commit to Practicing Medicine in a Designated Rural Area of the State for a Specified Period After Graduation.

A Medical Rural Bonded Scholarship Scheme could be implemented under Section 338I of the Public Health Service Act since it could be seen as an expansion of the existing

[424] RUPRI Center for Rural Health Policy Analysis, "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program."
[425] RUPRI Center for Rural Health Policy Analysis, "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program."
[426] RUPRI Center for Rural Health Policy Analysis, "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program."
[427] RUPRI Center for Rural Health Policy Analysis, "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program."
[428] RUPRI Center for Rural Health Policy Analysis, "Assessing the Impact of Rural Provider Services Mix on the Primary Care Incentive Payment Program."

Massachusetts Loan Repayment Program, as it shares the goal of providing financial support to students who cannot afford higher education on their own, while broadening eligibility to include a larger group of students.[429] While the Loan Repayment Program targets students who have already graduated and have existing loans to repay, the Medical Rural Bonded Scholarship Program focuses on students who have not yet entered higher education and therefore do not have outstanding loans. Unlike the Loan Repayment Program, this scholarship enables students to attend and graduate from higher education debt-free, providing them with financial support and a clear career path from the outset.

Such a Scholarship Scheme would be particularly effective in the state of Massachusetts, given that the state hosts numerous medical schools—four offering MD programs and one offering a DO. Among them, the University of Massachusetts T.H. Chan School of Medicine (UMass Chan), as the state's sole public medical school, would be best suited to serve as the primary pathway for students participating in the program. Nonetheless, private institutions such as Harvard Medical School (HMS) and Tufts University School of Medicine would also likely be willing partners, given their strong commitments to community health and service.

Background Research & Case Study:

Medical Rural Bonded Scholarship Schemes are an intervention relatively common in Australia.[430] One specific example is the Queensland Health Rural Scholarship Scheme (Allied Health) (QHRSS-AH). A case study conducted on recipients of this scholarship between the years 2000 and 2010 has identified that of 146 participants, 69.2% had completed or were

[429] The Massachusetts Loan Repayment Program (MLRP) – Overview. (n.d.). Retrieved from https://www.mass.gov/files/documents/2017/10/24/mass-loan-repayment-overview-2017.pdf

[430] Health. (2023, November 14). About the Medical Rural Bonded Scholarship Scheme. Retrieved from Australian Government Department of Health and Aged Care website: https://www.health.gov.au/our-work/medical-rural-bonded-scholarship-scheme/about

completing their service period, while 14.4% were still working on the study period.[431] This meant that only 16.4% of participants in the study had deferred or broken their service bonds, indicating a high rate of adherence. The study also found that most scholarship recipients reported that they felt motivated to go into rural and remote practices. One factor that could be improved if this program were implemented in Massachusetts is providing medical students with greater exposure to rural healthcare settings during their years in medical school. The same study did report that some students felt underprepared and unsupported when entering the workforce after graduation; addressing this issue would, without a doubt make the scholarship program even more effective in expanding the rural healthcare workforce.

Estimated Cost of Implementation:

Since the Medical Rural Bonded Scholarship Scheme can be considered an addition to Section 338I, the costs to run the program could be made through reallocating portions of the fund supporting the Massachusetts Loan Repayment Program. However, if reallocation of existing funds is insufficient, the medical schools themselves or locally based philanthropic organizations – such as the Boston Foundation and the Massachusetts Medical Society, both of which periodically offer grants to support community-focused initiatives – may be able to provide additional funding.

Medical Rural Bonded Scholarship Scheme	Annual Cost
Medical school tuition for 20 students (based on tuition for T.H. Chan	≈$1,150,000

[431] Devine, S., Williams, G., & Nielsen, I. (2013, October 24). Rural Allied Health Scholarships: do they make a difference? Retrieved from The International Electronic Journal of Rural and Remote Health Research, Educartion, Practice, and Policy website: https://search.informit.org/doi/epdf/10.3316/informit.311375601322232

School of Medicine and number of students involved with Australia's Rural Bonded Scholarship Scheme)[432,433]	
Administrative Costs (salaries for program coordinators, drafting legislation, maintaining database for tracking participant progress/service fulfillment)	$200,000

II. Modify the Massachusetts Loan Repayment Program (MLRP) Budget to Incentivize Rural Work Placements.

The Massachusetts State Office of Rural Health (SORH) should lobby the Massachusetts Department of Public Health, which funds the Massachusetts Loan Repayment Program (MLRP), to specifically incentivize rural work placements with increased loan forgiveness award amounts. Currently, the SORH domains include rural health resource distribution and the development of strong networks of rural health projects, partnerships, and initiatives.[434] The SORH administers two federal programs, the Rural Hospital Flexibility Program (Flex) and the Small Rural Hospital Performance Improvement Program (SHIP). While these domains and programs strengthen rural hospital infrastructure at a high level through equipment funding flexibility and operational improvements, they fail to specifically and directly address the healthcare professional experience. The SORH should consider a third financial domain, considering the need for financial incentives

[432] Tuition and Fees (T.H. Chan School of Medicine) AY 2025-2026New Page. (2025, July 10). Retrieved August 12, 2025, from UMass Chan Medical School website: https://www.umassmed.edu/awp/finances/som/tuition-and-fees-t.h.-chan-school-of-medicine-ay-2025-2026new-page.

[433] *Bonded Medical Schemes Research Outcomes Report*. (n.d.). Retrieved from https://nrhsn.org.au/wp-content/uploads/2022/11/Bonded-Medical-Schemes-Research-Outcomes-Report-Feb-2016-1.pdf.

[434] "State Office of Rural Health Overview." 2025. Mass.gov. 2025. https://www.mass.gov/info-details/state-office-of-rural-health-overview.

to increase healthcare recruitment. Currently, the MLRP offers up to $50,000 to health professionals for a two-year contract who:

1) Have unpaid health professional student loans

2) Work in an underserved community, Health Professional Shortage Area (HPSA) site

3) Have a license to practice in one of many healthcare disciplines[435]

There needs to be a specific rural healthcare placement distinction with unique benefits to incentivize rural work. Amidst alarming decreases in both rural physician employment and rural medical practice closures, there is an increased need to alleviate financial burden as a major barrier to rural health care recruitment. Many geographic regions are designated HPSA sites, including both rural and metropolitan locations. Therefore, rural communities may be overshadowed by metropolitan areas that may be seen as more attractive work and lifestyle locations. Previous studies cite "rural place stigma", including conceptions of rural locations as "boring" or "backwards" as significant work deterrents.[436] Rural work placements can better compete with urban and metropolitan placements if unique benefits are offered for rural work, either within the current MLRP or through a separate program specific to rural work. The MLRP site currently houses an HPSA database that allows users to search by state and county for funding-eligible sites. A chart populates with key information, including rural status (defined as non-rural, partially rural, or rural). Previous research supports that financial incentives are primary drivers of physicians' decision-making regarding work placement.[437] There is a need for financial incentives to set rural work sites apart.

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[435] "Massachusetts Loan Repayment Program (MLRP) for Health Professionals | Mass.gov." n.d. Www.mass.gov. https://www.mass.gov/info-details/massachusetts-loan-repayment-program-mlrp-for-health-professionals.

[436] Malatzky, Christina A. R., and Danielle L. Couch. 2023. "The Power in Rural Place Stigma." *Journal of Bioethical Inquiry* 20 (2): 237–48. https://doi.org/10.1007/s11673-023-10260-9.

[437] Arredondo, Kelley, Hilary N. Touchett, Sundas Khan, Matthew Vincenti, and Bradley V. Watts. 2023. "Current Programs and Incentives to Overcome Rural Physician Shortages in the United States: A Narrative Review." *Journal of General Internal Medicine* 38 (Suppl 3): 916–22. https://doi.org/10.1007/s11606-023-08122-6.

Currently, the National Health Service Corps (NHSC) grants funding to primary care and other providers in exchange for two years of service in an NHSC-approved Health Professional Shortage Area (HPSA) site.[438] Primary care providers may receive up to $75,000, and other providers up to $50,000 for this initial two-year term. Additional stipends are available for providers proficient in the Spanish language. One study evaluated NHSC clinicians and healthcare costs in Community Health Centers (CHCs).[439] Researchers found that each additional full-time equivalent (FTE) NHSC behavioral health staff worker was associated with a $3.55 reduction of behavioral health care costs per visit. Each FTE, NHSC behavioral health care staff worker in a rural CHC was associated with an even larger reduction of $7.95 in behavioral health care costs per visit.[440] The employment of non-NHSC behavioral health staff was not associated with any cost change.[441] Overall, the study found that NHSC clinicians effectively improved CHC capacity and functioning by increasing visits without increasing service costs.[442] This supports the power and purpose of similar programs, like the MLRP, which provide loan repayment awards in exchange for committed service.

The NHSC has received funding from myriad sources throughout its history. In the past, it has received discretionary appropriations, but with the passage of the 2025 Further Continuing Appropriations Act, 70% of NHSC's annual funding comes from the Community Health Center

[438] Arredondo, Touchett, Khan, Vincenti, and Watts, "Current Programs and Incentives to Overcome Rural Physician Shortages in the United States: A Narrative Review."
[439] Han, Xinxin, Patricia Pittman, and Leighton Ku. 2021. "The Effect of National Health Service Corps Clinician Staffing on Medical and Behavioral Health Care Costs in Community Health Centers." *Medical Care* 59 (Suppl 5): S428–33. https://doi.org/10.1097/mlr.0000000000001610.
[440] Han, Xinxin, Patricia Pittman, and Leighton Ku. 2021. "The Effect of National Health Service Corps Clinician Staffing on Medical and Behavioral Health Care Costs in Community Health Centers."
[441] Han, Xinxin, Patricia Pittman, and Leighton Ku. 2021. "The Effect of National Health Service Corps Clinician Staffing on Medical and Behavioral Health Care Costs in Community Health Centers."
[442] Han, Xinxin, Patricia Pittman, and Leighton Ku. 2021. "The Effect of National Health Service Corps Clinician Staffing on Medical and Behavioral Health Care Costs in Community Health Centers."

Fund (CHCF).[443] In fiscal year 2021, the American Rescue Plan Act issued an $800 million appropriation to expand loan and scholarship awards, as well as reserved $100 million in state funding for loan repayments.[444] From 2011 through 2023, more than 91,579 loan repayments and scholarships have been awarded to professionals who work in a variety of settings.[445]

A survey was conducted to gather information on the NHSC Loan Repayment Program (LRP) and clinicians' perceived needs, challenges, resources, reasons for applying (to both their job and the Loan Repayment Program), and factors influencing retention. The majority of respondents reported staffing shortages as a workplace challenge.[446] The majority of respondents, over 80%, listed benefits and paid time off as a key resource and support.[447] Over 90% of respondents reported financial assistance as their reason to apply to the Loan Repayment Program.[448] Regarding factors influencing intention to stay in their job, the top factor was salary and work hours/schedule.[449] Clearly, finances are a dominant factor influencing healthcare career decision-making, and thus, loan repayment is a critical intervention.

An adaptation to the MLRP, or the introduction of a separate rural program, may follow similar metrics of the NHSC for imitation purposes and provide a $75,000 maximum loan forgiveness award for all providers who commit to rural work.

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[443] Congressional Research Service. "The National Health Service Corps" Congress, April 9, 2025. https://www.congress.gov/crs_external_products/R/PDF/R44970/R44970.17.pdf

[444] Congressional Research Service. "The National Health Service Corps"

[445] Congressional Research Service. "The National Health Service Corps"

[446] Rowan, Kathleen, Savyasachi V. Shah, Alana Knudson, et al. 2024. “Health Professional Retention in Underserved Areas: Findings from the National Health Service Corps Loan Repayment Program Participants in the United States, 2019–2021.” Journal of Public Health Policy 45 (4): 639–53. https://doi.org/10.1057/s41271-024-00516-y.

[447] Rowan, Kathleen, Savyasachi V. Shah, Alana Knudson, et al. 2024. “Health Professional Retention in Underserved Areas: Findings from the National Health Service Corps Loan Repayment Program Participants in the United States, 2019–2021.”

[448] Fraher, Erin, Jacob Rains, Thomas Bacon, Julie Spero, and Emily Hawes. n.d. “Lessons Learned from State Efforts to Leverage Medicaid Funds for Graduate Medical Education.” Accessed July 31, 2025. https://www.shepscenter.unc.edu/wp-content/uploads/2024/02/Policy-Brief-Medicaid-GME-10-16-23_FINAL.pdf.

[449] “Final Report | Mass.gov.” 2017. Mass.gov. 2017. https://www.mass.gov/doc/final-report-6.

Additionally, the Commonwealth of Pennsylvania has plans for a similar statewide Rural Healthcare Grant Program under House Bill 157. Physicians are eligible if they

1) Practice at a rural hospital, clinic, birth center, or Federally Qualified Health Center within six months of accepting a position
2) Work full-time (at least 30 hours/week or 130 hours/month)
3) Commit to at least three years of work in the facility[450]

The MLRP should adopt similar language, specifically noting the first requirement, by specifically addressing rural hospitals, clinics, or centers in its requirements to healthcare professionals. Additionally, the Massachusetts proposal should adjust Pennsylvania's third requirement of three years of service and retain the current MLRP 2-year work requirement. This will ensure that the rural adaptation of the current MLRP is not perceived as less feasible or attractive.

This new adaptation or program should seek collaboration and funding from the Massachusetts Community Health and Healthy Aging Funds, which collaborates with the Massachusetts Department of Public Health (DPH) and Health Resources in Action (HRiA).[451] HRiA aims to tackle health inequities with intentional allocation. Although the Massachusetts Community Health and Healthy Aging Fund focuses on addressing racial disparities through fiscal efforts, a Massachusetts Rural Healthcare Grant program or MLRP adaptation can make its case in support of funding rural healthcare inequities, as rural areas and minority geographic areas face similar accessibility challenges as racial minority groups. Additionally, racial minorities living in

[450] "Bill S.900." 2025. Malegislature.gov. 2025. https://malegislature.gov/Bills/194/S900.

[451] "HomePage -MassachusettsHealth Funds." 2024.MassachusettsHealth Funds. July 31, 2024. https://mahealthfunds.org/.

rural regions have unique and substantial health and access challenges, so the overlap in aims is clear.[452]

Cost-Benefit Analysis:

Currently, the Massachusetts Department of Public Health (DPH) funds the MLRP program, which offers a maximum $50,000 award for a two-year service commitment. In fiscal years 2023, 2022, and 2021, $1,600,000 was available for the MLRP.[453] However, the program roughly awards 18 health professionals per year, roughly amounting to $900,000 (18 x 50,000 awards). Therefore, roughly $700,000 is not currently being used or is not publicly accounted for. We will assume the same $1,600,000 funding amount as a cap for MLRP spending ability in future years. This maximum figure be re-budgeted to account for a rural program with separate, and increased allocated funds. Currently, MLRP spends $1,600,000. MLRP awards roughly 18 health professionals per year and therefore spends $900,000 on loan repayment funds. Under my proposal, to increase rural workplace recruitment, rural workplace offerings must offer greater loan repayment assistance than urban and metropolitan locations. There should be a $75,000 award, in accordance with the current maximum National Health Service Corps (NHSC) funding. Therefore, using the same $1,600,000 cap, so as not to require additional funding from DPH and making better use of the remaining $700,000 ($1,600,000 - $900,000), the math is as follows:

[452] James, Cara V. 2017. "Racial/Ethnic Health Disparities among Rural Adults — United States, 2012–2015." MMWR. Surveillance Summaries 66 (23). https://doi.org/10.15585/mmwr.ss6623a1.
[453] "Human Services Loan Board_Eligible Workers_09.12.2022.Final_.Pdf | Mass.gov." 2022. Mass.gov. 2022. https://www.mass.gov/doc/human-services-and-home-health-workers-loan-repayment-program-board-meeting-september-2022.

$75,000 x 15 rural recipients = $1,125,000

\+ $50,000 x 9 non-rural recipients = $450,000

= $1,575,000

This value is $25,000 below the current annual allotment of $1,600,000 and makes better use of the available budget of $1,600,000. The proposed model does not require additional funding, but rather reconfigures existing funding. In doing so, rural work is incentivized, and the DPH and MLRP save money as the proposed model actually costs less money than MLRP funding has used in the past! Additionally, instead of servicing 18 health professionals per year, 24 health professionals receive funding, making this arrangement both more economical and far-reaching.

Limitations:

Under the proposed model, there may be less money for administrative or other fees; however, not every health professional will require the total $75,000 (for rural work) or $50,000 (for non-rural work) maximum award. Loan repayment will not exceed the loan need and debt amount, so the program may undercut this $1,575,000 figure each year.

Additionally, this proposal is $25,000 cheaper and therefore saves the DPH and other funding sources money. The main goal of the proposal is to incentivize rural work, and a $25,000 increase in funding from $50,000 to $75,000 is sure to stand out to healthcare professionals facing debt. The positive impacts of student loan repayment assistance are clear: A survey conducted reported that 95% of professionals with student debt were more willing to accept a job if it offered

student loan repayment.[454] Additionally, student loan repayment has a positive impact on stress and anxiety and can improve employee work performance.[455]

Implementation Logistics and Final Summary:

The Massachusetts General Laws provide the statutory authority for the MLRP. Title XVI, Chapter 111, Section 25N specifically allows for a healthcare workforce loan repayment program.[456] A rural adaptation to the MLRP would fall within these statutory allowances. The budget within the current MLRP should be modified to reallocate its annual $1,600,000 allowance to create specific rural provisions of a loan repayment award of $75,000.

Massachusetts League of Community Health Center Initiatives

I. Partner with Accrediting Bodies and Provide Support for Health Centers to Achieve Accreditation Statuses that Reward Quality Healthcare.

The Government Affairs and Public Policy team at the Massachusetts League of Community Health Centers should create a comprehensive assessment tool detailing standards of accreditation set by accrediting bodies like The Joint Commission or the Utilization Review Accreditation Commission. Mass League's assistance to rural CHCs in the process of achieving accreditation statuses will allow them to gain comparative advantages in grants, garner support

[454] "Human Services Loan Board_Eligible Workers_09.12.2022.Final_.Pdf | Mass.gov." 2022. Mass.gov. 2022. https://www.mass.gov/doc/human-services-and-home-health-workers-loan-repayment-program-board-meeting-september-2022.
[455] Fraher, Erin, Jacob Rains, Thomas Bacon, Julie Spero, and Emily Hawes. n.d. "Lessons Learned from State Efforts to Leverage Medicaid Funds for Graduate Medical Education." Accessed July 31, 2025. https://www.shepscenter.unc.edu/wp-content/uploads/2024/02/Policy-Brief-Medicaid-GME-10-16-23_FINAL.pdf.
[456] "General Law - Part I, Title XVI, Chapter 111, Section 25N." 2025. Malegislature.gov. 2025. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section25N.

for educational opportunities to increase upward mobility, and increase community confidence—all factors that contribute to the center's retention of their employees.[457]

Background Research & Case Study:

In 2024, Massachusetts became the first state to have all hospitals meet The Joint Commission's healthcare equity accreditation standard. By holding these statuses, MassHealth is predicted to complete race and ethnicity data for 80% of members by the end of this year and reported that all 79 entities, including Accountable Care Organizations, Managed Care Organizations, and hospitals, implemented online training for disability competent care, while 30 entities plan to also provide in-person training.[458] The state worked with hospitals to achieve these goals through an ongoing equity assessment tool and is part of a larger effort to lower barriers for residents to engage with state government.[459,460] A similar framework can be used for other accreditation standards, such as the workplace environment for community health workers or ambulatory care services.

A case study conducted by the Malaysian Family Physician evaluated the impacts of accreditation on primary healthcare (PHC) centers. The study found that accreditation programs had a positive outcome on the performance of PHC centers in quality, effectiveness, human resource management, and efficiency, among many other factors. These criteria were measured through staff training and satisfaction, cost-saving programs, and clinical management

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457 "Benefits of Joint Commission Accreditation Fact Sheet," The Joint Commission, https://www.jointcommission.org/resources/news-and-multimedia/fact-sheets/facts-about-benefits-of-joint-commission-accreditation/.

458 Matt Reynolds and Mary Beth Dyer, "What to know about MassHealth's Quality and Equity Incentive Programs," *Blue Cross Massachusetts Foundation,* July 2025, https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/acquiadam-assets/BCBSF-QEIP-IssueBrief-FINAL.pdf.

459 John LoDico, "Mass. Hospitals: First in Nation to Achieve Equity Standard," *Massachusetts Health and Hospital Association,* February 26, 2024, https://www.mhalink.org/mondayreport/mass-hospitals-first-in-nation-to-achieve-equity-standard/.

460 "Healey-Driscoll Administration Releases Inaugural Equity Assessment Report," *Mass.gov,* August 29, 2024, https://www.mass.gov/news/healey-driscoll-administration-releases-inaugural-equity-assessment-report.

services.[461] A year after receiving accreditation, over 50% of health departments improved utilization of resources, and 39% reported positive results in competitiveness for funding.[462] Newman Memorial—with critical access hospitals in Oklahoma, Texas, and Kansas—received rural health clinic accreditation by The Joint Commission. Over the course of 20 months, their services increased by 76% and staff grew by 63%.[463] While accreditation programs involve a cost and increased efforts for decision-making, the outcome offsets the costs by preventing errors and increasing quality services, patient satisfaction, and credibility.[464]

Cost-Benefit Analysis and Limitations

The costs of accreditation can vary widely, depending on the accrediting body as well as the size and scope of the health center. Factoring in the number of patients seen at rural CHCs annually (about 2,000 to 50,000 patients), accreditation from bodies like The Joint Commission or The Commission on Accreditation of Healthcare Management Education costs about $27,000 during the first year and $5,000 in subsequent years.[465,466] These costs cover everything from eligibility and training fees to personalized reviews and specialized support.[467,468] Most grants to rural CHCs in Massachusetts range from $100,000 to $700,000.[469,470] A study by Health Services

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[461] Jafar Sadegh Tabrizi et al, "Impacts of accreditation on the performance of primary health care centres: A systematic review," *Malaysian Family Physician* 18, (2023): 63, https://doi.org/10.51866/rv.274.
[462] Heffernan, "Here's How Accreditation Has Influenced Health Department Financial Status, And Why It Matters."
[463] Tom Vasko, "The Value of Rural Health Clinic Accreditation: Insights from Newman Memorial Hospital," *The Joint Commission,* Nov 21, 2024, https://www.jointcommission.org/en/knowledge-library/blogs/dateline-tjc-2024-11-the-value-of-rural-health-clinic-accreditation.
[464] Tabrizi, "Impacts of accreditation on the performance of primary health care centres: A systematic review."
[465] "Find a Health Center," *HRSA Data Warehouse, https://findahealthcenter.hrsa.gov/.*
[466] "Massachusetts Rural Definition," *Massachusetts State Office of Rural Health*, 2017, https://www.mass.gov/doc/massachusetts-rural-towns-list/download.
[467] "Candidacy/Accreditation Process and Certification in Healthcare, Quality & Safety & Population Health Management Related Fees Effective for Academic Year 2025-2026," *Commission on Accreditation of Healthcare Management Education*, July 30, 2025, https://cahme.org/wp-content/uploads/2025/07/CAHME-Candidacy-Accreditation-Process-and-Related-Fees_FY-2026_2025_07_30.pdf.
[468] Michael DeShields, "JCAHO: Benefits of The Joint Commission Accreditation," November 1, 2022, https://www.discoverynj.org/jcaho-benefits-of-the-joint-commission-accreditation/.
[469] "Agnes M. Lindsay Trust Grants," *Rural Health Information Hub,* https://www.ruralhealthinfo.org/funding/3788.
[470] "CHP Receives $285K Grant to Enhance Mental Health Treatment," *CHP Berkshires*, Oct 8, 2018, https://chpberkshires.org/chp-receives-285k-grant-behavioral-health/.

Research found that grants make up 46% of FQHCs' total revenue.[471] Approximately 11% accounts for federal grants from the Bureau of Primary Health Care via Section 330 of the Public Health Service Act; therefore, 35% of a CHC's revenue is reliant on other grants from smaller entities.[472,473] Since 39% of health departments reported increased competitiveness for funding after just one year of accreditation, having the added specificity and validation of accreditation status can be very advantageous.[474] Alternatively, this proposal may be limited as the more accreditation statuses are achieved by various health centers, the harder it becomes for accrediting bodies to distinguish where to allocate the funds. Still, with the urgency of the healthcare workforce crisis, earning these titles through quality care will direct resources and support for rural centers that are receiving less attention than their urban counterparts.

II. Utilize the Existing Scope of the Health Center Controlled Network (HCCN) within the Massachusetts League of Community Health Centers to Support the Adoption and Integration of Ambient Intelligence (AmI) Technologies in CHCs.

Ambient intelligence (AmI) is technology that is integrated into its environment. In a clinical setting, AmI can listen in on patient visits and generate detailed, structured notes regarding the patient's progress that would typically be handled by the physician. This

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[471] Peter Amico, Jon Chilingerian, and Martijn Van Hasselt, "Community Health Center Efficiency: The Role of Grant Revenues in Health Center Efficiency," *Health Services Research* 49, no. 2 (2014): 666-82, https:doi.org//10.1111/1475-6773.12106.
[472] Akash Pillai, Bradley Corallo, and Jennifer Tolbert, "Community Health Center Patients, Financing, and Services," *KFF*, January 06, 2025, https://www.kff.org/medicaid/issue-brief/community-health-center-patients-financing-and-services/.
[473] "Federal Grant Funding" *National Association of Community Health Centers*, https://www.nachc.org/policy-advocacy/health-center-funding/federal-grant-funding/.
[474] Megan Heffernan, "Here's How Accreditation Has Influenced Health Department Financial Status, and Why It Matters," *JPHMP Direct*, August 24, 2021, https://jphmpdirect.com/how-accreditation-has-influenced-hd-financial-status/.

innovation reduces the amount of time that physicians spend on patient documentation, allowing them to focus more time on actually caring for and speaking to patients.[475]

The Health Center Controlled Network (HCCN) within the Massachusetts League of Community Health Centers leads health information technology (HIT) initiatives to improve the quality of care provided by CHCs. Some current HIT initiatives in the HCCN include artificial intelligence, cybersecurity, data quality and reporting, digital health tools, and more.[476] The HCCN should leverage its current resources to provide workforce integration support and training programs for the adoption of AmI technologies across CHCs.

Currently funded by the Health Resources and Services Administration (HRSA), an agency of the United States Department of Health and Human Services, it is recommended that the state assume responsibility for providing funding to the HCCN instead, due to recent funding cuts. Specifically, the Applied AI Hub is a capital investment plan in Massachusetts, implemented by "Mass Leads: An Act Relative to Strengthening Massachusetts' Economic Leadership," that directly supports the integration of AI into areas including healthcare and the life sciences. In 2025, this grant program will provide $4 million to advance AI adoption; over the next four years, the program will supply a total of $24.6 million.[477,478] This support would offset the costs of integrating AI into healthcare and would increase the revenue generated by this technology.

Background Research, Case Study, & Cost/Benefit Analysis:

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[475] Vitals. "Sutter Health Study Highlights the Power and Potential of Ambient AI to Improve Clinician Well-Being | Vitals," May 2, 2025. https://vitals.sutterhealth.org/sutter-health-study-highlights-the-power-and-potential-of-ambient-ai-to-improve-clinician-well-being/.

[476] Massachusetts League of Community Health Centers. "Health Informatics and Technology Services," January 7, 2025. https://www.massleague.org/programs-initiatives/health-information-technology/.

[477] Budget.Mass.gov. "D050: Applied AI Hub | Capital Budget FY25," 2025. https://budget.digital.mass.gov/capital/fy25/beneficiary-agency/economic-development/eo-of-economic-development/d050/.

[478] Massachusetts Department of Public Health. "Economic Development Bill." Mass.gov, 2023, www.mass.gov/economic-development-bill.

In a 2025 study by the University of Kansas Medical Center, ninety-nine clinicians were surveyed on the effectiveness of an AmI documentation tool, Abridge. Prior to the implementation of Abridge, 82.8% of respondents reported that they frequently had to spend time on documentation tasks beyond regular clinical hours, and around 75.2% believed that the burden of administrative tasks contributed to their higher risk of burnout.[479] These statistics demonstrate the pressing issue of clinician burnout due to an overwhelming volume of administrative responsibilities. However, the survey indicates that AmI appears to offer a solution to this challenge. Among respondents, 81% of them agreed that AmI simplified their documentation workflow; in other words, clinicians who used AmI had nearly 7 times higher odds of perceiving the documentation workflow to be easier than those who had not used the technology.[480] Additionally, 77% noted that it reduced their documentation burden, 73% reported a decrease in time spent on documenting, 67% believed that it decreased their risk of documentation-induced burnout, and 64% felt increased job satisfaction.[481] Because of AmI, healthcare workers' perception of the quality of their work has dramatically improved, thus increasing the likelihood of them choosing to continue employment at their current hospital. With the implementation of AmI in rural CHCs, clinician burnout would decrease, and worker retention would increase.

AmI incorporates AI medical scribes to listen in on physician-patient interactions and quickly provide detailed summaries. On average, AI scribes cost $100 per month per user.[482]

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[479] Albrecht, Michael, et al. "Enhancing Clinical Documentation with Ambient Artificial Intelligence: A Quality Improvement Survey Assessing Clinician Perspectives on Work Burden, Burnout, and Job Satisfaction." JAMIA Open 8, no. 1 (2024). https://doi.org/10.1093/jamiaopen/ooaf013.

[480] Albrecht et al., *Enhancing Clinical Documentation.*

[481] Albrecht et al., *Enhancing Clinical Documentation.*

[482] Mess, Sarah A. et al. "Artificial Intelligence Scribe and Large Language Model Technology in Healthcare Documentation: Advantages, Limitations, and Recommendations." Plastic & Reconstructive Surgery Global Open 13, no. 1 (January 1, 2025): e6450–50. https://doi.org/10.1097/gox.0000000000006450.

With the total number of licensed physicians in Massachusetts being approximately 37,000, providing AI scribes for each physician would cost $44,400,000 per year.[483] In practice, however, it is likely that one AI scribe can be assigned to multiple physicians, reducing expenses. In comparison, human medical scribes earn $2,800 per month.[484] According to a 2023 estimate, there are approximately 100,000 medical scribes in the U.S., serving around 1,000,000 physicians.[485] By ratio, there are 0.1 medical scribes per physician. Since Massachusetts has roughly 37,000 physicians, it can be estimated that there are 3,700 scribes in Massachusetts. Thus, the annual cost of employing human medical scribes in Massachusetts is $124,320,000. Replacing human medical scribes with AI ones would save Massachusetts $79,920,000 per year. In addition, according to pilot studies at St. Luke's Health System in Idaho, AmI can increase annual revenue by $13,049 per clinician. In Massachusetts, this finding corresponds to an increase of $482,813,000 in annual revenue. However, the implementation of AmI would incur additional expenses. As previously mentioned, installing AI in Massachusetts healthcare systems would cost approximately $44,400,000 per year. Maintaining AI technologies, ensuring regulatory compliance, and upholding cybersecurity costs 30-50% of the initial investment, resulting in additional expenses ranging from $13,320,000 to $22,200,000.[486] In addition, on average, training employees on AI usage can cost $7,500 per employee, which amounts to an additional $277,500,000 in costs.[487] Finally, distributing educational handouts to patients via email and in print would cost approximately $1,000.[488] In total, the costs of implementing AmI

[483] KFF, *Professionally Active Physicians.*
[484] Mess, Sarah A. et al., *Artificial Intelligence Scribe.*
[485] Gellert, George A. "Medical Scribes: Symptom or Cause of Impeded Evolution of a Transformative Artificial Intelligence in the Electronic Health Record?" Perspectives in Health Information Management 20, no. 1 (January 10, 2023): 1d. https://pmc.ncbi.nlm.nih.gov/articles/PMC9860472/.
[486] Khambholja, Manushi. "Cost of AI in Healthcare: Implementation Expenses & Key Insights." Openxcell, March 24, 2025. https://www.openxcell.com/blog/cost-of-ai-in-healthcare/.
[487] Khambholja, Manushi. *Cost of AI.*
[488] State Cost (Savings) Biennium Biennium Dollars in Thousands. 2024

in Massachusetts healthcare are estimated to be $339,661,000. With the revenue being approximately $482,813,000, the calculated profit is $143,152,000.

In addition to generating additional revenue, AmI has the potential to dramatically increase productivity and reduce burnout. After one year of ambient AI usage in The Permanente Medical Group, this technology saved clinicians 15,791 hours of documentation time.[489] The time saved by this technology can restore the human touch in healthcare, allowing physicians to devote their full attention to interacting with and caring for their patients. The hours reclaimed would also grant physicians greater autonomy, allowing them to choose how they wish to spend their time—whether by taking a break, seeing more patients, engaging in professional development, etc.[490] AmI offers productivity gains that would increase clinician satisfaction with their jobs, alleviate moral injury, and mitigate burnout, thus improving healthcare worker retention.

Because of the relatively recent introduction of AmI to healthcare settings, it is uncertain how dramatically this technology will impact worker retention in the long term. To assess the lasting impact of AmI, pilot studies can be conducted in a small subset of rural CHCs in Massachusetts prior to implementation across the entire state. Modifications can be made accordingly to ensure effective and equitable AmI adoption.

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[489] Tierney, Aaron A., Gregg Gayre, Brian Hoberman, Britt Mattern, Manuel Ballesca, Sarah B. Wilson Hannay, Kate Castilla, et al. "Ambient Artificial Intelligence Scribes: Learnings after 1 Year and over 2.5 Million Uses." NEJM Catalyst 6, no. 5 (April 16, 2025). https://doi.org/10.1056/cat.25.0040.

[490] Fred, Herbert L. and Mark S. Scheid. "Physician Burnout: Causes, Consequences, and (?) Cures." Texas Heart Institute Journal 45, no. 4 (August 2018): 198–202. https://doi.org/10.14503/thij-18-6842.