Improving Access to Primary Care for Underserved Populations: A Review of Findings from Five Case Studies and Recommendations

EXECUTIVE SUMMARY

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Strong, accessible primary care improves population health outcomes. It prevents illness and death, and is associated with a reduction in health disparities. The United States falls short on many indicators that demonstrate the strength of a nation's primary care system, and underserved populations in the country experience significant barriers to accessing primary care.

In a series of five case studies (Grant County, New Mexico; Baltimore City, Maryland; Columbia County, Arkansas; Detroit, Michigan; and Kanawha County, West Virginia), we investigated the impact of policy initiatives that target primary care access at a local level. This paper synthesizes our findings and presents recommendations for federal and state policymakers, primary care practices, medical schools, and other relevant stakeholders.

Increasing Availability of Primary Care Providers

Rural underserved areas in the country are facing a general shortage of primary care physicians (PCPs), and urban areas, which otherwise have a high density of physicians, are facing a shortage of PCPs serving low-income populations and Medicaid enrollees in underserved neighborhoods. The limited supply of PCPs is making recruitment difficult for outpatient primary care clinics that predominantly serve underserved populations, such as federally qualified health centers (FQHCs). Key policy initiatives to improve the availability of PCPs include the following strategies.

Investing in the Primary Care Workforce.

The number of US-trained medical students who choose primary care residencies has been declining. Many programs have been implemented with the goal of attracting more medical students to practice primary care, especially in health professional shortage areas (HPSAs). Both federal and state governments offer a patchwork of financial incentives, such as scholarships and loan repayment assistance programs in exchange for medical students and residents agreeing to practice primary care in high-need areas for a period of time. However, employers of clinicians in underserved areas find that these programs can fall short of helping them recruit and retain providers because the award amounts can be insufficient, the programs are not marketed sufficiently, and burdensome requirements drive away interested students and residents.

Case study interviewees emphasized the importance of providing training opportunities in rural and other underserved areas to support recruitment efforts. States and communities can expand the number of primary care residency spots available in underserved areas by creatively leveraging Medicaid and other state funding. Clinic managers have also found success retaining physicians with preexisting local ties, and with efforts that encourage local K-12 and college students to pursue careers in health care. Area Health Education Centers (AHECs) established under a federal program in the 1970s are actively involved in developing and implementing these pipeline programs to support local students. However, AHECs' potential is frequently limited by insufficient funding. States can expand AHECs' impact by providing additional funding.

Interviewees find that providing training opportunities for medical residents in rural areas and safety net clinics in urban and rural areas can sometimes be more effective than financial incentive programs at retaining PCPs. When residency programs are run by or in partnership with an FQHC, there is a particularly strong track record of retention, and some FQHCs even operate their own residency programs with the help of the federal Teaching Health Center Graduate Medical Education (THCGME) program.

Changing the Way We Pay for Primary Care Services. Reimbursement-based reforms can affect the supply of providers in many ways, especially for underserved populations. Improvement opportunities include convincing more medical students to pick and stay in primary care, promoting the sustainability of outpatient primary care practices, increasing the likelihood that PCPs will accept more Medicaid beneficiaries and uninsured patients, and reducing PCP burnout by allowing them to spend more time with patients and to transition to team-based care.

However, simply increasing Medicaid fee-for-service (FFS) reimbursement for primary care has not improved provider participation in Medicaid significantly. Payment models that transform primary care practices to provide comprehensive care with financial rewards for high quality and good outcomes have the potential to reduce provider burnout and increase provider participation in Medicaid. Such payment models often require significant front-loaded investments that not all practices are able to make. However, the case studies identified at least one rural practice that has successfully implemented team-based care using care coordination and performance-based bonuses, and reduced provider burnout as a result.

Expanding the Care Team. Interviewees find that relaxing restrictions on nurse practitioners (NPs) and physician assistants (PAs), and allowing them to practice independently, has helped fill gaps left by PCP shortages. However, rising demand for NPs and PAs is making it hard for underserved communities to recruit and retain them. Some interviewees described efforts to find the most effective ways to improve their recruitment and retention. Further, medical support staff shortages and high turnover can contribute to provider burnout. Many providers have found success in paying local entry-level candidates to undergo training and certification to become medical assistants or technicians.

Recommendations for federal policymakers

1. Expand the scale and award amounts for National Health Service Corps loan repayment and scholarship programs. Continue funding State Loan Repayment Programs at the higher levels authorized under the American Rescue Plan Act.
2. Permanently fund the THCGME program and consider increasing the level of funding for it.

Recommendations for state policymakers

1. Leverage federal Medicaid dollars to fund expansion of primary care residency spots in underserved areas of the state.

2. Fund AHECs in the state to help them maintain and expand their reach within local communities. Additionally, fund and emphasize the importance of comprehensive program evaluation.
3. Provide incentives to universities and hospitals operating residency training programs to collaborate with urban and rural FQHCs and other community health centers to nurture resident interest in providing primary care for underserved populations.
4. For states that have not already eased scope-of-practice restrictions on advance practice providers consider doing so.
5. Establish collaborations between the state, local colleges, and local safety net employers to hire entry-level staff and pay them to train in support staff roles. Ensure that the pay scale for these roles reflect the critical role they play in improving patient care and mitigating provider burnout.

Improving Access to Outpatient Clinics for Underserved Communities

Interviewees said that private practices in underserved areas are either struggling financially, relocating to more affluent neighborhoods, or seeing fewer Medicaid or uninsured patients. Safety net clinics, especially FQHCs, are a vital source of primary care for underserved populations. Key policy initiatives to improve access to outpatient clinics for underserved communities include

Improving Private Practice Participation in Medicaid.

Efforts in Michigan and Maryland suggest that moving away from FFS and toward team-based, coordinated care payment reform can improve sustainability and participation in Medicaid networks. Both states provide per member fees and technical support to help practices transform.

Supporting and Expanding the FQHC Model.

Providers in states that provide additional state grant funding to FQHCs credit it with helping them expand their reach to high-need populations. State efforts to set standards for how Medicaid managed care organizations interact with FQHCs and pay them have also been beneficial for FQHC sustainability. Despite their promise, we find that FQHCs are likely to have a bigger footprint in urban regions than rural ones. Rural areas need strong local leadership, planning, and community support to successfully attract and sustain an FQHC in their community.

Supporting and Expanding the School-based Health Center Model.

School-based health centers (SBHCs) help children from underserved areas access primary care and have been associated with significant improvements in health and educational outcomes. However, only 10% of public schools have an SBHC. Some states like Michigan have recently increased funding for SBHCs, and interviewees credited an evaluation demonstrating the return on investment on SBHCs for generating bipartisan support. Other study states' SBHCs enjoy far less grant funding, and this has limited the expansion of the model in those states.

Recommendation for federal and state policymakers

1. Develop payment reform initiatives for primary care that focus not just on quality of care and outcomes, but also on improving the sustainability of primary care practices and their ability to see more Medicaid and uninsured patients.

Recommendation for federal policymakers

1. Continue to fund FQHCs at least at current levels.

Recommendations for state policymakers

1. Fund FQHCs to support an increase in capacity and services.
2. Fund the establishment of new SBHCs as well as expansion of established ones, especially in underserved areas. Funding can be contingent on more strategic SBHC service expansion to ensure they are meeting the state's population health goals.

Removing Structural Barriers to Primary Care

Interviewees across all case study locations find that the lack of access to affordable, reliable transportation is one of the greatest barriers to primary care. Patients who are paid hourly wages are also often unable to take time off during the workday to attend appointments. Key policy initiatives to remove these structural barriers to primary care include the following strategies.

Overcoming Transportation Barriers.

Many low-income patients and Medicaid enrollees lack reliable access to transportation to medical appointments. Further, chronic underinvestment in public transit has made it unreliable, and sometimes too costly for many low-income patients. Although Medicaid enrollees are supposed to have access to non-emergency medical transportation, providers uniformly found that this service was unreliable and inconvenient for patients. Some providers are partnering with ride-sharing services, like Lyft and Uber, and some operate their own van services. However, many providers find that lack of funding significantly limits their ability to provide transportation solutions. Some participants of state-led practice transformation efforts in Maryland and Arkansas have been able to use per-member per-month fees to offer transportation assistance.

Mobile Health as a Potential Solution.

Providers at four of the five case study locations have invested in mobile health for hard-to-reach populations. In addition to removing transportation barriers, mobile health can help patients feel more comfortable accessing health care by making it available to them within their communities. Many communities are interested in repurposing mobile vans that were launched to provide testing and vaccinations during the COVID pandemic to provide broader primary care services. However, some mobile health providers experience regulatory barriers in seeking reimbursement through Medicaid for primary care services.

The Pivot Towards Telehealth. All five case study locations saw a marked increase in the use of telehealth during the COVID pandemic. Many providers commended federal and state policymakers' decisions to require reimbursement parity for telehealth visits. Further, providers found that allowing audio-only telehealth visits eliminates the need for a smart phone or broadband internet, which are not always easily accessible to residents of underserved areas. Many interviewees supported making these pandemic telehealth flexibilities permanent. However, telehealth is far from a silver bullet: sometimes physical examinations are necessary, older patients can be more hesitant to adopt telehealth, and broadband access in rural areas and low-income urban areas can be spotty. A successful telehealth strategy needs to account for these barriers.

Making Appointments Work for Patient Needs.* Several providers offer early morning, lunch hour, after-work, and/or weekend appointments to accommodate patients' needs, but they are still unable to meet the demand. Staffing shortages can be a barrier. Some state-led primary care practice transformation efforts require participating practices to expand hours or provide a 24/7 phone line to patients connecting patients to an on-call provider and the monthly fees they provide to practices can help implement these requirements.

Recommendations for federal and state policymakers

1. Provide funding to providers who seek to establish or expand mobile health delivery systems. Provide guidance and technical assistance for providers who newly launched mobile health vans specifically in response to the COVID-19 pandemic on how they can pivot to providing broader primary care services.
2. Explore making audio-only telehealth services reimbursable beyond 2024, especially for safety net providers.
3. Keep evaluating the impact of COVID 19-related telehealth reimbursement flexibilities to ensure that they are improving health outcomes and not reinforcing health disparities.
4. Encourage providers participating in practice transformation efforts and alternative payment models to use additional funding to meet the needs of patients who need urgent and/or after-hours access to primary care.

* On May 3, 2023, the Centers for Medicare and Medicaid Services proposed new rules that seek to improve Medicaid enrollees' ability to access services by, among other things, setting maximum appointment wait time standards for certain services, including primary care; requiring states to ensure that MCOs are complying with these standards and publishing accurate provider directories; and requiring states to seek enrollee feedback on their experience using their Medicaid managed care plan. These changes have the potential to relax some of the barriers that Medicaid enrollees' face in accessing primary care. Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 88 Fed. Reg. 28092 (May 3, 2023) (to be codified at 42 C.F.R. pts. 430, 438, and 457).

Recommendations for state policymakers

1. Review the performance of Non-Emergency Medical Transportation service providers in the state. Remove administrative barriers that limit access to the benefit, such as requiring patients to demonstrate medical need and prohibiting parents from bringing their children.
2. Assess and remove barriers to Medicaid reimbursement for primary care provided through mobile health vans.

Making Primary Care More Affordable

High and rising cost sharing for services and prescription drugs, ineligibility of undocumented immigrants for public insurance programs, and consumer confusion over enrolling in and navigating coverage make primary care inaccessible for many low-income Americans. Key policy initiatives to make primary care affordable include the following strategies.

Making Enrollment Easier. A persistent minority of eligible low-income Americans face barriers when trying to sign up for subsidized insurance or Medicaid, and find the enrollment process, especially for marketplace plans, complicated and cumbersome. Easy or auto-enrollment programs, such as the ones in California, Maryland, Massachusetts, and Rhode Island that facilitate transitions between Medicaid and private insurance or allow enrollees to opt into coverage when filing their taxes, could offer relief if adopted more broadly.

Providing Financial Assistance to Undocumented Immigrants. Undocumented immigrants are ineligible for Medicaid or Affordable Care Act (ACA) marketplace premium subsidies. One insurer in Baltimore offers very low-cost health insurance coverage for undocumented immigrants, but the scale of this program is very small, and broader solutions are necessary.

Making Marketplace Coverage Affordable. ACA marketplace enrollees frequently pay high premiums and/or high levels of cost-sharing, which are a barrier to accessing primary care. Low-income families transitioning out of Medicaid, which does not have deductibles, find it hard to understand the concept once they move to ACA marketplace or employer-sponsored health plans, and sometimes choose cheap catastrophic coverage with large deductibles. State-run programs that provide premium subsidies to low-income young adults, and insurer-led initiatives that pay providers less per service while making up the difference through a monthly per-member payment to lower co-insurance amounts for enrollees can help mitigating these affordability issues.

Recommendations for state policymakers

1. Monitor the performance of programs such as Maryland's Easy Enrollment Health Insurance program and consider if a similar program might be right for the state.
2. Remove bureaucratic barriers to Medicaid eligibility determinations and enrolling in coverage.
3. Assess actions taken by some states to make state-funded coverage available to undocumented immigrants, and consider adopting similar measures.
4. Explore options for making state-funded premium subsidies available to undocumented immigrants so they can purchase plans either from a state-based marketplace (this might require a federal 1332 waiver) or outside the ACA marketplace.
5. Monitor the performance of state programs such as Maryland's premium subsidy program for young adults and consider if a similar program might be right for the state.

Improving Cultural Comfort and Communication Between Providers and Patients

Even when primary care services are available and affordable, primary care remains inaccessible if patients cannot comfortably connect or communicate with their providers. Key policy initiatives to improve comfort and communication between providers and patients include:

Supporting and Expanding the Community Health Worker (CHW) Workforce.

CHWs serve as liaisons between local communities and medical providers by engaging vulnerable residents and helping them access medical and social services. Their services are linked to improved health outcomes, increased trust between patients and providers, and reduced costs. However, establishing funding streams to support the CHW workforce has been challenging. CHWs are frequently paid through grants, and this can prevent employers from integrating them more fully into their organizations because the grants might not be renewed. Allowing CHWs to bill Medicaid as well as making CHW services reimbursable could help support this workforce, and some states are starting to do this. Lack of standardized training and certification of CHWs also makes payers more hesitant to pay for services and some providers more hesitant to integrate them into their practices. State departments of health can play a critical role in developing training and certification processes.

Providing Culturally Responsive and Patient-Centered Care.

Interviewees across all five case study sites attested to the importance of providing culturally responsive and patient-centered care in building trusting relationships with patients. One way that provider organizations have been able to build trust is by ensuring that their providers reflect the racial and ethnic makeup of the community they serve. Interviewees also emphasized the importance of nurturing diversity upstream, especially during residency training.

Recommendations for federal policymakers

1. Explore options to encourage practices participating in alternative payment models to employ CHWs and track their impact on patient access, satisfaction, and health outcomes.
2. Provide funding to support the development of training programs for providers focusing on improving communication with patients from low-income and underserved communities, and reducing stigma associated with diseases such as opioid use disorder.

Recommendations for state policymakers

1. Explore allowing CHWs to bill Medicaid and requiring MCOs to make CHW services more accessible to beneficiaries.
2. Adopt and standardize the certification and training of CHWs.

Planning for Population Health and Primary Care Needs

Interviewees spoke of the importance of having a central convener to bring together providers, social services organizations, state and local government officials, patient representatives, and payers to plan for a community's population health and primary care needs. Even when state and local governments have convened primary care stakeholders, many efforts have been narrowly focused on specific issues like diabetes care rate than on broadly improving access to and quality of primary care. Some of this leadership vacuum can be attributed to long-term underfunding of public health by both the federal and state governments. Public health funding can help boost the ability of local leaders to convene and plan for population health and primary care needs. The role of local health councils in both Grant County, New Mexico, and Baltimore, Maryland have waxed and waned in response to the vagaries of federal and state funding availability.

Recommendation for federal and state policymakers

1. Invest in developing and sustaining local health councils specifically focused on meeting their locality's population health and primary care needs.

About the Milbank Memorial Fund

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