



House Study Committee on Improving Access to Internal Medicine for Underserved Areas

Final Report

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Introduction

During the 2025 Legislative Session, the House adopted House Resolution 753 creating the House Study Committee on Improving Access to Internal Medicine for Underserved Areas. This study committee evaluated the most prudent and cost-effective ways to increase access to internal medicine in underserved Georgia communities, with particular focus on rural communities experiencing health transportation shortages. In 2022, one in 10 Georgians lived in a county with only one physician.¹ With three-quarters of Georgia's counties classified as rural, many communities face challenges in accessing quality healthcare. Recent reports show that about 40 counties, nearly a quarter of the state, lack an internal medicine physician.²

Georgia ranks forty-first nationally for its ratio of active patient care physicians to residents, with only one doctor for every 480 people.³ As of 2024, 142 out of 159 counties are designated as healthcare professional shortage areas, where each provider serves more than 3,500 patients.⁴ Rural communities in the state continue to struggle with recruiting and retaining healthcare providers and staff. Transportation remains a major concern, as three out of four Georgia counties are classified as health transportation shortage areas. These regions experience significant barriers to healthcare, including limited public transportation and high poverty rates.

Expanding access to medical services is essential for improving health outcomes in underserved areas. Achieving this requires coordinated planning and commitment from all healthcare participants at the local, state, and federal levels. In 2025, the House Study Committee on Improving Access to Internal Medicine for Underserved Areas held three meetings in Statesboro, Macon, and Lawrenceville at Georgia Southern University, Mercer University, and the Northside Hospital Resource Center. Healthcare officials and policy experts contributed valuable insights.

To view meeting recordings and digital copies of presentations, please visit the following link:
<https://www.legis.ga.gov/other-committees/house/2025/improving-access-to-internal-medicine>

¹ Georgia Public Policy Foundation, “Addressing Georgia’s Healthcare Shortage,” October 2022.

² Georgia Board of Healthcare Workforce, “Georgia Counties without Primary Care / Core Practitioners Based on 2023-2024 Licensure Renewals and New Licensees,” 2025.

³ Georgia Board of Healthcare Workforce, “Fact Sheet on Medical Education in Georgia,” AMA Physician Characteristics and Distribution in the U.S. 2008 Edition. Georgia’s ranking is 40th in the number of patient care physicians per capita, 2023.

⁴ Rural Health Information Hub, “Map of Health Professional Shortage Areas: Primary Care, by County,” July 2025.

Background

Hospitals are legally required under the ‘Emergency Medical Treatment and Labor Act’ (EMTALA) to stabilize patients and, if necessary, transfer them safely and effectively. This federal law ensures that patients requiring emergency care receive it, while those who can safely recover elsewhere do not occupy resources needed for emergency cases. A hospital’s ability to admit or transfer a patient is critical, as it directly affects the timeliness and quality of care. Not all hospitals have the same resources, equipment, or specialists. While smaller rural hospitals are well-suited for routine care, patients with severe conditions such as major trauma or heart attacks often require transfer to facilities with advanced capabilities.

When a patient requires a higher level of care than the local hospital can deliver, delays in the transfer process mean delays treatment. The admit or transfer decision is about getting the right care, in the right place, at the right time. A delayed transfer can violate these standards and pose a risk to patient harm. When a hospital transfers patients, it also loses revenue, because patients are the main source of its income. Every time a patient is admitted, treated, or has a procedure, the hospital bills private insurance, Medicare, Medicaid, or the patient directly.

The ability of rural hospitals to treat versus transfer has a significant impact on the coordination of care among hospitals, physicians, and families. Efficient transfers ensure that medical records and treatment plans accompany the patient, reducing the risk of information gaps or unnecessary repeated tests.

Timely and appropriate transfers are crucial, as they can significantly impact whether a patient experiences a successful recovery or faces serious complications. For example, stroke patients require immediate access to neurologists and specialized equipment that may not be available in smaller hospitals. Given the limitations in hospital beds, staff, and supplies, ability of rural hospitals to treat patients locally is vital for allocating resources effectively.

Hospital budgets strain under the pressure, yet the cost of healthcare never shrinks. Even when fewer patients occupy the beds, hospitals must still incur the same expenses for staff, equipment, electricity, and maintenance. Today, independent physician practices are declining, as large hospital systems and corporations are able to endure financial struggles. Limited access to internal medicine can cause minor health issues to escalate, increasing financial strain on families and healthcare systems. Internal medicine providers are essential for managing chronic conditions such as diabetes, heart disease, and high blood pressure.

Many Georgians, particularly in rural and low-income urban areas, face challenges affording these providers. As a result, people delay care, leading to worse health outcomes and higher costs for families, hospitals, and the state. Expanding access to internal medicine not only improves health, but also protects patients, supports providers, and reduces long-term expenses. Georgia reports one of the highest rates of medical debt for patients nationally.⁵ A significant proportion of Georgia's populations remain in the medical insurance coverage gap or incur high out-of-pocket expenses, limiting access to primary care and increasing dependence on emergency services.⁶

Patients in rural Georgia on average travel 60 to 90 minutes for routine follow-up appointments due to a limited number of internal medicine physicians practicing in underserved areas.⁷ Many attending physicians pursue subspecialties or relocate to metropolitan centers, resulting in inadequate coverage in rural counties.⁸ As a result, many families sacrifice preventive or follow-up care with internal medicine providers due to concerns about medical treatment. Health disparities grow in these underserved communities, more people use emergency rooms for issues that could have been treated earlier, and healthcare costs increase as untreated conditions get worse. These barriers perpetuate a cycle of worsening patient health outcomes, increased provider burnout, and escalating healthcare costs.

When patients cannot get to their appointments, their health problems may go undiagnosed or unmanaged, which can lead to worse outcomes and higher costs. These shortages also mean longer

⁵ Georgia Watch, "Report: Georgia ranks ninth for medical debt," September 2023.

⁶ Laura Harker, Georgia Budget Policy and Institute, "Fast facts on Georgia's coverage gap," January 2019.

⁷ Grady College of Journalism and Mass Communication at the University of Georgia, Grady Newsource, "Rural Georgia Struggles with Health Care Accessibility," October 2024.

⁸ Maggie L. Shaw, The American Journal of Managed Care, "5 Specialty Care Shortages in Rural Communities," September 2024.

wait times and fewer available appointments. High-quality internal medicine services further cut costs for emergency medical services, paramedicine, and other operations. It also leads to better management of chronic diseases, shorter hospital stays, and fewer readmissions. Primary care and psychiatry programs can help reduce hospital admissions, lower death rates, and ease the demand on emergency departments. Making internal medicine more accessible helps lower inpatient costs and addresses issues with insufficient reimbursement.

Committee Findings

Why Fewer Medical Students Pursue Internal Medicine?

A clear majority of internal medicine residents pursue a subspecialty fellowship after their residency. Recent trends show a decline in general internal medicine careers and a rise in hospital medicine and other subspecialty choices. Hospital medicine is a popular career path, especially for residents in traditional categorical programs. A majority of newly certified internists are now practicing as hospitalists. The Milbank Memorial Fund reported in 2024 that the share of internal medicine residents practicing exclusively outpatient primary care was only 21%, with only 4% of this group desiring to practice rural medicine.⁹

The percentage of internal medicine residents pursuing general outpatient careers is relatively low. Researchers suggest that the appeal of a predictable balanced workload and compensation package may be drawing residents away from traditional outpatient primary care roles. The following downsides were presented when starting a rural residency:

- Inability to meet the Accreditation Council for Graduate Medical Education (ACGME) requirements;
- Lack of board-certified physicians in the community to teach residents;
- Limited opportunities for scholarly activity;
- Difficulty attracting qualified residents to the community and to a new, unestablished program;
- Insufficient housing options in rural areas; and

⁹ Milbank Memorial Fund, "Reason 2: The number of trainees who enter and stay on the professional pathway to primary care is too low, and too few have community-based training." February 2024.

- The program is costly for the hospital and may not generate financial returns for several years.

According to the National Resident Matching Program (NRMP), the number of positions offered by a residency program typically have three reasons as to why a program that ranked an adequate number of applicants did not fill its quota:

1. Applicants demonstrated a preference for alternative programs.
2. Applicants did not include the program in their ranking submissions.
3. Applicants formally withdrew their participation from the matching process.

There are also three reasons why applicants may not match with their most preferred residency program:

1. The program has filled all positions with preferred applicants.
2. The program did not rank the applicant.
3. The program had withdrawn from the match.

Most doctors want to practice near where they were trained and Georgia's rural and underserved areas lack training sites. Approximately half of Georgia residents remain in the state where they complete their training.¹⁰ When residents have more chances to work in rural areas, they are more likely to choose rural practice later. Taking students to rural sites during clinical rotations can make a difference as more exposure leads to a greater impact and fewer than 10% of graduates get any rural training during residency. Physicians continue to be respected members of rural communities, and spending time in these areas during family medicine residency is linked to more graduates working in rural settings.

General internal medicine and primary care are currently the most sought-after specialties among hospitals and physician recruiters. Managed care expansion has elevated the role of general internists and other primary care physicians, which is a positive shift given their historical undervaluation by healthcare institutions, insurers, and patients. This increased recognition has encouraged more medical students to pursue primary care, improved job prospects for generalists,

¹⁰ Journal of Graduate Medical Education, "Family Medicine Residencies: How Rural Training Exposure in GME Is Associated with Subsequent Rural Practice," August 2022.

and led to a modest rise in primary care physician income. Despite these gains, medical students have concerns and reasons for avoiding internal medicine including:¹¹

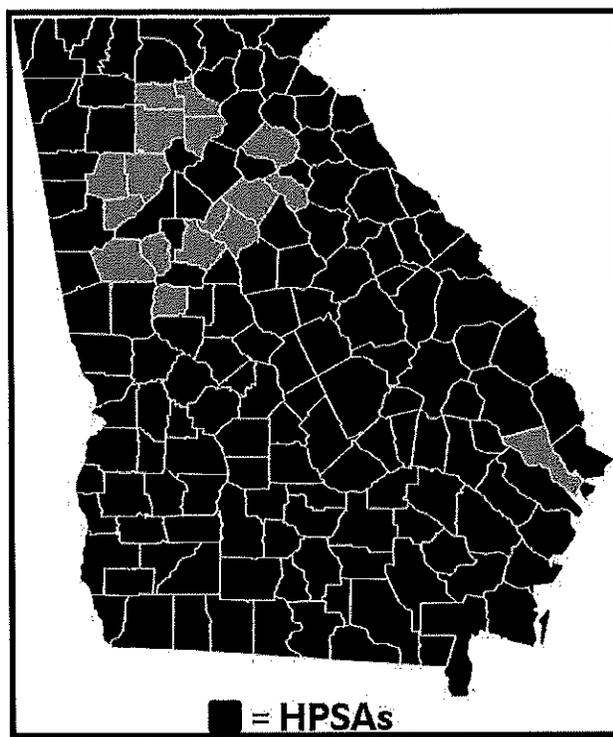
- Lower compensation compared to specialists;
- Less control over work-life balance;
- Administrative burden related to electronic medical records;
- Difficulty separating work from personal life;
- Declining Medicare reimbursement rates;
- High levels of educational debt; and
- Longer work hours.

Recent data from Coffee Regional Medical Center indicates that specialist physicians receive annual salaries ranging from \$404,000 to \$625,000, whereas internal medicine physicians earn between \$264,000 and \$287,000. Physician compensation is influenced by specialty, geographic location, and years of experience. Internal medicine, classified as a primary care field, consistently receives lower average compensation compared to specialties such as orthopedics and cardiology. Medical graduates must also make significant financial decisions, including relocation, home purchase, and family planning. In addition, medical residents typically begin their professional careers with substantial educational debt around \$250,000 and an average starting salary of \$60,000.

¹¹ Hauer KE, Durning SJ, Kernan WN, et al., "Factors associated with medical students' career choices regarding internal medicine," the Journal of the American Medical Association, September 2008.

Georgia's Provider Shortages

The United States Department of Health and Human Services, Health Resources and Services Administration (HRSA), defines a health professional shortage area (HPSA) as a geographic area, population group, or facility with an insufficient number of qualified health professionals. HPSAs are divided into three distinct categories of primary care, dental health, and mental health. Georgia is projected to be short more than 8,000 doctors by 2030. Nearly three million Georgia residents live in a HPSA as designations indicate areas where there are 3,500 or more patients for every one provider.



**Georgia Public Policy Foundation*

Several states are addressing physician shortages in underserved areas by streamlining licensure for internationally licensed physicians (ILPs), establishing an assistant physician (AP) program, expanding the roles of physician assistants, and advanced practice registered nurses (APRNs.) Internationally licensed physicians are doctors licensed abroad with strong clinical records. In Georgia, ILPs must complete a full residency to practice, as required of U.S. medical graduates. However, eighteen states, including Arkansas, Florida, Louisiana, North Carolina, Tennessee, Texas, and Virginia, grant full licenses to qualified international physicians without traditional residency. Sixteen states, including Georgia, have proposed or are considering similar legislation.

An assistant physician is a medical doctor or doctor of osteopathic medicine who has completed a four-year medical school program but has not completed residency training. The AP license requires collaborative practice agreements under physician supervision, limits the scope of practice, and mandates service in rural or underserved areas. Twelve states, including Alabama, Arkansas, Florida, Louisiana, Tennessee, and Texas, have enacted legislation establishing AP

licensing. Additionally, three states offer limited licenses to international physicians without further graduate medical education.

Policy approaches in this area can be categorized into two ways. The first policy involves a bridge license issued between medical school and residency, which is both temporary and renewable. The second encompasses licenses that are either continuously renewable or provide a direct pathway to full physician licensure. Despite growing interest in the assistant physician role, no state has designated this position as an alternative route to medical licensure. The clinical experience gained as an assistant physician may not be equivalent to the structured training offered in residency programs.

Other Barriers, Challenges, and Priorities

Healthcare experts highlighted a unifying theme, centering their insights on the following key points:

1. Ongoing staffing shortages and transfer delays continue to stand in the way of delivering optimal care.
2. Telehealth and centralized systems were supported as lifelines for overcoming rural healthcare obstacles.
3. A collective call emerged for unified trauma protocols across the state.
4. Training gaps in clinical documentation surfaced as a common concern.

On August 13, 2025, the Georgia Trauma Commission shared that more than 70% of leaders at level III and IV trauma centers see standardization and rural transfers as top priority. Delays in transport often happen because of crowded hospitals, bad weather, or tough terrain, all of which can slow down urgent care. Other major challenges include a lack of transport options, staff shortages, reimbursement issues, and gaps in training, infrastructure, and equipment. Problems with transfers are often due to limits in EMS and air transport, full facilities, slow decision-making, long distances, and communication problems between medical facilities. To help solve these issues, the Georgia Trauma Commission suggested during their presentation to the study committee that additional funding should go toward physician education and recruitment, building transport partnerships, expanding telehealth, and improving IT systems.

To counter these setbacks, many facilities are turning to teleconsultation and innovative technology. Medical professionals overwhelmingly agree that teleconsultation not only reduces needless patient transfers but also enhances safety. The committee found a clear and growing demand for rural-specific support tools, including trauma teleconsulting, EMS tracking, and a centralized hub for rural medical transfers. Integration of facilities through digital health technologies and coordination centers enables state administrators to promote equitable access, increase operational efficiency, and broaden health education initiatives. These measures may also decrease emergency medical services (EMS) response times, improve working conditions, and support increased compensation for paramedics.

During the 2025 Session, the House passed House Bill 154, designating ambulance services as an essential service, but that measure stalled in the Senate. HB 154 recognizes the importance of emergency medical services, but does not change existing regulations or coordination within territorial zones. Hospitals and medical centers may enhance policy and protocol updates by implementing standardized templates and technical support. Streamlined training programs can also accommodate the variable schedules of rural healthcare personnel. Other solutions presented by the Georgia Trauma Commission for consideration during the 2026 Legislation Session, include:

- Establishing a minimum number of ambulances in each county according to assessed population and healthcare needs;
- Allocate funds for additional ambulances, specifically in underserved areas;
- Allocate funds for EMS training and ensure local governments use funds for said purposes; and
- Provide payments for indigent transports.

Artificial Intelligence (AI) and Internal Medicine for Underserved Areas

Multiple health systems are implementing artificial intelligence (AI) to enhance patient care and operational efficiency. Emory Healthcare applies AI to advance diabetes management and WellStar Health System utilizes ambient AI technology to streamline clinical documentation. Colquitt Regional Health System reports increased efficiency in revenue cycle management and electronic health record (EHR) documentation. South Georgia Medical Center employs AI-

assisted robotic therapy to treat benign prostatic hyperplasia and the Tift Regional Medical Center uses AI for stroke imaging and workflow optimization.

Although the implementation of artificial intelligence in healthcare is increasing, rural healthcare adoption remains limited due to infrastructure challenges such as inadequate information technology (IT) systems, unreliable internet connectivity, and restricted IT budgets. Underserved regions face funding gaps due to limited resources, cultural perceptions, and unclear regulations. Many rural AI initiatives aim to improve healthcare access and affordability by leveraging established vendors and proven solutions. AI offers benefits such as enhanced healthcare access, early disease detection, streamlined operations, and reduced administrative costs.

The integration of AI in healthcare has resulted in several measurable benefits, including:¹²

- Increased diagnostic accuracy;
- Enhanced patient monitoring capabilities;
- Implementation of predictive analytics;
- Expansion of telehealth and telemedicine services;
- Development of clinical decision support systems;
- Improved operational efficiency;
- Reduction of repetitive administrative tasks and clinician burnout;
- Optimization of medication management processes;
- Implementation of advanced fraud detection mechanisms;
- Optimization of emergency response protocols;
- Enhanced usability of electronic health records (EHRs); and
- Improved financial forecasting, data management, and reporting capabilities.

Underserved areas, specifically in rural counties, encounter significant barriers such as high implementation costs, limited technical expertise, inadequate infrastructure, and reliance on external vendors. Additional challenges include training needs, resistance to new technology, integration issues, and ongoing maintenance expenses. Concerns also persist regarding critical

¹² Jimmy Lewis, HomeTown Health, "AI and Rural Health Presentation," September 2025

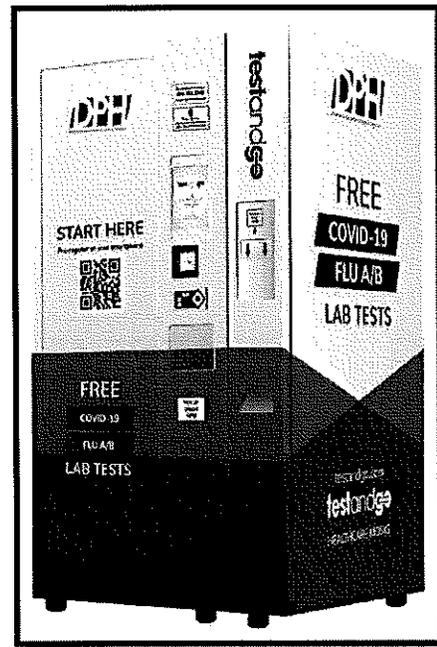
thinking, personal engagement, data privacy, and cybersecurity. Uncertainties about legal responsibility, regulatory compliance, and ethical risks associated with automation remain.

The Georgia General Assembly has introduced legislation regulating the use of artificial intelligence, but has only enacted House Bill 203 in 2023 for the use of eye exams and prescriptions. The following bills have been introduced, but have yet to pass the House and Senate:

<u>House Bill 147</u>	Georgia Technology Authority; annual inventory of artificial intelligence usage by state agencies.	03/27/2025 Senate Second Read
<u>House Bill 478</u>	Commerce and trade; require that AI generated content include a disclaimer indicating such content was generated using artificial intelligence.	02/20/2025 House Second Read
<u>House Bill 887</u>	Insurance; use of artificial intelligence in making certain decisions regarding coverage; prohibit.	01/11/2024 House Second Read
<u>Senate Bill 37</u>	'AI Accountability Act.'	01/28/2025 Senate Read
<u>Senate Bill 104</u>	State Government; use or installation of any artificial intelligence system on state equipment when the company that developed or deployed such artificial intelligence system is associated with the People's Republic of China; prohibit	02/06/2025 Senate Read

Expanding Internal Medicine Access with Healthcare Kiosks

The study committee received testimony regarding strategies to expand access to internal medicine and enhance healthcare delivery through the implementation of healthcare kiosks. The Georgia Department of Public Health has deployed Test and Go healthcare kiosks throughout the state to increase access to essential diagnostic testing services. These kiosks currently provide testing for COVID-19, influenza A, and influenza B. The kiosks operate continuously and are accessible at all times. Individuals may submit or collect laboratory test samples at any Test and Go kiosk. These services are provided at no cost, and do not require identification, a subscription, or a clinic visit.



LTS Health, based in Cobb County, Georgia, oversees maintenance, servicing, and inventory management operations. The Test and Go self-service kiosks provide continuous patient access at strategically selected locations, supporting public health and healthcare providers in expanding service delivery. The health kiosk provides respiratory function assessments, opioid overdose reversal agents, sexually transmitted infection (STI) screening, general health evaluations, wellness assessments, and personal hygiene supplies. The kiosk is suitable for both indoor and outdoor environments, requiring only level ground and a standard power source.

Committee Recommendations

Upon review of the information presented, the House Study Committee on Improving Access to Internal Medicine for Underserved Areas submits the following recommendations:

1. Support funding proposed in the state’s pending Rural Health Transformation Program (RHTP) application, building on current efforts and maintaining a focus on broadening medical practice in underserved areas, with opportunities to:
 - a. Augment GME residency and fellowship programs—including 75 new residency slots and 12 fellowship positions annually—enhance rural programs, and strengthen recruitment, retention, and placement of in-state and rural-area physicians.
 - b. Continue extending telemedicine to better serve rural counties and hospitals with limited resources.
 - c. Further enhance rural recruitment and retention, considering financial incentives to recruit new physicians to underserved areas.
 - d. Encourage medical schools to expand project-based and experiential learning programs in underserved regions to better address rural and underserved community needs.
 - e. Allocate additional ambulances, prioritizing regions with insufficient emergency services.
 - f. Provide emergency medical services (EMS) training and monitor local governments to ensure appropriate application of these resources.
 - g. Form a residency quality improvement committee to facilitate the systematic exchange of best practices.
 - h. Provide support for hospitals to adopt clear, proactive processes and technology capable of identifying eligible patients early and streamlining the financial assistance application process.
 - i. Increase school-based health care services, focusing on underserved areas that do not have existing facilities or currently provide coverage, and allowing medical providers to rotate between the hospital and the community.

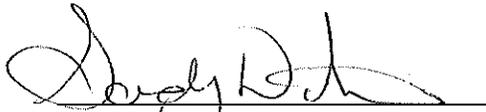
2. Consider state-funded stipends or increasing resident salaries for medical students enrolled in rural residency programs to enhance recruitment to underserved areas.

3. Consider a state tax credit to help provide housing for physicians working in rural areas.
4. Maintain a strong partnership with the Georgia Primary Care Association to strengthen Federally Qualified Health Centers (FQHCs) in Georgia through focused training, technical support, and strategic planning.
5. Upon RHTP approval, establish clear accountability measures, including the requirement of a business model, for FQHCs and community health centers approved for an allocation of \$250,000 in federal grant funds to three FQHCs to support New Access Point Grants. These new grants would offer between \$650,000 and \$1 million per year for three years.
6. Consider implementing community health kiosks and mail-order services in partnership with FQHCs and hospitals, aimed at reducing transportation barriers.
7. Consider strategically located healthcare access sites to expand the service capacity of FQHCs and hospitals.
8. Support [House Bill 154](#), designating ambulance services as an essential service.
9. Consider legislation requiring counties to maintain enough ambulances to meet the healthcare needs of their communities.
10. Consider medical mobile units, health kiosks, and home care to help more people in underserved areas get the health services they need.
11. Encourage designated resources to cover the costs associated with transporting indigent patients to alternative hospitals.
12. Consider increased support for case management and create effectual patient education programs.
13. Broaden and enhance AI-Health certification programs to facilitate accessible online entry-level certification for medical AI practitioners.
14. Create an AI Readiness Cohort for rural health organizations, offering weekly coaching sessions focused on key AI topics, practical uses, and proven best practices.
15. Develop AI workforce training programs, provide infrastructure grants, and allocate funding to support technical assistance and adoption.
16. Promote partnerships with AI vendors and establish frameworks to ensure health compliance and ethical standards.
17. Consider an allocation of funds to charitable care programs to address identified financial needs within underserved communities.

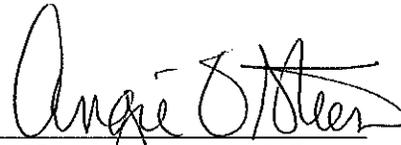
18. Consider initiatives that may lead to reduction in medical debt.
19. Facilitate the use of community health workers by establishing standardized certification and reimbursement processes, and the use of licensed professional counselors by implementing reimbursement mechanisms.
20. Upon RHTP approval, incorporate a targeted plan to enhance access to internal medicine and primary care services in medically underserved regions.
21. Consider legislation to establish an assistant physician medical license for clinical support in rural and underserved communities.
22. Encourage the Georgia Board of Healthcare Workforce to collect and report current data on practicing medical professionals.

Mr. Speaker, these are the findings and recommendations of the Study Committee on
Improving Access to Internal Medicine for Underserved Areas.

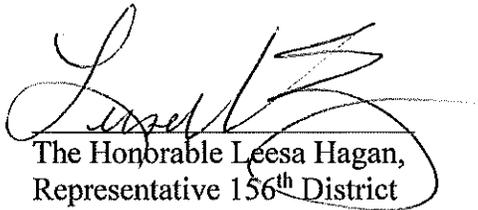
Respectfully Submitted,



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Chairman



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