The Effectiveness of Policies to Improve Primary Care Access for Underserved Populations:

An Assessment of the Literature

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- Part of McCourt School of Public Policy
- Legal & policy analysis
  - Federal and state regulation
  - Market trends
- Published reports, studies, blog posts
- Technical assistance

Overview

- Project on Access to Primary Care for Underserved Populations
  - Low-Income Populations
  - Racial and Ethnic Minority Populations
  - Populations living in rural and urban underserved areas
- Funded by the National Institute of Health Care Reform
- Includes:
  - Literature Review
  - Fact Sheets
  - Five Case Studies: Grant County, NM; Baltimore City, MD; Columbia County, AR; TBD

Defining Access with the "Five As"

- **Availability**, or the adequacy of the supply of clinicians.
- **Accessibility**, or the relationship between the location of health care services and the location of patients, which takes into account transportation barriers, travel time, distance, and cost.
- **Accommodation**, or how clinicians are set up to accept and see their patients, which takes into account hours of operation and appointment systems.
- **Affordability**, or the relationships among insurance status, out-of-pocket costs, and the ability to obtain health care services.
- **Acceptability**, or patients' comfort with the clinicians available to them.

Availability

- **Initiative 1:** Encouraging the selection of primary care as a specialty by Increasing Payment for Primary Care Services
  - ***What has been attempted?*** – ACA Medicaid fee bump in 2013-14. CMS Medicare fee bump in 2020.
  - ***Has it worked?*** – No evidence that increased payment attracted more people to primary care. However, Medicaid fee bump was temporary and Medicare fee bump is too recent.

Availability

- **Initiative 2:** State Efforts to Increase the Number of Primary Care Residencies in Underserved Areas
  - ***What has been attempted?*** – NM leveraged Medicaid funding and regulations governing FQHCs to develop additional spots. TX and GA appropriated money to support creation of new programs, specially for primary care.
  - ***Has it worked?*** – Some evidence that these efforts are seeing results. NM's efforts showed a modest increase in number of spots. TX created almost 400 new spots and in GA, majority of new spots were located in HPSAs.

Availability

- **Initiative 3:** Diversifying the Physician Workforce
  - ***What has been attempted?*** – A number of medical schools have shifted to holistic admissions processes. Many medical schools have also implemented pipeline programs.
  - ***Has it worked?*** – One study found that holistic admissions processes increased diversity for most racial and ethnic groups, but not for Black students. There is a lack of systematic evaluation of the impact of pipeline programs. Anecdotal evidence suggests that these programs need to be part of a system of change to see results.

Availability

- **Initiative 4:** Using Federal Funding to Bring Physicians to Underserved Areas
  - ***What has been attempted?*** – HRSA runs the NHSC Scholarship and Loan Repayment Program. HRSA also administers institutional grant programs like AHEC and THCGME.
  - ***Has it worked?*** – Loan repayment programs targeting physicians at end of training work better than service-obligation programs like scholarships targeting medical students. Exposure to HRSA's institutional grant program funding attracts more students to practice in underserved areas.

Availability

- **Initiative 5:** Leveraging the Conrad 30 Program to Attract Foreign-Trained Physicians to Underserved Areas
  - ***What has been attempted?*** – Allows each state to sponsor up to 30 foreign physicians to help meet state workforce needs.
  - ***Has it worked?*** – Relatively successful in urban areas. In rural areas, state loan repayment programs and rural track residency programs are more effective at retaining physicians.

Availability

- **Initiative 6:** Increasing NP Workforce by Easing Scope of Practice Restrictions
  - ***What has been attempted?*** – Some states have eased their scope of practice restrictions, allowing NPs to treat patients independently.
  - ***Has it worked?*** – Some evidence shows that states that give NPs more autonomy experience an increase in number of NPs and an increase in utilization among rural and vulnerable populations.

Accessibility and Accommodation – Bringing Outpatient Clinics Into Communities

- **Initiative 1:** Expanding the Community Health Center Model
  - ***What has been attempted?*** – FQHCs and RHCs receive enhanced Medicaid and Medicare payments and FQHCs receive additional grant funding to provide safety net services to underserved communities.
  - ***Has it worked?*** – Significant evidence shows FQHCs and RHCs improve access to primary care, particularly for low-income and minority patients. Grant funding has helped FQHCs significantly. But significant numbers of rural populations still lack access to an FQHC or RHC. Recent studies show that new FQHCS are less likely to be located in certain types of high-needs areas.

Accessibility and Accommodation – Bringing Outpatient Clinics Into Communities

– **Initiative 2:** Expanding the SBHC Model

- ***What has been attempted?*** – Because of state and foundation funding as well as expansion of federal support for FQHCs, the number of SBHCs doubled between 1999 and 2017.
- ***Has it worked?*** – Despite the expansion, only 10% of US public schools have access to an SBHC. Local leadership, significant state funding, and sponsorship by local FQHCs are critical to further expansion of this model.

Accessibility and Accommodation – Removing Structural Barriers

– **Initiative 1:** Deploying Telehealth Services

- ***What has been attempted?*** – COVID-19 resulted in a rapid expansion of telehealth and increased reimbursement for telehealth services.
- ***Has it worked?*** – Studies of telehealth have shown that while it does improve access, certain underserved populations are less likely to benefit from it because of the digital divide. More research and evaluation is needed to determine the best ways to make telehealth work for underserved populations.

Accessibility and Accommodation – Removing Structural Barriers

- **Initiative 2:** Leveraging Ridesharing Services
  - ***What has been attempted?*** – State Medicaid programs and providers are collaborating with ridesharing services to provide NEMT.
  - ***Has it worked?*** – Evidence suggests that these collaborations can result in fewer missed PCP appointments, lower average wait times for transportation, and higher rates of on-time pickups compared to other types of NEMT services. More research is needed on ways to improve access to NEMT in rural areas where rideshare services are more limited.

Accessibility and Accommodation – Removing Structural Barriers

- Initiative 3: Incentives for Increasing Access to After-Hours Care
  - ***What has been attempted?*** – One NC Medicaid MCO increased hours their PCPs were available and added telephone triage systems. Some public and private insurers have created financial incentives for after-hours care.
  - ***Has it worked?*** – In NC, children enrolled in this NCO used emergency departments less. More research is needed to assess the effectiveness of the enhanced financial incentives for after-hours care.

Affordability

- **Initiative 1:** Removing cost sharing barriers to primary care
  - ***What has been attempted?*** –VBID reduces cost sharing for high-value services like primary care. Several large employers, some state Medicaid plans and marketplace plans, and MA plans have implemented VBID programs to boost use of primary care.
  - ***Has it worked?*** – Enrollment in these VBID plans is associated with an increase in primary care visits and a general reduction in hospitalization and inappropriate ER visits. Despite positive impacts, these programs face many barriers like administrative burdens and enrollee pushback preventing expansion.

Affordability

- **Initiative 2:** Using network adequacy regulations to improve access
  - ***What has been attempted?*** –MA, Medicaid and marketplace plans are all required to give enrollees access to an adequate provider network.
  - ***Has it worked?*** – Research indicates that these requirements have done little to improve access to primary care. 2021 analysis of MA found substantial racial/ethnic disparities in access to wider MA networks for primary care among Hispanic and Asian enrollees. A 2014 OIG report raised questions about the adequacy of state Medicaid MCO network adequacy standards.

Acceptability

- **Initiative 1:** Building cultural competency in the health care workforce
  - ***What has been attempted?*** –Many individual providers are trying to better understand the social, emotional, and financial concerns affecting their patients, and finding ways to connect patients to social services. Providers are also requiring cultural competency training for their staff.
  - ***Has it worked?*** – Individual provider efforts have been sporadic and wide-ranging. No evaluations of these efforts or their impacts are available publicly. This area is ripe for research and programmatic development.

Acceptability

- **Initiative 2:** Integrating CHWs into Primary Care Delivery
  - ***What has been attempted?*** – Significant evidence shows that CHWs can help build a connection and trust between providers and the communities they serve, particularly vulnerable populations. Some states have passed laws authorizing CHW certification and authorizing CHWs to bill Medicaid.
  - ***Has it worked?*** – Even in states that certify CHWs and allow them to bill, the numbers of CHWs have not risen dramatically, because of need for better understanding for how practices can incorporate CHWs and lack of private insurance coverage of CHW services. More research is needed to find better ways to support CHW integration into primary care.

Case Study #1: Grant County, NM

- Southwest New Mexico
- Population ~28,000
- Demographics:
  - 50% Hispanic or Latino
  - 46% white
  - 2.5% American Indian or Alaska Native
- Median Household Income $37,843
- 24% of the population is under the FPL
- Primary Care HPSA Score: 20

What's Working in Grant County

- Relatively high proportion of employers offering comprehensive health benefits – union jobs and public employment
- Medicaid expansion
- Local leadership that came together to successfully implement a thriving FQHC in the county

The Success of the FQHC Model – Hidalgo Medical Services (HMS)

- Only FQHC system in Grant County: 5 community health clinics & 2 school-based health centers
- 82,000 patient visits each year: primary, dental, and mental health care
- Establishes new clinical sites according to community need
- Addresses patients' SDOH concerns
- Work with local students interested in health professions
- Runs a successful primary care residency program
  - Fully funded through the federal Teaching Health Center GME (THCGME) program established under the ACA
  - Leveraged federal funding to build a clinic that provides housing to residents on the top floor of its building
  - High levels of recruitment and retention through residency program

Barriers for Expanding Access to Primary Care in Grant County

- Difficulty attracting and maintaining primary care physicians
  - Lack of job opportunities for spouses and educational opportunities for children
- Limited Non-Emergency Medical Transportation
- Lack of Broadband Access Limits Capacity for Telehealth Services
- No Medicaid reimbursement for CHW services
- Local leaders lack financial support to collaborate on population health needs

Case Study #2: Baltimore City, MD

- Population ~585,700
- Demographics:
  - 58% Black
  - 28% White
  - 7.8% Hispanic or Latino
- Median Household Income $32,699
  - 20% of the population is under the FPL
- 12 areas in Baltimore designated as Primary Care HPSA
  - Scores range from 9 to 22
  - 48% of the city live in a primary care HPSA

Overview of Findings

- Shortage of primary care providers accepting Medicaid and treating lower-income residents
  - Medicaid enrollees experiencing long wait times
  - Shortage of non-physician providers like PAs and RNs, as well as staff
- FQHCs crucial to primary care access
  - FQHCs provide care to 65 percent of the estimated 213,000 people in Baltimore at or below 200% of FPL
- Physician recruitment and retention programs successful but insufficient
  - Providers in state and federal scholarship and loan repayment programs only make up 5-10% of all providers
  - No data on whether providers continue to serve Medicaid patients in the years following the program
- State decisions have increased health insurance enrollment
  - Expansion of Medicaid
  - Maryland easy enrollment programs and young adult premium subsidies
- School-based health center model has stalled because of lack of funding and administrative barriers
  - Only 17 out of 167 schools have a SBHC
  - State funding for SBHCs increased in 2020 but still insufficient

Case Study #3: Columbia County, AR

Coming soon!

Questions?

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