

Evaluating the Effectiveness of Policies to Improve Primary Care Access for Underserved Populations

Funding for this project was provided by the National Institute for Health Care Reform.

For More Information

Read the set of five fact sheets summarizing the evidence on policy initiatives in each dimension of primary care access. Or read the complete report, *The Effectiveness of Policies to Improve Primary Care Access for Underserved Populations: An Assessment of the Literature*.

Part 1: Increasing the Availability of Primary Care Clinicians

January 2022

The Association of American Medical Colleges forecasts a potential total shortfall of 21,400 to 55,200 US primary care physicians by 2033. This fact sheet summarizes the state of the evidence for policy interventions designed to increase the supply of and better redistribute primary care clinicians to improve access for underserved populations.

Primary care is a critical tool to prevent illness and death and improve equitable distribution of health in populations. However, access to this important source of care is lacking, especially for many underresourced communities, such as communities of color and those in rural areas. Attempts to improve access to primary care for these populations can be divided into five interrelated dimensions: 1) improving availability of primary care clinicians; 2) accessibility of primary care services geographically; 3) accommodation of primary care services in terms of appointment availability and hours; 4) affordability; and 5) acceptability in terms of comfort and communication between patient and clinician.

Encouraging the Selection of Primary Care as a Specialty by Increasing Payment for Primary Care Services. Since 2011, the number of US trained medical students who choose primary care residencies has declined. Medical students view the lower income potential of a primary care career as compared to that of other specialties as a barrier to choosing a primary care career.

- **What Has Been Attempted?** The Affordable Care Act (ACA) increased Medicaid reimbursement rates for primary care services to match Medicare rates in 2013 and 2014, resulting in a 73% average increase in Medicaid reimbursement for primary care services. In 2020, the Centers for Medicare and Medicaid Services (CMS) substantially increased Medicare reimbursement rates for primary care for the first time since the 1990s while cutting rates for specialists.
- **Has It Worked?** There is no evidence that these increases in payments attracted more people to primary care specialties. Further, there is insufficient evidence that increasing payment for primary care services has resulted in improving clinician participation in Medicaid or enrollee access to care. However, the ACA Medicaid fee bump was only temporary, and it is too soon to assess the impact of the 2020 Medicare fee increase.

Diversifying the physician workforce can have a significant impact on improving access for underserved populations and in underserved areas.

State-Level Efforts to Increase the Number of Primary Care Residencies in Underserved Areas.

Twenty years ago, the federal government, which funds residency positions through the Medicare program, limited the number of medical residencies. Federal efforts to increase the number of primary care residencies have been insufficient and some states have stepped in to find creative ways to create more residency spots.

- **What Has Been Attempted?** New Mexico leveraged federal Medicaid funding and regulations governing federally qualified health centers to develop additional primary care residencies in underserved locations across the states. The Texas and Georgia legislatures appropriated money to support the creation of new residency programs, particularly for primary care and in geographic areas lacking existing programs.
- **Has It Worked?** There is some evidence that these state efforts are seeing results. New Mexico's efforts created 10 primary care residency slots in high-need areas, which while modest is still an important development in a state that has struggled with health professional shortages. A 2019 report evaluating Texas's new programs found that they had created almost 400 new residency positions. As of 2018, 64% of new residency positions in Georgia were located in federally designated health professional shortage areas (HPSAs).

Using Public Policy and Financing to Diversify the Physician Workforce. Certain racial and ethnic minority physicians are more likely to practice primary care than white physicians, and they are also more likely to practice in federally designated medically underserved areas or health professional shortage areas, as well as rural areas. Diversifying the physician workforce can have a significant impact on improving access for underserved populations and in underserved areas. However, the representation of racial and ethnic minority physicians among primary care physicians remains low.

- **What Has Been Attempted?** A number of medical schools have attempted to increase diversity in health professions schools by shifting to holistic admissions processes that look at criteria beyond test scores and GPAs. Further many medical schools have implemented pipeline programs that intervene earlier by targeting, supporting, and recruiting minority middle school, high school, and college students into applicant pools.
- **Has It Worked?** At least one study found that holistic admissions processes increased the diversity for most racial and ethnic groups, but not for Black students. While there is a lack of systematic evaluation of the effects of pipeline programs, there is anecdotal evidence that pipeline programs can demonstrate results when implemented as part of a broader set of policy initiatives with support from the state and the community. Between 1978 and 2011, the Urban Health Program at the University of Illinois at Chicago, which

was established and funded by the Illinois General Assembly, had the highest graduation rate for minority health care professionals in the country after historically black colleges and universities.

Using Federal Funding to Bring Primary Care Physicians to Underserved Areas. A systematic review of 72 studies found that in addition to physician characteristics like race/ethnicity or being from a rural area, financial factors like debt and anticipated income, as well as exposure to rotations and residency programs in underserved areas, play a significant role in determining whether primary care physicians practice in underserved areas.

- **What Has Been Attempted?** The National Health Service Corps Scholarship and Loan Repayment programs run by the Health Services and Resources Administration (HRSA) directly reward medical students and licensed physicians who agree to practice in HPSAs for a certain period of time. HRSA also administers institutional grant programs like the Area Health Education Center (AHEC) and Teaching Health Center (THC) programs to create opportunities for primary care residents to practice in underserved areas.
- **Has It Worked?** Loan repayment programs that target physicians at the end of their training demonstrate a higher physician retention rate in underserved areas compared to service-obligation programs like scholarships that target medical students earlier in their career. Exposure to HRSA funding for Exposure to HSRAs institutional grant programs have also been demonstrated to attract more medical students and residents to practice in underserved areas. While there is some limited evidence that AHEC programs might be helping recruit and retain primary care physicians in rural underserved areas, there is stronger evidence that THCs attract residents from rural and/or disadvantaged backgrounds. The majority of graduates of THC programs practice primary care in a HPSA.

Leveraging the Conrad 30 Program as an Incentive for More Foreign-Trained Physicians to Practice in Underserved Areas. Foreign-trained physicians are more likely to choose primary care residencies and practices than US-trained physicians, and more than half of all foreign-trained physicians work in areas where the population has a per-capita income of \$30,000 or less, but many of these physicians face burdensome visa requirements. One such requirement is that foreign-trained physicians with J-1 category visas must return to their home country for two years before they can practice in the United States.

- **What Has Been Attempted?** The Conrad 30 Visa Waiver program by the federal government allows each state's department of health to sponsor up to 30 waivers of this home residency requirement for foreign-trained physicians to help states meet their health workforce needs.

Evidence shows that the Conrad 30 Visa Waiver program can bring primary care physicians to underserved areas, particularly in urban areas.

- **Has It Worked?** Evidence shows that the Conrad 30 Visa Waiver program can bring primary care physicians to underserved areas, particularly in urban areas. In rural areas, state loan repayment programs and medical school rural track programs have both been shown to be more effective than the Conrad 30 program at retaining primary care physicians. Cultural disconnect and less-than-optimal employment conditions could contribute to the inability of the Conrad 30 program to retain foreign trained physicians in rural underserved areas.

Increasing the Primary Care Nurse Practitioner Workforce by Easing Scope of Practice Restrictions. Nurse practitioners (NPs) have reported that scope of practice restrictions in several states are limiting their ability to admit and treat patients independently, despite some evidence showing that increasing the number of primary care NPs can expand access for underserved populations, particularly in rural areas.

- **What Has Been Attempted?** Some states have eased their scope of practice restrictions to allow NPs to treat patients independently.
- **Has It Worked?** Some evidence shows that states that grant NPs greater autonomy experience an increase in the number of nurse practitioners and an increase in health care utilization among rural and vulnerable populations. Another study shows that NPs are more likely to work in primary care in states with relaxed scope of practice laws; those odds further increase if the state pays NPs the same Medicaid rate as physicians.

Increasing the Capacity of Existing Primary Care Workforce by Transitioning to Team-Based Care. Team-based care is the provision of health services by a team of clinicians and non-clinicians who work with patients and their caregivers to accomplish shared goals and coordinate high-quality care. In theory, reallocating certain preventive, chronic, and acute care work to non-clinicians can open up the physician's time and expand capacity.

- **What Has Been Attempted?** Some foundations have funded demonstration projects that support practices in their transformation to team-based care and evaluated the new model in terms of a variety of outcomes, sometimes including access.
- **Has It Worked?** One study demonstrated that implementing NP-physician care teams in urban safety-net primary care practices significantly reduced the average time to obtain an appointment, but an evaluation of this study found it had very serious limitations. Case studies of some of the demonstration projects hint at the promise of team-based care in improving access, but significantly more research is needed to establish the relationship between team-based care and access for underserved populations.

Authors

Maanasa Kona
Assistant Research Professor

Megan Houston
Research Fellow

Emma Walsh-Alker
Research Associate