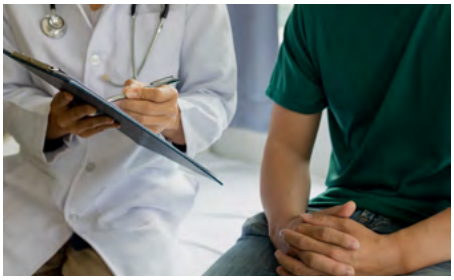
The State of Primary Care in New York

A 2025 Data Update

Primary care is the foundation of a healthy and equitable New York. It is where most New Yorkers first seek care, manage chronic conditions, and receive preventive services. Communities with strong primary care systems consistently experience lower hospitalization rates and longer life expectancy.[1] Yet access remains uneven across the state—shaped by workforce shortages, geography, and chronic underinvestment.



New York spends more than $300 billion annually on health care, among the highest state expenditures in the nation, but has only average health outcomes.[2, 3] When New Yorkers can't see a primary care provider when they need to, they end up sicker and are forced to turn to hospitals or emergency rooms, where care is more expensive.

These avoidable emergency department visits and hospitalizations for chronic conditions cost the State billions of dollars each year.[4, 5] Investing in accessible, high-quality primary care is essential for the State's long-term health and fiscal sustainability.

This brief, produced by the New York Health Foundation and the Primary Care Development Corporation, reviews the most recent data on three urgent challenges facing primary care in 2025: workforce capacity, rural access, and primary care investment.

New York's High Spending, Average Outcomes

New York's high health care spending has not guaranteed better health.

Recent data show that in New York:

Chronic disease burden remains high
More than 40% of New York adults live with at least one chronic disease.[6]

Six out of ten deaths in New York are attributable to chronic diseases.[7]

Avoidable emergency visits drive costs
The average cost of an emergency department visit in New York is $1,200 vs. $300 for a primary care visit.[8]

Approximately 7 in 10 hospital-based emergency department visits are non-emergent or could have been treated in a primary care setting.[9]

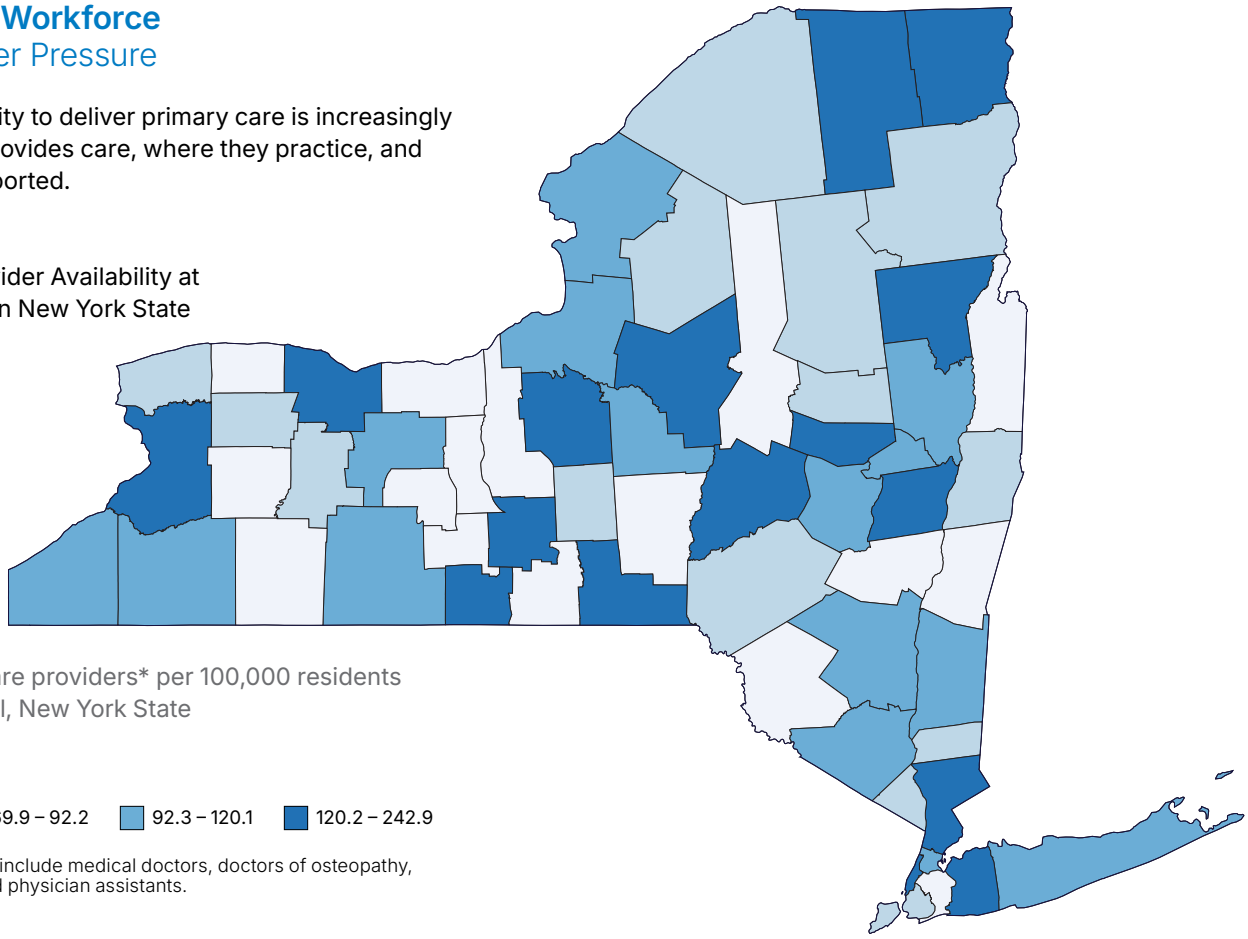
Racial inequities persist, particularly for Black and Latino New Yorkers
Potentially preventable hospitalization rates are 2.2 times higher for Black New Yorkers and 1.4 times higher for Latino New Yorkers compared with white New Yorkers.[10]

Premature death rates (<75 years) are 1.9 times higher for Black New Yorkers and 1.2 times higher for Latino New Yorkers compared with white New Yorkers.[11]

Primary Care Workforce
Capacity Under Pressure

New York's capacity to deliver primary care is increasingly defined by who provides care, where they practice, and how they are supported.

Figure 1
Primary Care Provider Availability at the County Level in New York State



Rate of primary care providers* per 100,000 residents at the county-level, New York State

Legend

39.4 – 69.8 | 69.9 – 92.2 | 92.3 – 120.1 | 120.2 – 242.9

* Primary care providers include medical doctors, doctors of osteopathy, nurse practitioners, and physician assistants.

Less than 25% of physicians in New York practice primary care, comparable to national trends.[12]

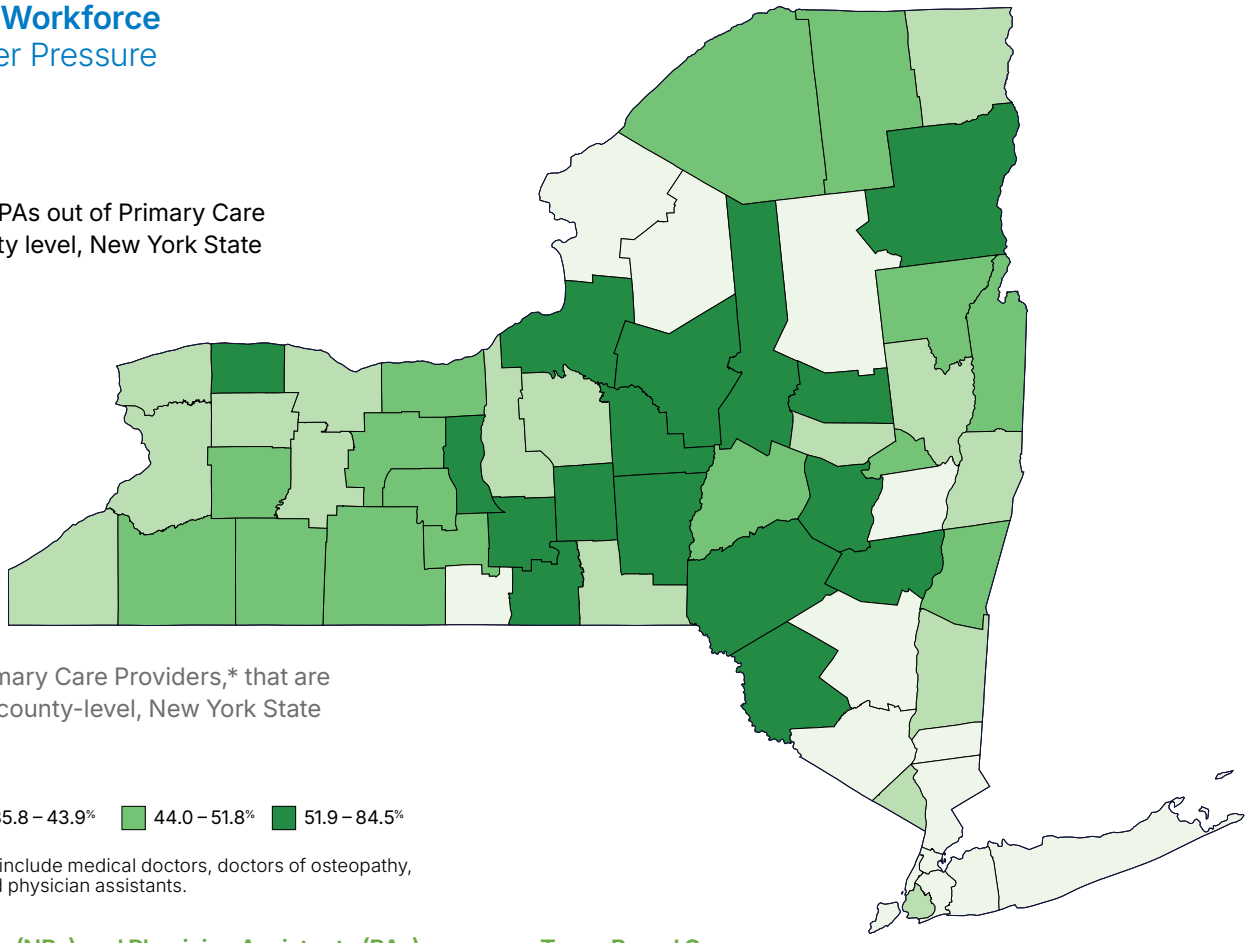
The primary care physician supply has grown by only 3.6% per year nationally since 2016, compared to 8.7% growth among other specialties.[13]

More than one-third of New York's primary care physicians are over age 60, indicating an impending wave of retirement that will reduce capacity.[14]

Primary care provider availability varies by county [Figure 1] and 4.7 million New Yorkers live in Primary Care Health Professional Shortage Areas (HPSAs). Addressing these shortages will require an estimated 1,013 additional primary care providers in the State.[15]

Primary Care Workforce
Capacity Under Pressure
continued

Figure 2
Share of NPs and PAs out of Primary Care Providers at County level, New York State



Percentage of Primary Care Providers,* that are NPs or PAs at the county-level, New York State

Legend

22.3 – 35.7% | 35.8 – 43.9% | 44.0 – 51.8% | 51.9 – 84.5%

* Primary care providers include medical doctors, doctors of osteopathy, nurse practitioners, and physician assistants.

Nurse Practitioners (NPs) and Physician Assistants (PAs) Are Filling Gaps, Facing Barriers

Expanding, diversifying, and better distributing the primary care workforce is essential to meeting New York's preventive and chronic care needs. NPs and PAs are increasingly filling these gaps, with several key trends shaping their impact:

Workforce growth and impact: NPs and PAs now make up about 30% of New York's primary care workforce, [Figure 2] with the NP workforce growing by 27% between 2018–2022.[16, 17]

Critical role in access: Approximately half of rural primary care practices employ at least one NP or PA.[18] Furthermore, NP participation in Medicaid has grown from 127 to 180 per 100,000 enrollees between 2016 and 2021, supporting access for underserved populations.[19]

Financial strain from unequal reimbursement: Under current policies, NPs in most states, including New York, typically receive 85-95% of the physician rate for delivering comparable services.[20, 21, 22] States with Medicaid reimbursement parity between NPs and physicians report cost-neutrality or cost savings.[23]

Team-Based Care: Frontline Roles Expanding Provider Capacity

Medical assistants (MAs) and community health workers (CHWs) are often members of the communities they serve and extend the capacity of primary care teams, improve patient engagement, and help clinicians focus on complex medical needs— essential strategies for addressing statewide workforce shortages.

MAs play a key role in building trust with patients and perform administrative and certain clinical duties under the direction of a physician.[24] New York employs nearly 40,000 MAs, with the workforce projected to grow 27% by 2032.[25]

> New York remains the only state that prohibits trained MAs from administering vaccines[26]: Two-thirds of recently surveyed providers say they would delegate vaccinations to MAs if permitted, reporting that expanding MA roles could lead to reduced burnout (59%) and increased productivity (48%).[27]

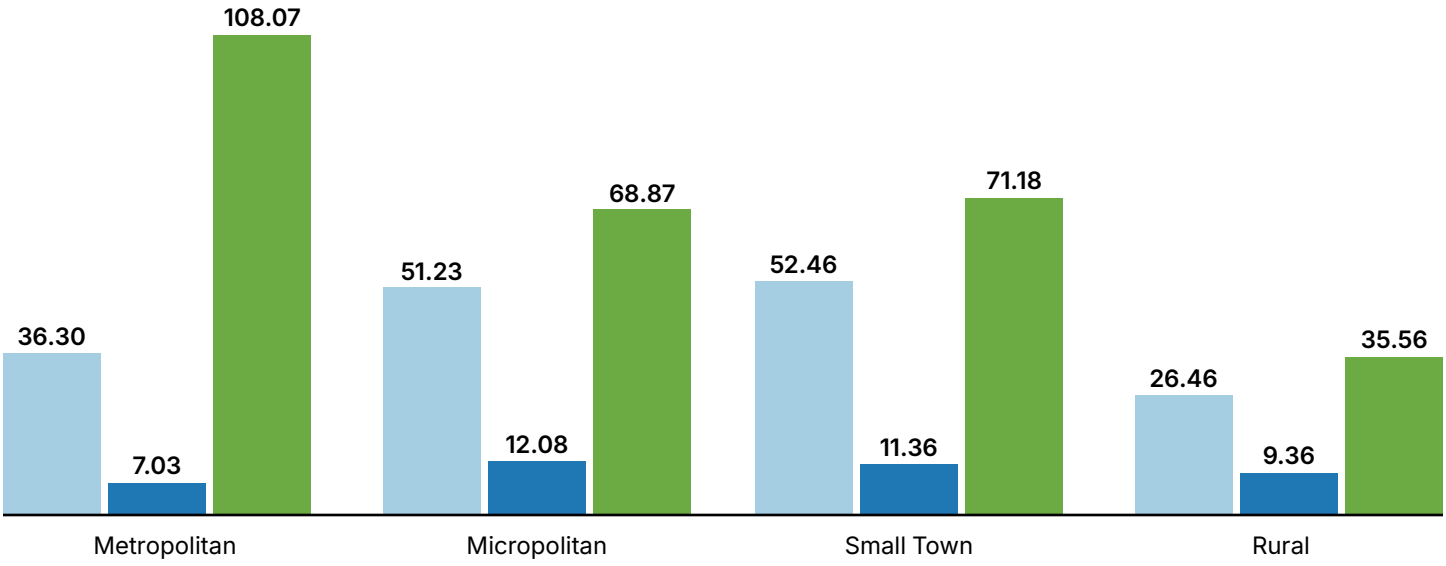
CHWs provide culturally and linguistically aligned support which helps patients navigate both health and social needs. The CHW workforce is projected to grow by 23% by 2032.[28]

> In 2023, New York joined 32 other states in reimbursing for CHW services by creating a Medicaid benefit to do so through a Centers for Medicare and Medicaid Service (CMS) State Plan Amendment.[29] Shortly thereafter, it also secured CMS approval, through a section 1115 Medicaid demonstration waiver, to similarly reimburse community-based organizations for CHW services.

Rural Communities
Closing the Distance to Care

More than 3 million New Yorkers live in rural communities, where access to primary care is constrained by provider and infrastructure gaps that widen disparities in health outcomes.[30]

Figure 3
Primary Care Provider Availability by Rural-Urban Commuting Area



Rate of Primary Care Providers per 100,000 residents, by provider type and by Rural-Urban Commuting Area (RUCA) Code, New York State

Legend

Nurse Practitioners | Physician Assistants | Medical Doctors/Doctors of Osteopathy

Too Few Providers—and a Growing Need

Rural New York faces overlapping patient needs and primary care pressures; rural providers must cover broader scopes of care with limited resources, which can accelerate burnout and increase access barriers. In New York, rural communities have:

Fewer providers per capita: rural areas have about 25% fewer primary care providers than urban areas.[31] [Figure 3]

Higher rates of preventable hospitalizations: these rates are nearly 50% higher in some rural counties than the state average.[32]

Older and sicker populations: in some rural counties, more than 25% of residents are aged 65+,[33] and chronic disease rates are 20% higher than the state average.[34, 35]

Infrastructure Barriers Are More Acute in Rural Communities

One in four rural households in New York lacks high-speed broadband, limiting the role telehealth can play in closing access gaps.[36]

Rural community residents are more likely to encounter transportation barriers, such as longer travel time, farther distances to providers, and limited public transit options.[37]

Due to Federal and State budget cuts—including HR1 budget rescissions and Medicaid reductions— rural hospitals and clinics face a disproportionate risk of closure or reduction to services which could create overcrowding in already overstretched rural primary care practices and community health centers.[38, 39]

Paying for Primary Care
Rebalancing the Scales

New York's health system—like many states—is out of balance, with primary care receiving only a small share of total health spending even though primary care doctors and nurses handle 1 out of every 3 health care visits.

New York's Current State of Investment

Primary care is underfunded: it receives only 3-5% of New York's total health spending, well below the 10–12% recommended by national experts and seen in other high-income countries.[40, 41]

The trend is moving in the wrong direction: primary care's share of total spending has declined in recent years, signaling an urgent need for policy to protect and strengthen access.[42]

Underinvestment drives higher downstream costs: avoidable hospitalizations and emergency department use cost New York State hundreds of millions of dollars each year.[43, 44, 45]

Primary Care Spending Saves Money

More than 20 states have adopted primary care measurement requirements or spending targets to counter chronic underinvestment. Early results show meaningful gains in access, quality, and cost savings.

Oregon found that every additional $1 invested in primary care generated $13 in savings across emergency, specialty, and hospital services.[46]

Massachusetts reported that provider organizations investing more in primary care delivered significantly better quality while spending less on inpatient and outpatient hospital services.[47]

Rhode Island demonstrated that increasing primary care investment expands the number of practicing primary care providers, helping to address shortages and quality.[48]

National evidence shows that a $10 increase in Medicaid provider reimbursement per visit increases the likelihood that an enrollee sees a doctor within two weeks by 1.4%.[49]

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Momentum for Reform in New York

New Data: Targeted Primary Care Drives Cost-Savings

A 2025 New York-specific analysis of commercial insurance claims shows that targeted primary care delivery could drive meaningful cost savings, especially for higher risk individuals. In a simulated scenario where high and medium-high risk enrollees are given two additional primary care visits, total spending is projected to fall by $26.1 Per Member Per Year (PMPY) in the first year and $79.2 PMPY in the following year.

If the same scenario and targeted primary care delivery are applied statewide among commercially insured New Yorkers, total costs could be reduced by an estimated $248.8 million in the first year and $753.4 million in the second year.[50]

The Primary Care Investment Act (S1634/A1915A), introduced in 2025, and passed by the New York Senate, would increase investment over time in primary care to 12.5% from an estimated 5%, leading to increased access to high-quality care and improved health outcomes for all people across New York.

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