

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

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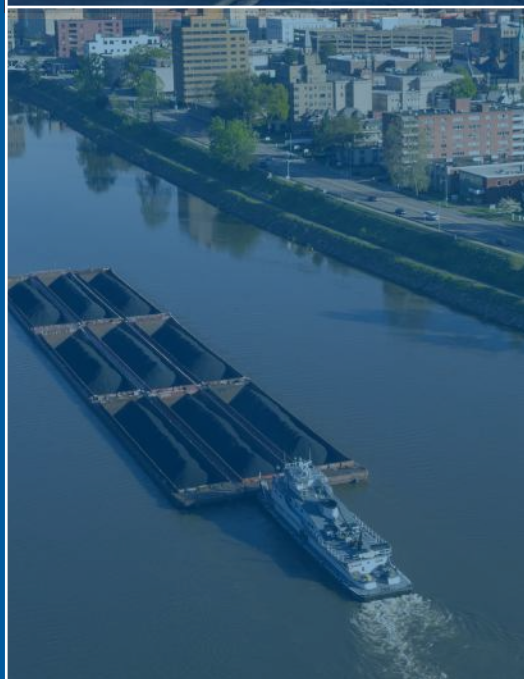


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EXECUTIVE SUMMARY

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 the following strategies.

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 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-19 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-19 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.

INTRODUCTION

Strong, accessible primary care contributes to robust population health outcomes. Evidence shows that primary care prevents illness and death,³ and is associated with a reduction in health disparities.⁴ Countries with strong primary care systems experience better health outcomes than those with weak primary care systems, including reduced unnecessary hospitalization and less socioeconomic inequality,⁵ as well as improved management of chronic diseases.⁶ Unfortunately, the United States falls short on many indicators that demonstrate the strength of a nation's primary care system.⁷

Improving access is key to strengthening a primary care system. The primary care access problem can be divided into five composite and interconnected dimensions, known as the five As: (1) *availability* of primary care clinicians, (2) *accessibility* of primary care services geographically, (3) *accommodation*, such as appointment availability and hours, (4) *affordability*, and (5) *acceptability*, such as comfort and communication between patient and clinician.⁸

In a Milbank Memorial Fund issue brief⁹ and five accompanying fact sheets,¹⁰ we assessed the available evidence to determine whether policy initiatives that target primary care access have been effective. In a subsequent series of five case studies, we assessed the impact of these policy initiatives at a local level to better understand implementation challenges and successes. The case study locations were Grant County, New Mexico;¹² Baltimore City, Maryland; Columbia County, Arkansas;¹³ Detroit, Michigan;¹⁴ and Kanawha County, West Virginia.¹⁵ The locations were chosen for their geographic diversity, demographic diversity, presence of federally designated health professional shortage areas (HPSAs), and evidence of state efforts to improve access to primary care.

This paper synthesizes our findings from all five case studies and presents recommendations for federal and state policymakers, primary care practices, medical schools, and other relevant stakeholders.

FINDINGS AND RECOMMENDATIONS

I. Increasing Availability of Primary Care Providers

The Association of American Medical Colleges projects that by 2034, the country will face a shortage of 17,800 to 48,000 primary care physicians (PCPs),¹⁶ and our case studies support these findings. The rural areas we studied are facing a general shortage of PCPs, and the urban areas, which otherwise have a high density of physicians, are facing a shortage of PCPs serving low-income populations and Medicaid beneficiaries in underserved neighborhoods.

Several practice managers of outpatient primary care clinics serving rural and urban underserved areas, such as federally qualified health centers (FQHCs), expressed concerns about the rising demand for PCPs and their inability to compete with large hospital systems during recruitment. Large hospital systems are frequently able to offer higher salaries, larger signing bonuses, and more administrative support to physicians. Even when practices are able to find mission-driven physicians willing to work for lower salaries, they struggle to retain them

because of the burnout associated with lean staffing and providing care to a patient population with complex needs.

Further, large hospital systems tend to employ their PCPs in hospital-owned outpatient primary care clinics, which are frequently located in wealthier neighborhoods, or in hospital settings. In recent years, over 70 percent of newly certified general internists practiced in hospital settings compared to the 8 percent that practiced in outpatient settings.¹⁷ Some providers at outpatient primary care clinics attribute this to insufficient exposure to outpatient clinical settings, especially in underserved areas, during medical school rotations and graduate medical education or residency training.

A. Developing the Primary Care Workforce Pipeline

Medical residents tend to practice in or close to the areas where they undergo residency training. Case study interviewees emphasized the importance of providing training opportunities in rural and other underserved areas to support recruitment efforts. Several outpatient primary care clinic managers also said that they have found success retaining physicians with preexisting local ties, and support efforts that encourage local K-12 and college students to pursue careers in health care.

Literature suggests that physicians from communities underrepresented in medicine are more likely to serve in underserved areas.¹⁸ Many outpatient primary care clinic managers we interviewed said that they have ramped up efforts to make their employee pools more diverse, but not just to improve recruitment and retention. They embarked on these efforts to foster trust and comfort between physicians and the underserved patient communities they serve, thereby ensuring better access to primary care for these communities.¹⁹

Increasing Local Residency Training Opportunities. In the United States, graduate medical education (GME) or residency spots are predominantly funded through Medicare, and there is a cap on the number of these spots. In 2021, for the first time in 25 years, the federal government announced plans to add 1,000 residency spots in federally designated HPSAs, with a focus on primary care and mental health specialties.

Our study suggests that states and communities can play a role in bringing further residency training opportunities to areas that need them. States have the opportunity to leverage Medicaid funding to support GME programs, and the majority of states do so.²⁰ However, only 13 states, including two of our study states, Michigan and New Mexico, direct their funding toward expanding residency positions in specialties where they are facing shortages, like family medicine.²¹ In 2019, Michigan appropriated \$5 million for its Michigan Doctors (MIDOCs) program and combined it with funding through Medicaid and from state medical schools to create residency slots in primary care and other high-need specialties in underserved areas of the state. Once the program is fully implemented, it is expected to add 30 physicians to the workforce per year.²² New Mexico established its Graduate Medical Education Expansion Program in 2019, under which the state has invested \$1.5 million to expand its GME programs, especially for primary care training in rural and underserved areas. The program is expected

to increase the number of GME programs from 8 to 16 as well as the number of primary care residents training in the state from 142 to 275.²³

At least one medical school in West Virginia has taken a different approach to improve the retention of medical school graduates in state for residency training and beyond. Almost three-quarters of West Virginia medical school graduates who go on to train in state primary care residency programs continue to practice in the state compared to just one percent of graduates who leave the state for residency and come back to West Virginia. The West Virginia University School of Medicine (WVU) has procured waivers from the national residency matching program allowing their residency programs to recruit WVU medical school graduates directly instead of participating in the national match. An evaluation of these programs and their impact on retention of primary care physicians in underserved areas is pending, but state policymakers and medical educators are hopeful given the trends they have seen.

Recommendation for federal and state policymakers

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

Recommendations for state policymakers, medical schools, and residency programs

1. Assess whether in-state medical students are more likely to practice locally if they also receive their residency training in state.
2. Assess whether efforts to bypass the national resident match (like the WVU School of Medicine's waivers) improve recruitment and retention of primary care providers in underserved areas.

Developing a Local Pipeline for the Health Care Workforce. Several outpatient primary care clinic managers and residency program faculty serving underserved areas shared the importance of considering candidates' local ties during the recruitment process. However, they also found that it can be challenging to find such candidates, especially in rural areas. Programs encouraging and supporting K-12 students and college students within a geographic area to pursue careers in health care can help boost the local workforce pipeline.

In almost every case study location, the organization most active in developing and implementing these pipeline programs was the local Area Health Education Center (AHEC). The federal AHEC program was established in the 1970s to develop the health professional workforce and develop training networks within communities. AHECs operate programs that support K-12 students, college students, and students in health professional schools, as well as practicing providers.

However, stakeholders from AHECs serving Grant County, New Mexico, and Detroit, Michigan, have found that that federal funding can be insufficient to meet program goals. These stakeholders shared that additional state funding is critical to maintain and expand program offerings. For example, state funding enabled the AHEC serving Grant County to hire staff and expand its reach to middle school students. Administrators of the Michigan AHEC, on the other hand, expressed frustration over the lack of state funding at the time they were interviewed for our case study.

Recommendation for state policymakers

1. 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.

Many AHEC program administrators find it challenging to evaluate the long-term effectiveness of their efforts, which can hamper their ability to secure funding from federal and state sources. West Virginia AHEC attributes its success in securing state funding to its dedicated program evaluator and a system for tracking participants, which help it to meet reporting requirements.

B. Guiding Students and Residents Toward Primary Care and Underserved Areas

Since 2011, the number of US-trained medical students who choose primary care residencies has declined.²⁴ These shortages have been acutely felt in medically underserved areas like our case study sites. A host of federal, state, and residency-level programs have been implemented with the goal of attracting more medical students to practice primary care, especially in HPSAs. In our case study locations, they have had mixed success.

Role of Federal and State Financial Incentive Programs. The average medical student owes over \$250,000 in debt after graduation.²⁵ Many federal and state recruitment and retention efforts focus on providing financial incentives, like scholarships and loan repayment assistance, in exchange for medical students and residents practicing primary care in high-need areas for a period of time. At the federal level, the National Health Service Corps provides loan repayment assistance to trained primary care residents and operates a scholarship program for medical students.

The federal government also provides funding to states to operate a State Loan Repayment Program (SLRP). States are usually required to match these federal grants (the recently enacted American Rescue Plan Act temporarily increased federal funding and removed the state matching requirement).²⁶ All of our study states except Arkansas operate a SLRP. Program administrators in Michigan expressed enthusiasm over the state's decision to exceed the required 1:1 state match. In 2019, for example, the state contributed \$1.4 million and local employers contributed \$600,000 to match the \$1 million federal grant. Michigan has the second largest SLRP in the country, and they have found that calculating awards based on education debt rather than providing a flat dollar amount has helped extend the reach of this program.

Recommendations for state policymakers

1. Require local employers who benefit from provider placements to contribute to funding for SLRP and other state-run loan repayment and scholarship programs.
2. Tailor SLRP award amounts to actual debt owed by candidates instead of providing a flat dollar amount to increase the number of recipients who benefit from the program.

States can also offer a variety of fully state-funded and operated financial incentive programs.

- West Virginia and Arkansas both offer programs where the state contributes \$10,000 per year and requires a rural community or employer to contribute an additional \$10,000 per year to offer a loan repayment incentive to a primary care resident and/or physician willing to serve that community.
- West Virginia provides tuition waivers to out-of-state medical students who are enrolled in a state medical school

and choose to practice in the state for a period of time after completing their residency or fellowship training.

- Maryland operates a program that gives state income tax credits to clinicians who mentor students and trainees enrolled in programs in underserved areas.

Still, health care employers in underserved areas find that these federal and state programs can fall short of helping them recruit and retain providers. First, award amounts can be insufficient considering the rising demand for PCPs and the increasing burden of educational debt. While financial incentive programs can help safety net employers recruit and retain PCPs,²⁷ many FQHCs we interviewed said that the edge these programs gave them is waning because of competition from large hospital systems. In West Virginia, the state has struggled to find applicants for their SLRP and is planning to increase award amounts with additional federal funding under the American Rescue Plan Act.

Second, this patchwork of federal and state funding can be difficult for potential recipients to navigate. Many medical students and residents are either unaware of the opportunities available to them or struggle to understand how the programs interact with one another. State officials in some states conduct annual outreach to promote financial incentive programs at medical schools, but the effectiveness of these efforts is unclear.

Third, administrative barriers can limit the reach of these programs. Certain safety net providers in Charleston, West Virginia, for example, are ineligible for certain federal financial incentive programs because the presence of large hospital systems in the city has reduced the area's HPSA scores, which determine eligibility. Though "there is a need in the population, it does not show up in the numbers."²⁸ Additionally, some states, like Arkansas, allow for a provider's medical license to be revoked if they default on a state financial assistance program's service obligation. Some employers find that such stringent penalties can deter young PCPs from participating in the program, especially when they have access to other financially lucrative offers with fewer strings attached.

Finally, like AHEC administrators, state financial incentive program administrators find that it can be challenging to evaluate the long-term effectiveness of their programs. Lack of staff and funding as well as the difficulty of tracking program participants once their service obligation period has ended make evaluation difficult.

Recommendations for state policymakers

1. Respond to the changing market for PCP recruitment by increasing award amounts or lifting penalties associated with defaulting on a program's service obligations.
2. Improve outreach to potential program participants. Streamline program offerings and application processes to minimize applicant burden and confusion. Ensure that potential participants understand how they can combine the benefits of different programs.
3. Participate in multi-state collaborative efforts, such as the National Rural Recruitment and Retention Network's (3RNet) Provider Retention & Information System Management (PRISM) program to improve participant tracking and program evaluation.

Recommendations for federal policymakers

1. Expand the scale and award amounts for NHSC loan repayment and scholarship programs. Continue funding SLRPs at the higher levels authorized under the American Rescue Plan Act.
2. Ensure that HPSA scores consider the number of providers who accept and serve uninsured patients and Medicaid beneficiaries.

Developing Training Opportunities in Rural Areas and Safety Net Clinics. Safety net employers and policy experts familiar with their state's workforce issues find that providing opportunities for medical residents to train in rural areas and safety net clinics serving both urban and rural areas can sometimes be even more effective than financial incentive programs at retaining PCPs. They find that PCPs recruited through financial incentive programs tend to leave once the service obligation period ends whereas those who train in the community build a connection with the populations they serve. Training in underserved settings can help nurture interest in serving underserved populations at a time when students and residents are still considering career options. In fact, employers in Columbia County, Arkansas, note that the lack of such training programs is making it particularly difficult for them to recruit and retain PCPs.

Several residency program directors and employers find that when residency programs are run by or in partnership with an FQHC, there is a particularly strong track record of retention. For example, over 90% of the graduates from Johns Hopkins University's Urban Health Track residency program, which is based out of a local FQHC, continue to work in primary care and

75% of them have stayed in Baltimore. The program's focus on providing training at an FQHC has helped it recruit residents interested in the mission of urban health for underserved populations.

Some FQHCs operate their own residency programs with the help of the federal Teaching Health Center Graduate Medical Education (THCGME) program established under the Affordable Care Act. Hidalgo Medical Services (HMS), an FQHC with a prominent presence in Grant County, New Mexico, has had success recruiting and retaining PCPs through its residency program. HMS also leveraged federal funds to build housing for their residents above their clinic, which has helped residents better integrate into the community. HMS receives far more applications than it is currently able to accept.

Recommendation for federal policymakers

1. Permanently fund the THCGME program and consider increasing the level of funding for it.

Recommendations for state policymakers

1. Support the development of residency programs in FQHCs and other community health centers by developing a learning collaborative of all state residency program directors.
2. 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.

In establishing its residency training program, HMS has benefitted from participating in the New Mexico Primary Care Training Consortium, which brings together residency program directors across the state to support community-based organizations like HMS in developing new residency training programs. In contrast, without similar support, FQHCs in Kanawha County, West Virginia, have struggled to establish their own residency programs. One local FQHC spoke of early attempts to partner with a local hospital system falling apart because of their inability to solve certain accreditation-related issues.

3. Hiring International Medical Graduates.

The federal Conrad-30 program, or the J-1 visa waiver program, removes certain immigration restrictions for foreign physicians who agree to practice in a HPSA or a medically underserved area (MUA) for three

years. Each state is allowed to request up to 30 waivers a year and most study states used almost all the waivers available to them. Program administrators and safety net employers in Baltimore and Detroit find that the program has been more successful in bringing specialists to large hospital systems, because these larger employers have the resources necessary to pay the legal fees involved in employing a foreign worker and helping them and their family immigrate permanently.

Recommendation for state policymakers

1. Provide technical assistance and support to help safety net clinics in underserved areas take better advantage of the Conrad-30 program.

C. Changing the Way We Pay for Primary Care Services

Increasing investment in primary care and reforming payment mechanisms can impact access to primary care.²⁹ There are many ways reimbursement-based reforms can potentially affect the supply of providers, especially for underserved populations: 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.

Increasing Medicaid Reimbursement for Primary Care. The passage of the ACA and rising demand for PCPs has steadily increased PCP compensation over the years, but a significant pay gap persists between PCPs and specialists.³⁰ In 2013 and 2014, the ACA temporarily increased Medicaid rates paid to PCPs to that of Medicare rates. Prior to the fee bump, Medicaid services were reimbursed at about 70% of Medicare rates. Given the temporary nature of this increase and certain operational barriers, the effect on PCPs' acceptance of Medicaid beneficiaries was modest at best.³¹ Its impact on bringing more medical students to primary care, improving practice sustainability, or reducing PCP burnout is likely muted given the temporary nature of this policy change, but has been insufficiently studied.

Recommendation for state policymakers and researchers

1. Study the impact of increased Medicaid reimbursement on PCP participation in Medicaid, primary care practice sustainability, PCP burnout, and resident decisions to continue practicing primary care.

As of 2016, 19 states, including three study states (Maryland, Michigan, and New Mexico), continued to pay higher Medicaid reimbursement rates for PCP services.³² However, providers and public health officials we interviewed for our Baltimore and Detroit case studies noted that provider participation in Medicaid in the cities continues to be very low, especially among PCPs in private practice and those employed in hospital-affiliated outpatient clinics.

Reducing Physician Burnout Through Payment Reform. Most payers reimburse for primary care services on a fee-for-service (FFS) basis, which pays PCPs based on the number of patients they see and the number of covered services they provide. These payments typically do not reflect the quality of care provided or patient health outcomes. The FFS payment model rewards providers who deliver a high volume of services. For example, in Kanawha County, West Virginia, one practice reported scheduling a new patient every 15 to 20 minutes.

While appointments of this length might be sufficient for more affluent patients with regular access to care, they fall short when treating underserved populations with high and complex needs. Frequently, FFS systems do not reimburse PCPs for vital tasks such as care coordination or referring patients to necessary social services. These pressures contribute to physician burnout and make it harder to retain PCPs, especially those serving populations with complex needs in underserved areas.

Despite recent efforts across the health care system to shift reimbursement away from FFS and toward alternative payment models, such as capitation or shared savings programs, the dominance of FFS payment in primary care continues.³³ Transforming primary care practices to provide the kind of comprehensive, high-quality care that will generate more revenue under such alternative payment models requires significant front-loaded investments that not all practices are able to make.

It is unclear from the available evidence and our case study interviews whether participation in practice transformation efforts is reducing administrative burdens on physicians. For example, a participant in the Maryland Primary Care Program (MDPCP) to implement primary care practice transformation reports that it has not yet reduced administrative burdens.

At the same time, in Arkansas, state officials touted a rural practice that successfully implemented team-based care with the help of per-member per-month bonuses for care coordination and performance-based bonuses for quality improvement from both public and private payers.³⁴ The practice “went from being desperate to hire people to having people knocking on doors wanting to join the practice” at least partly because of reduced provider burnout.

Recommendation for researchers

1. Study the short- and long-term impacts of different payment arrangements on provider burnout. Consider whether the increased administrative burdens associated with heightened reporting requirements are balanced by the reduction in burnout associated with transitioning to team-based care.

D. Expanding the Care Team

In the face of a PCP shortage, measures to support and expand the number of non-physician clinicians and other medical staff on a team can improve access to primary care for underserved population in two key ways: filling access gaps caused by PCP shortages, and reducing physician burnout by dispersing patient care responsibilities across a larger team.

Elevating the Role and Availability of Advance Practice Providers (APPs) in Primary Care. Safety net providers in all three rural case study locations find that relaxing restrictions on APPs, such as nurse practitioners (NPs) and physician assistants (PAs), and allowing them to practice independently, has helped fill gaps left by PCP shortages.

An FQHC provider in Kanawha County, West Virginia said that their clinical staff is currently 60% APPs and 40% physicians, and that having APPs manage their own patient panels has eased the pressures caused by the PCP shortage. Another practice in Columbia County, Arkansas, found that prior state requirements that physicians supervise NPs limited the practice's ability to offer more appointments. Now that the state has eased these restrictions, the practice predicts they will be able to accept and see more patients.

While many states have eased "scope-of-practice" restrictions on NPs, these flexibilities are not always extended to PAs. Stakeholders in Grant County, New Mexico noted that they have seen no difference in the quality of PA and NP services in their community and find that their state's restrictions on PAs' ability to see patients independently might be serving as a barrier to primary care access.

Recommendation for state policymakers

1. For states that have not already eased scope-of-practice restrictions on APPs, consider doing so.

Recommendation for researchers

1. Study the impact of easing these restrictions on access to appointments, continuity of care, quality of care, and health care outcomes.

At the same time, rising demand for APPs,³⁵ is making it hard for underserved communities, especially rural ones, to recruit and retain APPs as they struggle to compete with larger health systems in bigger cities. In Kanawha County, for example, one local community leader said that most nurses graduating from a local college end up leaving the area. To counteract this, local safety net providers have taken advantage of federal and state loan repayment programs to attract more APPs.

A review of studies on recruitment and retention of NPs found that financial incentives are not always the dominant factor in an NP's decision to practice in underserved settings, and that NPs motivated by financial incentives are less likely to continue practicing in underserved settings after fulfilling their obligations.³⁶ The review found that preexisting ties with underserved areas and educational training focused on underserved communities can play a stronger role in retaining NPs in underserved areas.³⁷

West Virginia has established a new family medicine NP residency program in an FQHC and long-term rural rotations for PA students to encourage more APPs to practice in rural and underserved settings. Advocates hope that evaluations of programs such as these will help them assess the most effective ways to improve recruitment and retention of in rural and underserved areas.

Recommendation for researchers

1. Further study the factors influencing NP and PA decisions to practice long-term in rural areas and underserved settings, such as FQHCs.

Recommendations for state policymakers and health professions schools

1. Focus APP recruitment efforts towards recruiting students from underserved areas and establishing more training opportunities for APPs in rural areas and safety net settings, such as FQHCs, and less on financial incentive programs, such as loan repayment and scholarship opportunities.
2. Ensure that these efforts are being comprehensively and periodically evaluated for effectiveness.

Improving Recruitment and Retention of Medical Support Staff.

Medical support staff are key health care professionals providing non-clinical assistance to clinicians and patients, such as medical assistants, laboratory technicians, and pharmacy technicians. These professionals are essential to ensuring the smooth functioning of medical practices. Several practices and providers serving underserved areas expressed concern about support staff shortages and high turnover; both have been exacerbated by the COVID-19 pandemic.³⁸ One FQHC residency program director said that the frequent turnover of support staff at the FQHC is negatively impacting the resident experience, and they worried about it deterring residents from pursuing careers at FQHCs. Practice managers also worried about the impact these staffing shortages have on patient experience and physician burnout.

Some providers have implemented creative programs to improve the recruitment and retention of support staff. FQHC providers in Detroit and Kanawha County described programs that pay local entry-level candidates to undergo training and certification to become medical assistants or technicians. One FQHC in Baltimore reevaluated the pay scale for all its support staff and increased wages for these roles. This wage increase has helped them weather pandemic-fueled shortages better than other local practices.

Recommendation for state policymakers and safety net practices

1. 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.

II. Improving Access to Outpatient Clinics for Underserved Communities

Having access to primary care is vital for improving population health outcomes, especially for underserved communities.³⁹ The further a patient has to travel to receive care, the more likely they are to forgo necessary preventive and primary care, which can increase the use of overtaxed hospital emergency departments. In the five underserved locations we studied,

primary care is delivered mostly at private practices; hospital-affiliated or hospital-based outpatient clinics; and at safety net clinics, such as FQHCs, rural health centers, school-based health centers, and free clinics.

In both urban and rural underserved areas, interviewees said that private practices were either struggling financially, relocating to more affluent neighborhoods, or seeing fewer Medicaid or uninsured patients. In four of five case study locations, safety net clinics, especially FQHCs, were a vital source of primary care for underserved populations.

A. Shortage of Private Practices Serving Medicaid Beneficiaries and Uninsured

Private practices currently play a small and diminishing role in providing primary care to underserved populations in most of the locations studied. Stakeholders at multiple case study locations reported that many practices limit the number of Medicaid beneficiaries they are willing to see or refuse to see Medicaid beneficiaries because of low reimbursement rates. For example, stakeholders in Detroit have found that private primary care practices, especially those without connections with larger health systems, have “struggled to keep their doors open” and have relocated from the city center to the suburbs, where there are more privately insured patients.

Improving Private Practice Sustainability and Provider Participation in Medicaid through Payment Reform. In addition to contributing to provider burnout, FFS payment arrangements can reduce the sustainability of private practices and make them less willing to see Medicaid beneficiaries. Efforts in two study states suggest that state payment reform can improve sustainability and participation in Medicaid networks. The state-run Michigan Primary Care Transformation Project (MiPCT) created physician organizations to assist practices in converting to patient-centered medical homes (PCMH) and provide them with monthly per member fees to support these efforts. Interviewees observed that participation in

MiPCT has helped improve the sustainability of many private practices and made them more willing to see Medicaid beneficiaries.

The recently established, state-run Maryland Primary Care Program (MDPCP) provides participating primary care practices funding and operational support to transition to team-based, coordinated care. Under the program’s payment structure, practices can make up to twice what they would have made under traditional FFS payments. MDPCP also provides enhanced payments for PCPs who practice in high-need areas. To participate in MDPCP, practices must accept new patients. Program officials hope

Recommendations 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.
2. For payment reform initiatives already in progress, consider evaluating the impact of the initiative on practice sustainability and access to care for Medicaid and uninsured patients.

that the incentives and program conditions will improve primary care practice sustainability and participation in Medicaid.

Providing Incentives to Hospitals to Invest in Primary Care. Due to a sustained push from public and private payers over recent years and pressures related to the COVID-19 pandemic, some hospitals across the country have been gradually moving away from FFS and toward alternative payment arrangements, such as population-based payment models.⁴⁰ Paying hospitals on the basis of improving the health of the population they serve instead of the volume of services they provide can nudge them to invest more in upstream primary care.

Maryland's unique Total Cost of Care (TCOC) model is an example of federal and state actions that increased hospital investment in primary care. Under the TCOC model, hospitals are given a global budget for managing the health of the population residing in their service area. The goal is to have hospitals invest more in outpatient primary care to improve population health and reduce utilization of inpatient services. One hospital in Baltimore City has used funds received under the TCOC model to expand home-based primary care and bring primary care to areas within the city with the highest needs.

However, it is worth noting that the TCOC model does not currently require hospitals to invest a specific amount of money in primary care and one local official said that they have not seen any notable investment in primary care. The official supported the development of more prescriptive standards incorporating the input of local stakeholders for hospital investment in primary care. They emphasized the importance of centralized planning to ensure that hospital investments are driven by population health needs and not taking place in a piecemeal and potentially ineffective way.

Some hospital systems, particularly in urban areas, also have had a longstanding history of partnering with local safety net clinics even without the incentive of value-based payment. Hospital systems in Baltimore and Detroit have established relationships with local FQHCs that allow the FQHCs to refer patients to the hospitals for free or discounted specialty care and supply FQHCs with funding, providers, and trainees. Hospital systems tend to make these investments as part of their community benefit obligations, but they take place in an ad hoc way with limited state oversight.

Recommendations for public and private payers

1. When implementing population-based payment models for hospitals, consider including more prescriptive standards on how hospitals should invest their savings into primary care.
2. When implementing payment reform efforts, ensure that local communities' input and needs are considered.

Recommendation for state policymakers

1. Develop tax incentives to spur hospital investment in primary care. Leverage state community benefit requirements to promote primary care investment by hospitals.

B. Federally Qualified Health Centers (FQHCs)

FQHCs play a vital role in the delivery of primary care in four of the five case study locations. In rural Grant County, New Mexico, the presence and expansion of the local FQHC system has helped low-income and uninsured residents gain access to primary care. In Kanawha County, many privately insured patients go to the local FQHC because private practices are at maximum capacity. In urban areas like Baltimore and Detroit, FQHCs are the predominant source of health care for many low-income residents.

However, many FQHC providers find that their resources are spread thin, and they are not always able to expand their services or patient population. As a result, there are many low-income residents who are unable to take advantage of these safety net clinics.

Providing State Support for FQHCs. Providing state grant funding for FQHCs can increase the number of uninsured patients they are able to see.⁴¹ As of 2018, 29 states provided funding for FQHCs, including three of the five study states—Maryland, Michigan, and New Mexico. FQHC providers in Baltimore credit both federal and state funding with helping them expand their reach to high-need populations. The state also provides capital grants to FQHCs for purchasing equipment or space, as well as targeted funding for specific projects intended to improve community health.

New Mexico similarly offers no-cost loans and grants to FQHCs through a capital funding program. Providers in the state credited the state's early decision to align the FQHC federal certification process and the state grant application process with increasing the number of FQHCs in New Mexico. Michigan is on the lower end of the 29 states in terms of how much funding it provides, but stakeholders find that the state's proactive efforts to set standards for how Medicaid managed care organizations (MCOs) interact with FQHCs and pay them have been beneficial to FQHCs.

Recommendations for state policy-makers

1. States that have not expanded Medicaid yet should do so.
2. Fund FQHCs to support an increase in capacity and services.

Recommendation for federal policy-makers

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

Aside from funding, states can support FQHCs by expanding Medicaid eligibility under the ACA. Medicaid expansion has been linked to increases in FQHC revenues, staffing, and patient visits.⁴² These findings are confirmed by our case studies. Multiple FQHC providers said that a large portion of their center's revenue now comes from billing Medicaid and Medicare, and that the increased financial stability has allowed them to expand staff and services. However, increases in insured patients can prompt reductions in state support. Both Arkansas and West Virginia cut their funding to FQHCs once they made the decision to expand Medicaid eligibility under the ACA.

and West Virginia cut their funding to FQHCs once they made the decision to expand Medicaid eligibility under the ACA.

Expanding FQHC Locations, Especially in Rural Areas. The presence of FQHC clinical sites in an area reduces primary care appointment wait times for Medicaid patients and improves access.⁴³ Yet, FQHCs are not uniformly distributed across high-need areas in the country. FQHCs are more likely to be present in urban regions than rural ones.⁴⁴ Our case studies are consistent with this finding. Urban study sites—Baltimore, Detroit, and Charleston (an urban center in the middle of a more rural county)—are served by multiple FQHC systems, while the rural study sites—Grant County, New Mexico, and Columbia County, Arkansas—are served by one and zero FQHC systems, respectively.

Local leadership in Grant County, through the Grant County Community Health Council, was instrumental in bringing an FQHC system into the county. Since opening its first clinic, this FQHC system has made primary care more accessible in the county. The FQHC system has used a community needs assessment to identify areas in need of new clinical sites, including remote areas without adequate public transportation options. The FQHC has also invited a number of private practices to join the FQHC umbrella, and local leaders say that these mergers have been “good for the community.” Converting an outpatient primary clinic into an FQHC clinical site in Baltimore has also helped increase the number of Medicaid beneficiaries and uninsured patients a practice sees. For some FQHCs in Kanawha County, though, expansion has been driven more often by opportunity than population health needs.

Successful expansion of FQHCs also relies on garnering local support. When an FQHC system tried to expand into Columbia County, some local providers and leaders opposed it even as many recognized the need for more providers for low-income populations. The FQHC system, a relatively large organization, failed to gain the trust of the community it wished to serve. Leaders pointed to issues like the high salary the FQHC organization pays to its CEO as an indication that this company might not be the best fit for their community.

Recommendation for local and community leaders

1. Assess the need for safety net clinical sites in the community and include the local provider community in the decision-making process. Proactively plan for the community’s primary care needs by leading discussions around establishing new FQHC sites.

Recommendation for state and federal policymakers

1. Provide funding and technical assistance to support local and community leadership in driving a safety net expansion strategy.

C. School-Based Health Centers

School-based health centers (SBHCs) help children from underserved areas and their families overcome barriers to primary care such as lack of transportation, parents' inability to get time off from work, and lack of affordability. Although SBHCs have been associated with significant improvements in health and educational outcomes, only 10% of US public schools have access to an SBHC.⁴⁵

Federal and state policymakers are increasingly prioritizing funding for SBHCs. Congress increased funding for SBHCs from \$5 million in 2021 to \$30 million in 2022.⁴⁶ As of 2017, 16 states and the District of Columbia provided additional state grant funding to SBHCs.⁴⁷ Four of our study states—Arkansas, Maryland, Michigan, and New Mexico—provide funding for SBHCs.

In Michigan, especially, SBHCs have enjoyed relatively stable funding over the years, and the state recently increased funding from \$8 million to \$33 million.⁴⁸ Stakeholders familiar with the legislative process behind the funding increase credited an evaluation demonstrating the return on investment on SBHCs for generating bipartisan support.

Not all SBHCs can rely on such robust state funding. Advocates in Baltimore said that SBHCs tend to run at a loss because they care for many uninsured patients and deliver services they cannot bill for (including support for nonmedical needs, attending school meetings, and providing care coordination). Local leaders said that Baltimore has not seen a significant expansion of SBHCs in many years. Though Maryland recently increased funding for SBHCs from \$2.4 million to \$9 million,⁴⁹ the funding must be divided among 89 SBHCs. Similarly, in Arkansas, which funds SBHCs through a state tobacco excise tax, a state program manager said that the grant funding “only goes so far.” The state encourages SBHCs to pursue diversified funding, and many SBHCs add dental and vision services, which tend to bring in additional revenue.

Much like FQHCs, SBHCs also need “buy-in” from community stakeholders to succeed. In Columbia County, Arkansas, local leaders found that the general distrust some local providers have for FQHCs can extend to SBHCs. A state-level advocate for SBHCs found that having a coordinator to rally support of local providers and the community, while educating school district officials about the benefits of a healthy student population, can help. In Kanawha County, West Virginia, where there is much less mistrust of FQHCs, one FQHC provider observed that communities have an easier time supporting new or proposed SBHCs when they are affiliated with established FQHC organizations with which the community already has a good relationship. Additionally, SBHC sponsors in Kanawha County have found that “once a school nurse or principal works at a school with an SBHC and sees the benefits,” they are likely to try and establish SBHC services again when they go to another school.

Recommendation for researchers and SBHC program administrators

1. Conduct periodic evaluations of SBHC clinical outcomes and impact on system-wide costs.

Recommendations for state policymakers

1. 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.
2. Assess and remove any barriers to Medicaid reimbursement for SBHCs.⁵⁰

Recommendation for local leaders and school officials looking to establish SBHCs

1. Conduct outreach and education about the value of SBHCs and develop of process for soliciting and incorporating community input on the establishment of SBHCs.

III. Removing Structural Barriers to Primary Care

Many patients, particularly from underserved communities, forgo necessary primary care services because of structural barriers such as inability to get to and from primary care clinics. Low-income patients who are paid hourly wages also find themselves facing barriers because they are unable to take time off during the workday and lack paid leave.⁵¹ These structural barriers result in many low-income people using 24-hour emergency departments despite having a regular primary care clinician.⁵² Both those with private and public insurance experience long wait times for appointments[†] and constraints due to conventional business hours.⁵³

A. Overcoming Transportation Barriers

Providers and local leaders across all case study locations uniformly said that the lack of access to affordable, reliable transportation is one of the greatest barriers to primary care. They find that many low-income patients and Medicaid beneficiaries lack reliable access to a car or a friend or family member who can drive them to appointments.

[†]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).

Problems with Public Transportation. Decades of underinvestment in public transportation across the country has made it difficult, if not impossible, for patients to rely on it.⁵⁴ Stakeholders from rural areas such as Columbia County, Arkansas, and Grant County, New Mexico, as well as the rural areas outside of Charleston in Kanawha County described public transportation infrastructure as limited and spotty. In Kanawha County, public transportation mostly caters to the Charleston metro area. Local leaders in the Grant County Community Health Council recognized the need for reliable transportation and expanded the county's public bus transportation system, but interviewees said that even now the bus system is oriented toward residents of Silver City and remains inaccessible to those in more rural parts of the county.

Recommendation for local policymakers

1. Invest in public transportation as part of a broader population health strategy.

Stakeholders from urban areas—Detroit and Baltimore—also described problems with the public transportation system. In Baltimore, one provider spoke of patients having to take two or three different buses to get to a clinic. Further, local providers cited both cost and travel time as significant barriers to using the city's bus system.

Medicaid NEMT Benefit Struggles to Meet Patient Needs. The Medicaid Non-Emergency Medical Transportation benefit is intended to help Medicaid beneficiaries overcome these barriers and get to their appointments. However, across all case study sites, providers said that the benefit is not working as intended for patients. Providers gave numerous reasons for why NEMT fails patients, including:

- Lack of awareness among patients about the benefit;
- Services unavailable at the times patients need them;
- Patients required to demonstrate medical need to use the benefit;
- Inability to bring children along;
- Requiring anywhere from 1 day to 3 days' notice to schedule;
- Not being available door-to-door;
- Being unavailable to uninsured patients; and
- Vans running hours behind schedule.

At least one clinician attributed some of these issues to the fact that Medicaid reimbursement is too low and NEMT providers are "inundated" with service requests.

Recommendations for state policymakers

1. Review the performance of NEMT 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. Develop alternative payment strategies, such as performance targets with bonuses and penalties, that incentivize high quality NEMT services.
3. Study the outcomes of state experiments using apps such as Uber, Lyft, Veyo, and FlyWheel, and evaluate whether these alternative delivery models could perform better than traditional NEMT services.

Provider Solutions to Overcome Transportation Barriers. Providers interviewed across all five case study sites spoke of trying to fill the need for better transportation. In Baltimore, providers offer subsidies for public transportation and help patients complete necessary paperwork to sign up for public transportation subsidies. Clinics in urban areas—Baltimore and Detroit—rely on ride-sharing applications, like Uber and Lyft. Many providers in these areas offer patients free or discounted rides through these services. Providers in both urban and rural areas have also purchased vans and operate their own transportation services.

Recommendation for state policy makers

1. When developing alternative payment models, ensure that practices are encouraged and able to reinvest a portion of additional earnings towards mitigating transportation barriers.

Practices find that lack of funding is a key obstacle to developing and maintaining transportation assistance programs. However, participants of practice transformation efforts like MDPCP in Maryland and the PCMH program in Arkansas, which provide practices with per-member per-month fees, have used these additional payments to offer transportation assistance programs.

Mobile Health Emerges as a Potential Solution. Many providers have turned to mobile health as a solution to the transportation problem. At least one provider found that mobile services increase access and increase patient comfort with the care being provided. Providers at four of the five case study locations (the exception is Columbia County, Arkansas) have invested in mobile health for hard-to-reach populations.

A successful model is the Wayne Health Mobile Unit, launched in Detroit in 2019. The unit operates eight vans, deploys a team of almost 100 people, and has logged 82,000 encounters with 56,000 patients. The program has conducted significant marketing and outreach with community organizations and church groups to build trust within the community and relies on a robust information exchange system to identify “hotspots” for disease risk in the city. The system considers emergency room visit data as well as data on social vulnerability, such

as low high school graduation rates and historic redlining. As the program works to make their services financially sustainable, one barrier is the inability to bill for preventive services if a Medicaid beneficiary has been assigned a PCP through their Medicaid MCO. The program is also working on making a financial case to employers in the Detroit area, who can decrease absenteeism by having a mobile health van visit their sites.

Providers at three of the four locations deploying mobile health vans noted that the COVID-19 pandemic spurred them to establish or expand their mobile health delivery services. They used vans to provide widespread testing and vaccination against COVID-19. Many providers wondered about the feasibility of continuing to use these vans once pandemic-related flexibilities and funding wind down. In 2022, Congress responded to these questions by creating additional grant funding opportunities for the development of mobile health in rural and underserved areas.⁵⁵

Recommendation for state Medicaid agencies

1. Assess and remove barriers to reimbursement for primary care provided through mobile health vans.

Recommendation for public and private payers, including employers

1. Incorporate mobile health vans into care delivery strategies.

Recommendation for federal and state policymakers

1. Continue to 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.

The Pivot Toward Telehealth. All five case study locations saw a marked increase in the use of telehealth during the COVID-19 pandemic. Many providers commended federal and state policymakers' decisions to require reimbursement parity for telehealth visits.⁵⁶ One local leader in Columbia County, Arkansas, claimed that this decision had the biggest impact on increasing the availability of telehealth in the county because "it became worth the physicians' time to provide virtual care."

One pandemic-based telehealth policy that has been particularly meaningful in underserved areas is the federal government's decision to allow providers to seek reimbursement for audio-only telehealth. Providers we interviewed found that audio-only telehealth visits eliminate the need for a smartphone or broadband internet, which are not always easily accessible to residents of underserved areas. Audio-only visits remain popular at safety net clinics two years after the pandemic.⁵⁷ Policy advocates in study states support making some pandemic telehealth flexibilities permanent, especially for FQHCs and rural health clinics. West Virginia's Medicaid agency is partnering with a state university to evaluate how maintaining pandemic flexibilities for telehealth can benefit the state's Medicaid population.

However, telehealth is far from a silver bullet in removing transportation and other structural barriers to primary care. First, many primary care services require physical examinations and diagnostic testing. Second, many patients prefer in-person encounters. At least one FQHC provider has found that the majority of patients now ask to be seen in person.

Third, older patients can be more hesitant to adopt telehealth. Some providers have launched programs to help older adults better use telehealth. For example, the Baltimore City Health Department has partnered with a local hospital to help patients who come to senior centers navigate telehealth. Offering these services in a location like a senior center that older adults are already visiting has helped the program be more successful. Some practices in Columbia County, Arkansas, have used funding from the state's PCMH program to send nurses with smart tablets to older patients' homes to guide them through telehealth appointments.

Fourth, broadband access is limited in rural areas as well as certain low-income urban areas. Policymakers have worked to expand broadband access, however. In Baltimore, the mayor has hired a digital equity coordinator to improve broadband access across the city. Arkansas, New Mexico, and West Virginia have recently invested in broadband access projects in rural areas. In 2023, the federal government announced it would invest \$42.5 billion in the Broadband Equity and Deployment Program, which provides states grants to bring broadband to communities without access.⁵⁸

Recommendations for federal and state policymakers

1. Explore making audio-only telehealth services reimbursable beyond 2024, especially for safety net providers.
2. Keep evaluating the impact of these telehealth reimbursement flexibilities to ensure that they are improving health outcomes and not reinforcing health disparities.
3. Encourage providers participating in practice transformation efforts and alternative payment models to use additional funding to decrease disparities in telehealth usage.

Recommendation for researchers

1. Evaluate the effectiveness of pilot and demonstration programs that aim to make telehealth more accessible to underserved communities, such as older adults, racial and ethnic minority communities, and rural communities.

B. Making Appointments Work for Patient Needs*

After-hours appointments are critical for low-income patients who have inflexible work schedules, lack paid leave, or face difficulty finding childcare.⁵⁹ Several safety net clinics in the five case study locations mentioned that they offer early morning, lunch hour, after-work, and/or weekend appointments to accommodate patients' needs. However, some providers find that these appointment slots are the first to fill up and do not come close to meeting the demand among patients. Providers in multiple case study locations have found that staffing shortages are a barrier to further expanding appointment flexibilities.

Recommendation for federal and state policymakers

1. 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.

Some state primary care practice transformation efforts require participating practices to expand hours (MDPCP in Maryland) or provide a 24/7 phone line to patients connecting patients to an on-call provider (Arkansas PCMH), and potentially provide the funding and support necessary to implement these requirements.

Stakeholders from rural counties—Grant County, New Mexico, and Columbia County,

Arkansas—said that urgent care centers can be yet another source of after-hours appointments, but that they tend to provide services primarily to privately insured and self-pay patients.

IV. Making Primary Care More Affordable

Insurance coverage is associated with better access to primary care and reduced likelihood of being hospitalized for preventable reasons.⁶⁰ 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 push many low-income Americans away from obtaining timely primary care.

A. The Importance of Expanding Medicaid

State decisions to expand Medicaid eligibility to all low-income adults under 133% of the federal poverty level, as authorized under the ACA, is associated with higher levels of insurance coverage and improved health care outcomes.⁶¹ All five case study states made the decision to expand Medicaid, and in all states this decision resulted in a reduction in uninsurance rates.

*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).

B. Making Enrollment Easier

Still, a persistent minority of eligible low-income Americans face barriers when trying to sign up for subsidized insurance or Medicaid. According to one safety net provider, some patients find the enrollment process, especially for Marketplace plans, to be complicated and cumbersome, and choose to forgo coverage. At least one study state, Maryland, recently enacted an Easy Enrollment Health Insurance Program, which allows people to opt into insurance coverage while filing their tax return. Though the program was only implemented recently in 2019, early evaluation shows that the program resulted in a modest increase in enrollment, especially among low-income working adults, who make up a disproportionate share of the uninsured.

Recommendation 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.

C. Providing Financial Assistance to Undocumented Immigrants

Though Medicaid expansion and Marketplace premium subsidies have made insurance coverage accessible for many, undocumented immigrants continue to be shut out of these programs. Several safety net providers worried about this gap in coverage. One FQHC provider in Detroit serving a predominantly immigrant community does not expect the uninsurance rate among their patient population to fall below 50%. Several FQHCs are required by federal law to offer sliding scale fees to uninsured patients, but patient advocates have found that worry over immigration enforcement can prevent undocumented immigrants from taking advantage of these. At least one insurer in Baltimore offers very low-cost health insurance coverage for those, like undocumented immigrants, who are ineligible for public coverage or Marketplace plans. However, the insurer limits program availability to 100 enrollees a year, which does not meet the needs of the undocumented immigrant community.

Recommendations for state policymakers

1. Assess actions taken by some states to make state-funded coverage available to undocumented immigrants,⁶² and consider adopting similar measures.
2. Explore options for making state-funded premium subsidies available to undocumented immigrants so they can purchase plans either from a state-based ACA Marketplace (this might require a federal 1332 waiver) or outside the ACA Marketplace.⁶³

D. Making Marketplace Coverage Affordable

While Medicaid beneficiaries are shielded from unaffordable premiums and high out-of-pocket costs, ACA marketplace enrollees are frequently subject to these financial barriers to primary care. Families with incomes just above the Medicaid eligibility threshold are particularly vulnerable. One safety net provider finds that even when premium subsidies are available, many families still purchase cheap catastrophic coverage and have large deductibles. 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 insurance.

In 2021, Maryland enacted a law providing additional insurance subsidies for low-income young adults ages 18 to 34, who are most likely to be uninsured. The goal of this policy is not only to improve insurance coverage rates for this hard-to-reach population, but also to draw young people into the risk pool, which lowers health insurance premiums for everyone. Though it is too soon to evaluate this policy, initial reports suggest that enrollment by young adults increased by 6% during the 2022 open enrollment period.

Recommendations for state policymakers

1. Conduct marketing and outreach to ensure that everyone eligible for Marketplace subsidies, especially low-income families just above the Medicaid eligibility threshold, understands their coverage options.
2. 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.

At least one commercial insurer in Arkansas has sought to combat the issue of high cost-sharing by reducing the rates they pay providers per service and making up the difference by providing a monthly capitation payment to the provider. They have found that this reduces enrollees' cost-sharing by about half, helping many rural Arkansans.

V. Improving Comfort and Communication between Providers and Patients

Primary care is effectively inaccessible if patients cannot comfortably connect or communicate with their providers. Policy initiatives that help build bridges between patient and provider communities include deploying community health workers (CHWs) and encouraging PCPs to provide culturally responsive care.

A. Supporting and Expanding the CHW Workforce

CHWs are public health workers who serve as liaisons between local communities and medical providers by engaging vulnerable residents and helping them access medical and social

services. CHWs are frequently members of the communities they serve, which helps build relationships. Evidence links CHWs to improved health outcomes, increased trust between patients and providers, and reduced costs.⁶⁴

Creating Reimbursement Pathways for CHWs. Despite the value CHWs bring to underserved communities, establishing long-term and sustainable funding streams to support the CHW workforce has been challenging. During the COVID-19 pandemic, the federal government invested about \$500 million in the CHW workforce to help underserved communities weather the pandemic.⁶⁵ However, as this funding runs out, community organizations and health departments have laid off hundreds of CHWs.⁶⁶ Providers and CHW advocates in four case study sites said that CHWs are frequently paid through grants, and that this can create barriers for primary care clinicians who want to integrate CHWs more fully into their organizations because the grants might not be renewed.

Recommendation for state policy-makers

1. Explore allowing CHWs to bill Medicaid and requiring MCOs to make CHW services more accessible to beneficiaries.

Recommendation for state policy-makers and researchers

1. Conduct surveys like the one recently fielded by the Maryland Department of Health to better understand how many primary care providers are tracking outcomes related to CHW services, and which outcomes they are tracking. Assess the value of at least temporarily standardizing the outcome measures employers are using to allow for easier comparison and study.

Recommendation for CHW advocates, providers, state policymakers, and researchers

1. Compile outcome information from primary care providers employing CHWs to demonstrate the return on investment in hiring CHWs to legislators and payers.

One potential solution is to allow CHWs to bill Medicaid by making CHW services reimbursable. Of the five study sites, Michigan and New Mexico reimburse CHW services through Medicaid;⁶⁷ the Michigan legislature allocated \$28.3 million for Medicaid reimbursement of CHW services in 2023.⁶⁸ Michigan and New Mexico also set requirements for Medicaid MCOs to ensure that beneficiaries can access CHW services. Michigan requires MCOs to make one CHW available for every 5,000 beneficiaries and New Mexico requires CHW salaries, training, and service costs to be paid out of MCO administrative costs.⁶⁹

Advocates in Michigan credited studies demonstrating that CHWs generate cost savings as instrumental in securing funding for CHW services. Providers in Baltimore, Maryland, and Columbia County, Arkansas, found that demonstrating this return on investment and getting payers to reimburse for CHW services has not been easy. However, a recent report based on a survey by the Maryland Department of Health found that the vast majority of CHW employers surveyed already track and link health outcomes to CHW services, and the state sees an opportunity for quantifying their value.⁷⁰

Developing Training and Certification Infrastructure. Lack of standardized training and certification of CHWs makes payers more hesitant to pay for their services and some providers are hesitant to integrate them into care teams. Of the five study states, only Maryland and New Mexico currently oversee the certification and training of CHWs through their respective Departments of Health.

Recommendations for state policymakers

1. Adopt and standardize the certification and training of CHWs.
2. Establish an office within the health department specifically dedicated to supporting the CHW workforce.

In Arkansas and Michigan, the state CHW association has established certification and training requirements. Advocates in Arkansas are pushing the state legislature to codify requirements set by the CHW association and to require the Arkansas Department of Health to certify CHWs. Advocates believe that a more official state-run certification process will encourage more providers to incorporate CHWs in their practices. West

Virginia, however, according to state leaders, has been “very far behind” surrounding states in terms of building a regulatory infrastructure for its CHW workforce. A newly formed CHW consortium along with the state AHEC, medical schools, and FQHCs are working together to fill in some of the gaps left by a lack of state leadership.

Encouraging Providers to Integrate CHWs. CHW advocates across all study states spoke of varying levels of difficulty in getting providers to integrate CHWs into their care teams. Stakeholders familiar with CHW workforce issues in Arkansas have found that hospitals and FQHCs are often more receptive to CHWs than private practices, and that younger practitioners are more open to them than older ones. In Michigan, however, some primary care providers are recognizing the value offered by CHWs and are paying local residents to undergo CHW training. At least two state-run practice transformation efforts—MDPCP in Maryland and the State Innovation Model in Michigan—have encouraged participating practices to incorporate CHWs into their teams and to use incentive payments to pay for CHW services. In Michigan, even once the model ended, several participating practices continued to employ CHWs.

Recommendation for state and federal policymakers overseeing practice transformation and payment reform efforts

1. Explore options to encourage participating practices to employ CHWs and track their impact on patient access, satisfaction, and health outcomes.

B. Providing Culturally Responsive and Patient-Centered Care

Providers across all five case study sites attested to the importance of providing culturally responsive and patient-centered care in building trusting relationships with the communities they serve.

Prioritizing Diversity in Hiring. Provider organizations can build better ties with patient communities with clinicians and staff that reflect the racial and ethnic composition of the community they serve. Several studies demonstrate that patients are more willing to trust and receive necessary health services from providers they can relate to.⁷¹ One clinic in Columbia County, Arkansas attributes their high level of community engagement to six of their nine providers being people of color. A Detroit clinic reports that it is "intentional" about hiring Black women for staff and medical positions. Interviewees believe doing so has created a "more welcoming and positive experience for many of their patients."

Several providers also emphasized the importance of nurturing diversity upstream, especially during residency training, noting that this can have a positive impact on trainees and patient communities. Staff with a Baltimore residency program have found that their diversity, equity, and inclusion initiatives have helped them recruit residents from communities underrepresented in medicine. A residency program in Detroit has intentionally built a diverse resident class, in part through outreach to historically black colleges and universities and the development of marketing and outreach materials that speak of the residency program's value of diversity.

Recommendations for residency programs and primary care clinics operating in underserved areas

1. Establish staff positions for the promotion of diversity, equity, and inclusion.
2. Assess hiring criteria to ensure that community needs are being adequately considered as a factor.

Recommendation for state policymakers

1. Provide funding and technical assistance to practices embarking on new efforts to prioritize diversity.

Conducting Community Outreach. In addition to diversifying the providers serving underserved communities, many practices relied on targeted community outreach to hard-to-reach populations. For example, the Baltimore residency program encourages residents to participate in the local neighborhood association and to conduct community site visits

[‡] On June 29, 2023, the Supreme Court ruled that race-conscious college admissions processes violate the Constitution in *Students for Fair Admissions Inc. v. President & Fellows of Harvard College*. This decision might have an impact on efforts by medical schools and residency programs to recruit diverse candidates from communities underrepresented in medicine.

to provide basic preventive services. Providers in Columbia County, Arkansas, and Detroit, Michigan, have also developed partnerships with community organizations and church groups to build trust with the community. One Detroit clinic manager found that creating a "community advisory committee," in which stakeholders discuss how to conduct community outreach in a culturally responsive manner, has proven valuable.

Recommendation for residency programs and primary care clinics operating in underserved areas

1. Build partnerships with community organizations and faith-based groups to build trust with patient communities.

Recommendation for state policymakers

1. Provide funding to support providers in underserved areas conducting community outreach.

Centering Patient Needs. The case studies highlighted the importance of reworking how providers interact with patients to ensure that patients feel heard. One FQHC trains providers to move away from "this is my plan for you" to "what's our plan together?" A provider in Columbia County, Arkansas, found that many patients are confused when physicians use "jargon or scary language" and encourages finding ways to communicate with patients with language or health literacy barriers. In Kanawha County, West Virginia, providers are focusing on training health professions students on opioid use and dismantling prejudices that many might have about it.

The use of appointment wait times to measure patient access to care can be counterproductive. Some informants argue that such metrics force providers to emphasize clinical efficiency over the needs of the complex patient population they see. At least one FQHC in Baltimore City that serves a particularly high-need population has chosen to expand appointment times per patient from 15 to 30 minutes, and they find that this has made both providers and patients happier.

Recommendation for residency programs and primary care clinics operating in underserved areas

1. Train providers to center patient needs and appropriately interact with patients facing communication barriers or stigma associated with diseases such as opioid use disorder.

Recommendation for federal and state policymakers

1. 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.

VI. Planning for Population Health and Primary Care Needs

A central convener to bring together providers, social services organizations, state and local government officials, patient representatives, and payers can be an effective mechanism to plan for a community's population health and primary care needs.⁷² However, in the three urban case study locations—Baltimore, Detroit, and Charleston, within rural Kanawha County—interviewees said that various stakeholders were operating in silos and they lacked leadership to bring them together. Even when state and local governments have convened primary care stakeholders, many efforts have been piecemeal and narrowly focused on specific issues like diabetes care, instead of on broadly improving access to and quality of primary care. One local health official in Baltimore found that while most stakeholders in the city recognize the need for better access to primary care, they have different ideas on how to achieve this.

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 Grant County, New Mexico, and Baltimore, Maryland have waxed and waned in response to the vagaries of federal and state funding availability. Most recently, the government response to the COVID-19 pandemic funded local and community efforts to coordinate health care services across the country, but stakeholders worry about finding ways to sustain these gains once the pandemic funding runs out.

Comparing the two rural areas studied—Grant County, New Mexico, and Columbia County, Arkansas—it's clear that the Grant County Community Health Council played a significant role in improving access to primary care by expanding bus routes and most importantly, intentionally selecting and inviting an FQHC system to expand into the county. A lack of similar leadership has left the residents of Columbia County without access to an FQHC.

Recommendation for state and federal policymakers

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

RECOMMENDATIONS

Recommendations for federal policymakers

- **Increasing Availability of Primary Care Providers**
 - Expand the scale and award amounts for NHSC loan repayment and scholarship programs. Continue funding SLRPs at the higher levels authorized under the American Rescue Plan Act.
 - Ensure that HPSA scores consider the number of providers who accept and serve uninsured patients and Medicaid beneficiaries.
 - Permanently fund the THCGME program and consider increasing the level of funding for it.
- **Improving Access to Outpatient Clinics for Underserved Communities**
 - 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.
 - For payment reform initiatives already in progress, consider evaluating the impact of the initiative on practice sustainability and access to care for Medicaid and uninsured patients.
 - Continue to fund FQHCs at least at current levels.
 - Provide funding and technical assistance to support local and community leadership in driving a safety net expansion strategy.
- **Removing Structural Barriers to Primary Care**
 - Continue to 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.
 - Explore making audio-only telehealth services reimbursable beyond 2024, especially for safety net providers.
 - Keep evaluating the impact of COVID 19-related telehealth reimbursement flexibilities to ensure that they are improving health outcomes and not reinforcing health disparities.
 - Encourage providers participating in practice transformation efforts and alternative payment models to use additional funding to decrease disparities in telehealth.

- 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.
- **Improving Comfort and Communication between Providers and Patients**
 - Explore options to encourage practices participating in federal alternative payment models to employ CHWs and track their impact on patient access, satisfaction, and health outcomes.
 - 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.
 - Invest in developing and sustaining local health councils specifically focused on meeting their locality's population health and primary care needs.

Recommendations for state policymakers

- **Increasing Availability of Primary Care Providers**
 - Leverage federal Medicaid dollars to fund expansion of primary care residency spots in underserved areas of the state.
 - Assess whether in-state medical students are more likely to practice locally if they also receive their residency training in state.
 - Assess whether efforts to bypass the national resident match (like the WVU School of Medicine's waivers) improve recruitment and retention of primary care providers in underserved areas.
 - 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.
 - Require local employers who benefit from provider placements to contribute to funding for SLRP and other state-run loan repayment and scholarship programs.
 - Tailor SLRP award amounts to actual debt owed by candidates instead of providing a flat dollar amount to increase the number of recipients who benefit from the program.
 - Respond to the changing market for PCP recruitment by increasing award amounts or lifting penalties associated with defaulting on a program's service obligations.

- Improve outreach to potential program participants. Streamline program offerings and application processes to minimize applicant burden and confusion. Ensure that potential participants understand how they can combine the benefits of different programs.
- Participate in multi-state collaborative efforts, such as the National Rural Recruitment and Retention Network's (3RNet) Provider Retention & Information System Management (PRISM) program to improve participant tracking and program evaluation.
- Support the development of residency programs in FQHCs and other community health centers by developing a learning collaborative of all state residency program directors.
- 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.
- Provide technical assistance and support to help safety net clinics in underserved areas take better advantage of the Conrad-30 program.
- Study the impact of increased Medicaid reimbursement on PCP participation in Medicaid, primary care practice sustainability, PCP burnout, and resident decisions to continue practicing primary care.
- States that have not already eased scope-of-practice restrictions on APPs consider doing so.
- Focus APP recruitment efforts towards recruiting students from underserved areas and establishing more training opportunities for APPs in rural areas and safety net settings, such as FQHCs, and less on financial incentive programs, such as loan repayment and scholarship opportunities. Ensure that these efforts are being comprehensively and periodically evaluated for effectiveness.
- 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**
 - 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.
 - For payment reform initiatives already in progress, consider evaluating the impact of the initiative on practice sustainability and access to care for Medicaid and uninsured patients.
 - Develop tax incentives to spur hospital investment in primary care. Leverage state community benefit requirements to promote primary care investment by hospitals.
 - States that have not expanded Medicaid yet should do so.
 - Fund FQHCs to support an increase in capacity and services.
 - Provide funding and technical assistance to support local and community leadership in driving a safety net expansion strategy.
 - 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.
 - Assess and remove any barriers to Medicaid reimbursement for SBHCs.⁷³
- **Removing Structural Barriers to Primary Care**
 - Review the performance of NEMT 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.
 - Develop alternative payment strategies, such as performance targets with bonuses and penalties, that incentivize high quality NEMT services.
 - Study the outcomes of state experiments using apps such as Uber, Lyft, Veyo, and FlyWheel, and evaluate whether these alternative delivery models could perform better than traditional NEMT services.
 - When developing alternative payment models, ensure that practices are encouraged and able to reinvest a portion of additional earnings towards mitigating transportation barriers.
 - Assess and remove barriers to Medicaid reimbursement for primary care provided through mobile health vans.

- Continue to 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.
- Explore making audio-only telehealth services reimbursable beyond 2024, especially for safety net providers.
- Keep evaluating the impact of these telehealth reimbursement flexibilities to ensure that they are improving health outcomes and not reinforcing health disparities.
- Encourage providers participating in practice transformation efforts and alternative payment models to use additional funding to decrease disparities in telehealth usage.
- 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.
- **Making Primary Care More Affordable**
 - 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.
 - Remove bureaucratic barriers to Medicaid eligibility determinations and enrolling in coverage.
 - Assess actions taken by some states to make state-funded coverage available to undocumented immigrants,⁷⁴ and consider adopting similar measures.
 - 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.⁷⁵
 - Conduct marketing and outreach to ensure that everyone eligible for Marketplace subsidies, especially low-income families just above the Medicaid eligibility threshold, understands their coverage options.
 - 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 Comfort and Communication between Providers and Patients**

- Explore allowing CHWs to bill Medicaid and requiring MCOs to make CHW services more accessible to beneficiaries.
- Compile outcome information from primary care providers employing CHWs to demonstrate the return on investment in hiring CHWs to legislators and payers.
- Conduct surveys like the one recently fielded by the Maryland Department of Health to better understand how many primary care providers are tracking outcomes related to CHW services, and which outcomes they are tracking. Assess the value of at least temporarily standardizing the outcome measures employers are using to allow for easier comparison and study.
- Adopt and standardize the certification and training of CHWs.
- Establish an office within the health department specifically dedicated to supporting the CHW workforce.
- Explore options to encourage practices participating in state alternative payment models to employ CHWs and track their impact on patient access, satisfaction, and health outcomes.
- Provide funding and technical assistance to practices embarking on new efforts to prioritize diversity.
- Provide funding to support providers in underserved areas conducting community outreach.
- 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.
- Invest in developing and sustaining local health councils specifically focused on meeting their locality's population health and primary care needs.

Recommendations for medical schools and residency programs

- **Increasing Availability of Primary Care Providers**
 - Assess whether in-state medical students are more likely to practice locally if they also receive their residency training in state.
 - Assess whether efforts to bypass the national resident match (like the WVU School of Medicine's waivers) improve recruitment and retention of primary care providers in underserved areas.

- **Improving Comfort and Communication between Providers and Patients**

- Establish staff positions for the promotion of diversity, equity, and inclusion.
- Assess hiring criteria to ensure that community needs are being adequately considered as a factor.
- Build partnerships with community organizations and faith-based groups to build trust with patient communities.
- Train providers to center patient needs and appropriately interact with patients facing communication barriers or stigma associated with diseases such as opioid use disorder.

Recommendation for non-physician health professions schools

- **Increasing Availability of Primary Care Providers**

- Focus APP recruitment efforts towards recruiting students from underserved areas and establishing more training opportunities for APPs in rural areas and safety net settings, such as FQHCs, and less on financial incentive programs, such as loan repayment and scholarship opportunities. Ensure that these efforts are being comprehensively and periodically evaluated for effectiveness.

Recommendations for safety net providers

- **Increasing Availability of Primary Care Providers**

- 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**

- For SBHC administrators, conduct periodic evaluations of SBHC clinical outcomes and impact on system-wide costs.

- **Improving Comfort and Communication between Providers and Patients**

- Establish staff positions for the promotion of diversity, equity, and inclusion.
- Assess hiring criteria to ensure that community needs are being adequately considered as a factor.
- Build partnerships with community organizations and faith-based groups to build trust with patient communities.

- Train providers to center patient needs and appropriately interact with patients facing communication barriers or stigma associated with diseases such as opioid use disorder.

Recommendations for public and private payers

- **Improving Access to Outpatient Clinics for Underserved Communities**
 - When implementing population-based payment models for hospitals, consider including more prescriptive standards on how hospitals should invest their savings into primary care.
 - When implementing payment reform efforts, ensure that local communities' input and needs are considered.
- **Removing Structural Barriers to Primary Care**
 - Incorporate mobile health vans into care delivery strategies.

Recommendations for local and community leadership

- **Improving Access to Outpatient Clinics for Underserved Communities**
 - Assess the need for safety net clinical sites in the community and include the local provider community into the decision-making process. Proactively plan for the community's primary care needs by leading discussions around establishing new FQHC sites.
 - Conduct outreach and education about the value of SBHCs and develop of process for soliciting and incorporating community input on the establishment of SBHCs.
- **Removing Structural Barriers to Primary Care**
 - Invest in public transportation as part of a broader population health strategy.

Recommendations for researchers

- **Increasing Availability of Primary Care Providers**
 - Study the impact of increased Medicaid reimbursement on PCP participation in Medicaid, primary care practice sustainability, PCP burnout, and resident decisions to continue practicing primary care.
 - Study the short- and long-term impacts of different payment arrangements on provider burnout. Consider whether the increased administrative burdens associated with heightened reporting requirements are balanced by the reduction in burnout associated with transitioning to team-based care.

- Study the impact of easing these restrictions on access to appointments, continuity of care, quality of care, and health care outcomes.
- Further study the factors influencing NP and PA decisions to practice long-term in rural areas and underserved settings, such as FQHCs.
- **Improving Access to Outpatient Clinics for Underserved Communities**
 - Conduct periodic evaluations of SBHC clinical outcomes and impact on system-wide costs.
- **Removing Structural Barriers to Primary Care**
 - Evaluate the effectiveness of pilot and demonstration programs that aim to make telehealth more accessible to underserved communities, such as older adults, racial and ethnic minority communities, and rural communities.
- **Improving Comfort and Communication between Providers and Patients**
 - Compile outcome information from primary care providers employing CHWs to demonstrate the return on investment in hiring CHWs to legislators and payers.
 - Conduct surveys like the one recently fielded by the Maryland Department of Health to better understand how many primary care providers are tracking outcomes related to CHW services, and which outcomes they are tracking. Assess the value of at least temporarily standardizing the outcome measures employers are using to allow for easier comparison and study.

CONCLUSION

Many Americans, especially those from underserved and low-income communities, struggle to access affordable primary care services. Rural communities have an aging provider population, challenges recruiting and retaining young providers, and isolation driven by inaccessibility of public transportation and broadband internet. Urban underserved communities live next door to wealthier communities and university hospitals, but primary care is still out of reach because of unreliable public transportation, private practices limiting or refusing to see uninsured or Medicaid patients, and a lack of available appointments at local safety net clinics.

Driving a lot of these issues is the PCP shortage, which is the result of decades of underinvestment and undervaluing of primary care in medical education, reimbursement policy, and research. It is time for an overhaul of policies to encourage medical students to pursue careers in primary care, pay for primary care, and prevent burnout among PCPs.

Safety net clinical sites, such as FQHCs and SBHCs, are critical to access to primary care for underserved populations. However, the lack of guaranteed and sufficient funding prevents these provider sites from strategically expanding and reaching larger proportions of underserved populations.

The expansion of mobile health and telehealth, spurred by the COVID-19 pandemic, offers a hopeful path toward making primary care more accessible. While recent federal and state investments in these modalities are a step in the right direction, research is necessary to ensure that they do not exacerbate any preexisting disparities in access to quality primary care.

The relationship between provider and patients from underserved communities has always been strained due to a lack of trust, and the COVID pandemic has contributed to greater mistrust of medical and public health expertise. It will be critical to invest in strategies to repair and strengthen the provider-patient relationship, such as strengthening the CHW workforce and making primary care more culturally responsive.

Our case studies demonstrate that many stakeholders—policymakers, providers, payers, patient advocates—are engaged in a number of initiatives to improve access to primary care, but the impact of these efforts remains muted in many cases. State and community-level leaders need to conduct research, planning, and effective oversight to respond to this complex web of factors contributing to primary care access gaps and develop a responsive population health strategy.

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