

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

A CASE STUDY ANALYSIS OF COLUMBIA COUNTY, ARKANSAS

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ABSTRACT

This case study of Columbia County, Arkansas, is the third in a series of case studies designed to assess the effectiveness of various policy initiatives to expand access to primary care in a region, particularly for underserved populations. Columbia County is a rural county with a higher proportion of Black residents than the rest of Arkansas. The median income of Columbia County is significantly lower than the rest of the state, and about a fifth of the county's residents fall below the poverty line. The county is classified as a primary care health professional shortage area, and the underserved residents of the county experience several barriers to accessing primary care.

The entire state of Arkansas, including Columbia County, is experiencing a significant shortage of primary care physicians. A lack of medical schools and residency training opportunities in the region have made it especially difficult for health systems and provider groups in Columbia County to recruit and retain new doctors. The high demand for primary care physicians and the large compensation packages that big, more urban hospital systems can offer have made it difficult, if not impossible, for outpatient family medicine clinics in areas like Columbia County to compete. Recently enacted scope-of-practice expansions for nurse practitioners and other non-physician providers could help alleviate some of the provider shortages experienced by Columbia County and other rural areas in the state.

Columbia County currently has no federally qualified health centers (FQHCs) or school-based health centers, but it does have a rural health clinic that serves as a safety net provider for the community. Many residents of the county also lack access to transportation, and few providers offer after-hours appointments. While the COVID-19 pandemic has spurred an increase in the use of telehealth, the benefits have not been widely shared, as many residents do not have smartphones or high-speed broadband.

A few of the state's health policy decisions have helped improve access to primary care for underserved populations. Expanding Medicaid has helped make primary care more affordable. The state has also encouraged a Medicaid patient-centered medical home program that has helped primary care practices deliver higher-quality care. However, these efforts have been insufficient in terms of improving access to primary care in Columbia County. The state's investment in primary care, whether in terms of improving recruitment and retention of primary care clinicians or supporting the expansion of safety net clinics, has been limited and piecemeal. Counties like Columbia County lack the financial and systemic support necessary to strategize about improving population health in the long term.

INTRODUCTION

It is difficult to overstate the importance of primary care to ensure robust population health outcomes. Evidence shows that not only can primary care prevent illness and death,¹ but it is also associated with a reduction in health disparities.² 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,³ as well as improved management of chronic diseases.⁴ Unfortunately, the United States falls short on many indicators that demonstrate the strength of a nation's primary care system.⁵

To strengthen a primary care system, a key issue to consider is how to improve access. 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.⁶

In a Milbank Memorial Fund issue brief⁷ and five accompanying fact sheets,⁸ we assessed the evidence to determine whether policy initiatives that target primary care access have reduced health care disparities. Now, in this series of five case studies, we assess the impact of these policy initiatives at a local level to better understand implementation challenges and successes. The first two case studies focused on Grant County, New Mexico,⁹ and Baltimore City, Maryland.¹⁰

This case study, the third in the series, focuses on efforts to improve access to primary care in Columbia County, Arkansas. The final two case studies will focus on one urban primary care health professional shortage area and one rural primary care health professional shortage area, both with relatively large historically underrepresented or low-income populations.

BACKGROUND

Geography and Demographics

Columbia County is located in the southwest corner of Arkansas, bordering Louisiana. The county has a population of about 22,600 people¹¹ with a population density of roughly 30 people per square mile, which is well below the national average of 90 people per square mile. The county is federally designated as a rural county.¹² About half of Columbia County's population is concentrated in the county seat, Magnolia.¹³ (See Figure 1.) While other areas of the state — particularly northwest Arkansas — have seen steady population growth over the last decade,¹⁴ the southern counties, including Columbia County, have experienced a considerable decline in population, with Columbia County losing about 8% of its population since the 2010 census.¹⁵

Columbia County has a higher proportion of Black people than the rest of the state and the country. Over 35% of Columbia County residents are Black, compared with the state average of 15.7% and the national average of 13.6%.¹⁶ The county's households have a median income just shy of \$38,000, which is significantly lower than the state average of \$49,475.¹⁷ Almost

Figure 1. Columbia County, Arkansas



a fifth of Columbia County residents fall below the poverty line, compared with the state average of 16.3% and the national average of 11.4%.¹⁸ The county's unemployment rate has fluctuated throughout the pandemic, hovering around 5% as of June 2022 – slightly higher than the corresponding statewide unemployment rate of 3.2%.¹⁹

Despite higher-than-average levels of poverty and unemployment, Columbia County has a relatively low proportion of residents without health insurance: 9.8% in July 2021, compared with the national average of 10.2%.²⁰ Arkansas is one of the 39 states that expanded access to Medicaid for low-income adults under the Affordable Care Act (ACA), and this expansion in 2013 reduced the state's uninsurance rate by 12.3 percentage points.²¹ According to one estimate, 38.1% of county residents are covered under employee plans, 25.9% through Medicaid, 14% through ACA marketplace plans, and 13.5% through Medicare.²²

The federal government uses two main designations for areas and populations experiencing primary care provider shortages: primary care health professional shortage area (primary care HPSA) and medically underserved area/population (MUA/P). Columbia County is designated as a shortage area under both measures.

Primary Care Provider Shortage Designations

Health professional shortage area (HPSA) scores provide a basis for determining eligibility and resources for several federal and state programs targeting primary care access across the country. The federal government designates areas as primary care HPSAs when they have (1) a high population-to-primary-care-provider ratio, (2) a high percentage of population below the federal poverty line, (3) poor infant health quality, and (4) longer travel times to the nearest source of care. The federal government scores HPSAs from 0 for the areas with the lowest need to 25 for those with the highest need. With a score of 21, Columbia County is a federally designated primary care HPSA, specifically for low-income populations.²³

Medically underserved area/population (MUA/P) designations are the basis of eligibility for the federally qualified health center program and the federally qualified health center look-alike program. MUA/P designations depend on an Index of Medical Underservice (IMU) score, which is based on (1) number of primary care providers per 1,000 people, (2) percentage of population at the federal poverty level, (3) percentage of population over 65, and (4) infant mortality rate. IMU scores fall between 0 and 100, and a score of 62 or below results in a MUA/P designation. Since 1999, Columbia County has been a designated MUA with an IMU score of 58.4.²⁴

Key Stakeholders

Numerous state and local entities are involved in Columbia County's primary care landscape. At the state level, the **Rural Health & Primary Care Office** within the Arkansas Department of Health administers a variety of federal and state grants to bolster the state health care workforce, provider loan repayment, charitable health clinics, and investment in rural hospitals.²⁵ The office also provides technical assistance to new and established rural primary care sites. **Arkansas School Health Services** is a partnership between the Arkansas Department of Health and the state Department of Education,²⁶ which provides funding and other support for the creation of school-based health centers (SBHCs) in school districts around Arkansas.²⁷ The **state Medicaid agency** runs a patient-centered medical home program, which plays an important role in supporting primary care practices across the state. (See Box 2.)

Additionally, a variety of nongovernmental organizations support primary care access state-wide. **Community Health Centers of Arkansas** provides financial and programmatic support for community health centers in Arkansas (including federally qualified health centers and rural health centers).³¹ The **Arkansas Community Health Worker Association** advocates for the interests of CHWs in the state and certifies them.³² **Arkansas Foundation for Medical Care (AFMC)** partners with public and private payers as well as providers in Arkansas to develop and implement strategies to improve health outcomes while reducing costs.³³ AFMC is also responsible for overseeing the nonemergency medical transportation benefit for Medicaid beneficiaries in the state. The **Arkansas Rural Health Partnership** is a network of rural hospitals, medical schools, and FQHCs in south Arkansas that run workforce pipeline programs and offer insurance enrollment assistance through certified CHWs.³⁴

Arkansas Medicaid's PCMH Program

The state Medicaid agency created a patient-centered medical home (PCMH) program in 2014 to improve population health; enhance quality, access, and reliability of care; and control health care costs. PCMH is a voluntary program, and primary care providers (PCPs) who enroll receive a per member per month payment to help them transform their practices to be more team-based and population health-focused as well as to provide care coordination services. These payments are in addition to their usual fee-for-service payments.

To enroll in the PCMH program, practices have to see a minimum of 150 Medicaid patients, and this minimum number has been reduced since the program began to allow more practices in the state to enroll. Other conditions of participation include ensuring 24/7 phone access to a provider, offering same-day appointments, and using electronic medical records. About 200 practices (92% of the practices in the state) are enrolled in the program, covering about 350,000 Medicaid beneficiaries. Since many of the conditions for participation require practice-wide changes, even non-Medicaid patients of participating practices have seen some spillover benefits from the PCMH program.²⁸

Participating practices with sicker or older patients receive higher monthly payments and are also eligible for bonus payments for meeting certain quality and utilization metrics. According to stakeholders familiar with the program, PCPs have used these monthly payments in a variety of ways to improve access: purchasing vans to provide transportation in rural areas, allowing nurses to perform home visits with iPads so they can connect patients with their doctors via video calls, hiring care coordinators and community health workers (CHWs), and developing telehealth capabilities in response to the COVID-19 pandemic.

In Arkansas, the state Medicaid agency pays commercial insurers premiums to purchase coverage for the Medicaid expansion population. These commercial payers have collaborated with the state Medicaid agency to develop their own PCMH programs that align with the state-run PCMH program.²⁹ They try to use similar quality metrics and impose similar structural demands on participants.³⁰ These multipayer efforts have helped expand the PCMH model and achieve higher levels of practice transformation.

Columbia County has a few key primary care providers:

- University of Arkansas for Medical Sciences (UAMS) sponsors 21 primary care “regional campuses”³⁵ across the state that serve as clinical sites for patient care and medical resident rotations. In 2012,³⁶ UAMS took over operations of Columbia County’s only rural health clinic (RHC; see Box 3) and created the **UAMS Health Family Medical Center** in Magnolia.³⁷ In 2013, UAMS established a three-year family medicine regional training program in Magnolia, but in June 2022, UAMS shut it down, citing plans to restructure it as a rural training track residency program.³⁸ UAMS continues to operate the family medical center. The center participates in the state Medicaid agency’s PCMH program and is one

of the few providers in the county that accepts Medicaid patients.

- **Magnolia Regional Medical Center** is a 49-bed, city-owned acute care nonprofit hospital,³⁹ which runs a number of local outpatient clinics providing both specialty and primary care. The primary care clinics affiliated with the Magnolia Regional Medical Center include the **Magnolia Family Medical Clinic**, run by two nurse practitioners (NPs) with physician oversight;⁴⁰ the **Magnolia Murphy Clinic**,⁴¹ which cares for older patient populations; and the **Magnolia Primary Care Clinic**, located inside the Magnolia Multispecialty Center and led by a physician and an advanced practice registered nurse.
- Columbia County has a few other **private practices** and one **urgent care clinic** that provide some primary care services to county residents, but most providers who accept Medicaid patients are affiliated with UAMS or Magnolia Regional Medical Center.⁴²

The **Columbia County Health Unit**,

affiliated with the Arkansas Department of Health, serves as the county's public health department. This department has a limited presence in the county, but it coordinates public health programs and provides a small number of primary care services, such as family planning, HIV testing, and immunizations.⁵²

Methodology

To better understand how policy interventions and stakeholder efforts have impacted primary care access in Columbia County, we conducted 10 qualitative interviews with local and state stakeholders including health care providers, advocates, researchers, and government officials with ties to Columbia County and/or knowledge of rural primary care in Arkansas. Interviews occurred between July 6, 2022, and August 4, 2022.

Rural Health Clinics

The rural health clinic (RHC) designation was created by Congress in 1977 to improve the supply of physicians treating Medicare beneficiaries in underserved rural areas, and to increase the use of nurse practitioners (NPs) and physician assistants (PAs) in rural areas.⁴³ To qualify as a RHC, the practice has to be located in a rural area that is a federally designated primary care shortage area.⁴⁴ The practice also has to employ a NP or PA who works at the clinic for at least 50% of the operating hours.⁴⁵ RHCs are paid enhanced reimbursement rates for providing services to Medicare and Medicaid beneficiaries. Practices receive⁴⁶ an all-inclusive rate per visit for qualified primary and preventive services.⁴⁷ As of 2022, about 4,400 rural health clinics provide care to around 7 million people across the country,⁴⁸ but one report found that 388 rural health clinics had shut down between 2012 and 2018.⁴⁹ In 2021, Congress allocated over \$470 million in funding for RHCs to help them maintain and expand their COVID-19 testing and mitigation services.⁵⁰ Eligible RHCs received a flat payment of up to \$100,000.⁵¹

Descriptive Analysis and Findings

1. Availability of Primary Care Clinicians

A Dwindling Population and an Aging Cohort of Providers Contribute to Primary Care Provider Shortages

One local leader described Columbia County as a “no-growth area.” Several local stakeholders expressed concern over the departure of younger people, including PCPs, from the area because of the higher pay and amenities that bigger cities can offer. Stakeholders familiar with the primary care landscape in the county said that local PCPs skew older and are close to retiring, but no younger doctors are available to take their place.

Further, given the low supply of PCPs and the high demand for their services, there are many demands on the time of a rural PCP, making the job even less attractive. As one stakeholder put it, “the new generation of doctors do not want to be that small-town doctor everybody is calling at midnight. They want to be able to clock in and clock out.” In fact, one local provider recalls that residency applicants for the local family medicine residency program were willing to “take less money if they did not have to [be on call].”

However, some are pinning their hopes on the PCMH model, arguing that shifting primary care practices to a team-based model can make them more attractive to younger practitioners. According to a state Medicaid official, in neighboring El Dorado county, a local practice, SAMA HealthCare Services,⁵³ “went from being desperate to hire people to having people knocking on doors wanting to join the practice.” They attributed this to reduced burnout from the implementation of team-based care.

Lack of Medical Training Opportunities

Significant evidence shows that rural areas can improve recruitment and retention of PCPs when they provide medical training opportunities in the area⁵⁴ and recruit candidates with local ties or from other rural areas to participate in these training opportunities.^{55, 56} Until 2014, Arkansas had only one medical school. In 2015 and 2017, the state became home to two new osteopathic colleges,^{57, 58} which are institutions that train osteopathic physicians (DOs), who are licensed to practice medicine and perform surgery much in the same way that graduates of medical school (MDs) are. While DOs tend to practice primary care more often than MDs,⁵⁹ it is unclear whether Columbia County is likely to benefit from these new schools, given that both schools are located in northern parts of the state. Local providers are optimistic, however, that because these new schools seem to have a focus on recruiting from rural areas, the new graduates might be more receptive to working in an area like Columbia County.

Residency training after medical school is also an important opportunity to attract young physicians to practice in rural areas like Columbia County. Until June 2022, UAMS ran a family medicine residency program out of a regional campus in Magnolia, the county seat. Residents practiced at the UAMS-run family medicine clinic as well as the Magnolia Regional Medical Center, the local acute care hospital. Unfortunately, to the disappointment of several local stakeholders, UAMS terminated the residency program in June 2022. However, UAMS has announced plans to open a rural training track residency program in the county.

Local providers worried that the shutdown of the residency program would result in the loss of two to three full-time family medicine residents as early as 2022, significantly “impact[ing] the number of clinicians available to the community.” One local leader said that “we really needed those residents.” A stakeholder familiar with some of the inner workings of the residency program attributed the shutdown to difficulties recruiting faculty for the program and a lack of funding.

However, stakeholders familiar with the residency program found that even while it was operational, the program did not always prioritize selecting residents with local ties or from rural areas, which hurt the county’s chance of retaining them. One local provider said that “most of the physicians currently working long-term in Magnolia came from rural areas,” but the residency program often recruited residents from other states and those who had never lived in a rural area before. A local leader mentioned that, before the residency program was shut down, community members had started getting involved in the interview process to help the program better assess whether residency applicants would be the right fit for the community.

Federal and State Recruitment Incentives Fail to Compete

Several stakeholders familiar with recruitment and retention issues in rural Arkansas and Columbia County found that federal and state programs that offer loan repayment or scholarships in return for an obligation to serve in rural underserved areas for a specific amount of time have “not kept pace...with the cost of education and the changing dynamics of [physician recruitment].” Indeed, a poll by a national physician recruitment firm has found that the demand for newly trained doctors, particularly PCPs, far outstrips the supply, with most final-year primary care residents receiving over 50 job offers.⁶⁰ One local stakeholder who has tried recruiting physicians has found that government workforce programs have been “very ineffectual” and do not serve as a “decision maker” for physicians. Because the demand is so high, PCPs can pick a health system employer somewhere else that gives them better financial benefits and imposes fewer obligations.

The federally funded National Health Service Corps loan repayment program offers up to \$50,000 to clinicians who practice in an underserved area for at least two years. The state of Arkansas offers two of its own financial assistance programs to attract more PCPs to rural areas. The Community Match Rural Physician Recruitment Program awards PCPs who have recently completed their residencies \$20,000 a year (\$10,000 provided by the state and \$10,000 by a community in need of a PCP) for four years to practice in the community.⁶¹ The Rural Practice Scholarship Program offers educational loans and scholarships to UAMS medical students who are residents of the state and have financial need in return for an obligation to practice primary care full-time in a qualifying rural community in Arkansas. This program offers \$12,000 a year for four years of medical school.⁶² However, under state law, a physician who defaults on these state programs can lose their license.⁶³ One local leader in Columbia County pointed to this risk as a potential deterrent driving away medical students and residents who might otherwise have been interested in these programs.

Stakeholders mentioned that the strongest financial offers to graduating family medicine residents tend to come from certain large hospitals, which are willing to pay “\$300,000 to \$500,000” in loan repayment, far more than the \$50,000 in loan repayment offered by the federal government and the \$80,000 offered by the state.⁶⁴ One rural provider noted that they have had to “be careful” when offering signing bonuses to new recruits, because if the bonuses are not large enough, hospitals might cover the bonus and hire the recruits away. Another provider called government loan repayment programs “cumbersome” and found that these programs just added “another layer of commitment” for medical residents who “are being inundated with offers of employment in their last year.”

While increasing investment in government loan repayment programs could help rural areas like Columbia County compete with offers from private hospitals in more urban areas, one local provider thought that simply increasing awareness about federal and state workforce programs and their benefits would also help. There “needs to be a more concerted effort to educate practitioners when they are in residency or medical school,” this provider observed.

Scope-of-Practice Expansions for NPs, PAs, and Pharmacists Offer Some Promise

In 2021, the Arkansas legislature enacted bills broadening the scope of what NPs, PAs, and pharmacists can do without the active supervision of a physician. NPs with three years of experience practicing under a collaborative agreement with a physician can now obtain a license to practice independently.⁶⁵ While PAs in the state cannot practice independently, the state legislature added a PA seat to the medical board, allowed PAs to prescribe certain controlled substances, and replaced the requirements for a supervisory “protocol” with a requirement for a “delegation agreement.”^{66,67} The legislature also provided pharmacists the ability to provide vaccinations and immunizations and allowed them to dispense birth control pills without a prescription in many situations.⁶⁸

One local provider predicted that the impact of these bills will be “huge,” and said that the requirement for physician supervision of NPs has meant that their practice is unable to offer as many appointment slots as their NPs can handle. They said that it would be “helpful to have NPs and PAs assisting physicians and supplementing their practice.” However, this provider (a pharmacist) also expressed concern about the fact that patients in rural areas tend to be sicker and have more complex conditions, and wondered whether NPs would be able to provide the same level of care that a physician would.

2. Improving Access to Outpatient Clinics for Underserved Communities

Lack of Trust in Federally Qualified Health Centers

Federally qualified health centers (FQHCs) are community health clinics that primarily serve underserved communities with high rates of uninsured individuals and individuals eligible for Medicaid, Medicare, and the Children’s Health Insurance Program (CHIP).⁶⁹ They receive federal grants to provide no- or low-cost primary care services, and they are eligible to receive enhanced payments for services provided to patients covered under Medicare, Medicaid, and CHIP.⁷⁰ The 12 FQHCs operating in Arkansas serve around 270,000 patients. In the last

year alone, the number of FQHC service sites in the state expanded from around 160 to 190. However, none of these sites are located in Columbia County.

A local leader in Columbia County told us that the county needs an FQHC site to serve the high proportion of Medicaid beneficiaries and low-income individuals in the county. However, when one organization that operates FQHCs in the state tried to expand into the county, local providers and leaders opposed it. According to one local stakeholder, this company's practices have created some "major enemies" both in the county and across the state. In particular, some PCPs have questioned the ethics of this FQHC company using federal funding intended to provide services for the underserved to pay a very high six-figure salary to its CEO.

These concerns are not limited to Arkansas. High pay for FQHC executives is raising eyebrows in other parts of the country as well.⁷¹ Several respondents mentioned a general "ongoing conflict" between FQHCs and other providers in southern Arkansas. State-level policymakers have found that PCPs who practice independently assert that "FQHCs get an unfair advantage because they get paid more" even though this enhanced payment is meant to reimburse FQHCs for uncompensated care. Partly due to this tension, when Arkansas expanded Medicaid under the ACA, it shut down state-level funding for FQHCs, arguing that the increase in Medicaid revenue could make up the difference. However, local leaders mentioned ongoing conversations to bring a new FQHC organization into Magnolia to help address the provider shortage.

[A Limited Number of Primary Care Practices in Columbia County Accept Medicaid](#)

While Columbia County has no FQHCs, its RHC is one of the only practices to accept Medicaid patients in the county. It was no small feat to set up and operate this RHC. A local stakeholder familiar with the process described it as "complicated," with federal rules that place significant administrative burdens on RHC operators. To navigate the bureaucracy, the county required the services of a consultant who specialized in the policies and procedures governing RHCs. This stakeholder also described "a cash flow problem" that can serve as a barrier to setting up RHCs: Medicare pays RHCs a set rate per visit during the first year, and this rate cannot be adjusted to meet the actual needs of the clinic until the following year.

Despite data demonstrating that the vast majority of Arkansas physicians accept new Medicaid patients,⁷² one local provider asserted that finding a primary care provider who accepts Medicaid patients in Columbia County can be a "huge problem" for beneficiaries. Private practices in the county "are really limited in the number of Medicaid patients they take" because of Medicaid's low reimbursement rates. Another local provider worried that the closure of the residency program would further limit access to primary care providers for Medicaid beneficiaries.

Even when Medicaid beneficiaries find an outpatient primary care clinic that will accept their insurance, access issues persist. One local provider who works at a clinic that accepts Medicaid said that while they have "plenty of appointments," they "have no providers to staff them." Almost every stakeholder we spoke to said that given the severe shortage of primary care physicians in the state, expanding the number of outpatient clinics alone would not do much to improve access to primary care.

The School-Based Health Center Model Has Yet to Reach Columbia County

School-based health centers (SBHCs) help children from underserved areas and their families overcome barriers to primary care such as lack of transportation, inability of parents to get time off from work, and unaffordability.⁷³ According to a state public health official, Arkansas has an estimated 68 SBHCs, and over half of them are funded through the state, while about 15 are funded through the federal government or private foundations and 14 are funded by FQHCs. Columbia County has no SBHCs.

The state provides funding to SBHCs through a state tobacco excise tax,⁷⁴ awarding up to half a million dollars over five years for schools to establish new SBHCs. However, according to one state program manager, this grant funding “only goes so far.” The state encourages SBHCs to pursue diversified funding from the federal government, local government, and private entities. It also recommends that SBHCs complete a community assessment to evaluate gaps in care and identify which services are likely to bring in revenue.⁷⁵ One state public health official found that SBHCs often tend to add dental and vision care to bring in additional revenue.

Generally speaking, Arkansas does not regulate its SBHCs. While the clinicians who staff SBHCs are themselves licensed to provide medical services, there is no licensing process for the SBHC itself and no reporting requirements once it is established. SBHCs are permitted to serve the general community beyond the school without any state approval, and according to a public health official, about 60% of the state-funded SBHCs do. Arkansas also allows school districts and providers to bill Medicaid for reimbursement.⁷⁶

Despite state grants and minimal regulatory burdens, SBHCs still struggle to gain a foothold in many parts of Arkansas, including Columbia County. According to a state public health official, SBHCs need “buy-in” from community stakeholders to succeed. The general distrust that local primary care providers have for FQHCs can sometimes extend to SBHCs. A stakeholder familiar with the politics of SBHCs in the state finds that some private practices worry about new SBHCs encroaching on their business. This stakeholder found that having a coordinator to rally the support of local providers and the community, while educating school district officials about the benefits of a healthy student population, can help establish new SBHCs and sustain existing ones.

3. Removing Structural Barriers to Primary Care

Transportation Remains a Major Barrier

Multiple stakeholders emphasized that lack of access to transportation is a significant barrier to primary care access in Columbia County. Many residents do not have reliable access to a personal or family vehicle, and public transportation infrastructure is limited. One local provider responds to this widespread problem by not turning away patients who are late for their appointments.

Arkansas Medicaid enrollees are eligible for nonemergency medical transportation (NEMT) services. These services are provided through a third-party organization that oversees transportation vendors across the state. South Central Arkansas Transit (SCAT) is one of

the vendors that provides NEMT services to Columbia County residents. While the state covers the cost of SCAT's services for Medicaid beneficiaries, SCAT is available "at a reduced rate to any person, regardless of income."⁷⁷ However, as in other states,^{78,79} the utility of the state-provided NEMT services is limited. Beneficiaries are required to request transportation services 72 hours in advance; this requirement hinders patients from accessing time-sensitive primary care services and same-day appointments.

Though Columbia County residents have always struggled to find and use NEMT services, one local stakeholder noted an increase in patients missing primary care appointments over the last five years due to transportation barriers. This stakeholder was unsure of the cause of the broader trend but noted that rising gas prices have been of particular concern to patients, and transportation vendors are asking for more funding from the state.

In other parts of the state, some practices have responded to the limits of the NEMT program by leveraging PCMH program funds to purchase their own vans. One nongovernmental organization deploys a mobile health unit, which reaches about nine different counties. However, similar interventions have yet to make their way to Columbia County.

Improvements in Telehealth Access Due to the COVID-19 Pandemic

According to local providers, much like everywhere else in the country, telehealth utilization in Columbia County increased significantly with the COVID-19 pandemic. According to a local expert, payer reimbursement for telehealth services had "the biggest impact" on availability of these services in the county, because "it became worth the physicians' time" to provide virtual care. Medicaid, Medicare, and private payers in Arkansas are currently required to reimburse providers for telehealth at the same rate as in-person services.⁸⁰

Local providers were encouraged by their patients' willingness to use telehealth during the COVID-19 pandemic, noting that older patient populations in particular appreciated receiving care from home despite sometimes struggling with the technology. Local providers found that lack of smartphones and poor cell service made video calls infeasible, so they pivoted to providing care over telephone. However, one provider noted that some regions of Columbia County even lack sufficient cell service to support telephone calls. Some PCMH practices across the state (although not in Columbia County) reported using their incentive funding to send nurses with iPads to patients' houses to assist with telehealth appointments. This hybrid telehealth and home-based care model has promising implications for reducing the transportation barriers faced by many underserved communities in Arkansas.

Limited Availability of After-Hours Care

After-hours appointments are critical for ensuring access to primary care for low-income patients who have inflexible work schedules, lack paid leave, or face difficulty finding childcare.⁸¹ Access to after-hours appointments in Columbia County is limited. The county seat, Magnolia, has one walk-in urgent care clinic that offers primary care services outside traditional nine-to-five hours and on the weekends,⁸² but the clinic primarily sees privately insured and self-pay patients.

As a condition of participation in the PCMH program, the UAMS Family Medical Center in Magnolia offers a 24/7 phone service connecting patients to an on-call provider or medical professional.⁸³ A provider at the center noted that the clinic tries to extend its availability by not closing for lunch, but the clinic does not offer in-person appointments outside of traditional business hours or on the weekends. Staffing shortages have prevented the clinic from expanding its operating hours.

4. Making Primary Care More Affordable

Structure of Arkansas Medicaid Hinders Access for Some Beneficiaries

As of May 2022, Arkansas has over a million Medicaid and CHIP enrollees, which is double the number of people who were enrolled in these programs around the time Medicaid expansion went into effect in 2013.⁸⁴ While some of this increase can be attributed to temporary changes in Medicaid policies made during the COVID-19 public emergency period,⁸⁵ the majority of the increase in enrollment stems from Medicaid expansion.⁸⁶ Today, over one-quarter of the Arkansas population is enrolled in Medicaid or CHIP, one of the highest proportions in the country.⁸⁷

After enactment of the ACA, Arkansas took a unique approach to Medicaid expansion. Instead of simply extending Medicaid to individuals up to 138% of the poverty line, as most states did, Arkansas received a federal waiver to create a “private option.”⁸⁸ For its Medicaid expansion population (319,000),⁸⁹ the state Medicaid agency purchases coverage from commercial insurers, and these commercial insurers pay providers the same rates they pay for their private marketplace enrollees, which are about 40% higher than the rates Medicaid pays for beneficiaries enrolled in traditional fee-for-service Medicaid. Individuals who are deemed eligible for Arkansas Medicaid enter the traditional fee-for-service delivery system. Beneficiaries then complete a self-assessment questionnaire in which they can choose to identify as “medically frail,” or having more complex health care needs. Individuals that identify as such remain in traditional Medicaid to access additional benefits not available through the commercial insurers.⁹⁰ In 2021, 15% of the Arkansas Medicaid population was covered in the traditional fee-for-service delivery system.⁹¹ Stakeholders are concerned that because of the lower reimbursement rates, traditional Medicaid patients are being “crowded out” of appointment slots by those covered under private plans. This likely places a greater burden on the sickest patients. In Columbia County, only two of the five primary care clinics accept traditional Medicaid patients, while the rest only accept those Medicaid enrollees who are covered through the “private option.”⁹²

Enrollment and Affordability Issues Serve as Barriers to Insurance Coverage

According to a local provider, the uninsurance rate in Columbia County is driven by patients who find enrolling in health insurance too cumbersome. “Some people just don’t want to do the paperwork and go through the steps of enrolling,” especially because they know that they can just go to the emergency room if they really need to. The provider found that this was a problem for both Medicaid and ACA marketplace populations; those eligible but not enrolled in subsidized marketplace plans in particular skewed young and lacked education about the

importance of insurance coverage and primary care. National polls of those eligible but not enrolled in marketplace coverage, however, find that the primary reason people do not sign up is the lack of affordability.

Even those enrolled in health insurance can find health care unaffordable. A provider at the local RHC expressed frustration with the high deductibles that accompany many commercial health insurance plans. At least one commercial insurer in the state has tried to combat this problem by reducing the rates paid to providers for each service and making up the difference through a monthly capitation payment to providers in order to lower enrollees' cost-sharing by about half. They have found this to be a "huge deal," especially in rural Arkansas.

5. Improving Comfort and Communication between Providers and Patients

Building Trust in Medicine

Even when primary care services are available and affordable, primary care remains inaccessible if patients cannot comfortably connect or communicate with their providers. As one local provider put it, "there is general mistrust" of medical providers and institutions in Columbia County. The provider attributed this to the fact that physicians tend to use "confusing jargon or scary language," which hampers patients' ability to "truly understand their disease." The provider emphasized the importance of helping patients understand the disease in terms of consequences for their lives. The provider routinely sees patients who cannot read or write, or who dropped out of school as early as elementary school. During the COVID-19 pandemic, the clinic at which the provider works started using handouts with pictures, which was particularly helpful in giving important information to patients.

Another local provider found that the "race/ethnicity of the provider matters" in Columbia County because of its high proportion of Black residents. The provider has noticed that "if a physician looks like the patient, they are more likely to take their advice." Though this provider's clinic does not have any specific initiatives to recruit providers of color, six out of nine providers working at the clinic in the last year were providers of color. This provider observed a noticeable difference in the level of community engagement these providers were able to generate.

The provider also noted that their clinic partnered with churches to provide COVID-19 vaccines. "In the African American community in the south, church is everything," the provider said, explaining that the preachers helped build trust both in the providers and in the vaccine itself. The provider added that there could be opportunities to extend this partnership beyond COVID-19 to bring more regular screenings to churches in the county.

Community Health Workers Can Serve as a Key Link Between Patients and Providers

CHWs serve as liaisons between local communities and medical providers by engaging vulnerable residents and helping them access medical and social services. According to a CHW advocate, there are about 200 CHWs in the state. The state association for CHWs recently created a voluntary certification program, which they hope that the state legislature will

codify and operate through the Arkansas Department of Health. The advocate hopes that certification will help CHWs secure employment and payment for their work. A stakeholder familiar with state-level policy issues said that certification can serve as way for health centers and other providers “to know that the CHWs they are hiring will provide quality care.” The association has developed a scope of practice for CHWs and is interested in ensuring that they do “not tread on other people’s territory or scope of practice.”

The CHW advocate has found that hospitals and FQHCs have generally been more receptive to CHWs than private practices, and “CHWs linked to an organization normally have better success than those working independently.” According to the advocate, across the state, some practitioners, particularly younger ones, can be very receptive to CHWs, but older practitioners tend to be more skeptical.

The CHW advocate said that one of the biggest issues with getting CHWs paid through public and private payers is the lack of standardized training. The other major problem is the difficulty of demonstrating the value of CHWs to payers. One state-level policy researcher found that private insurers are not likely to invest in long-term resources like CHWs for populations that may only be enrolled with a particular insurer for a short time because their coverage fluctuates when their income changes. The association conducted a pilot program to assess the impact of CHWs on long-term care a few years ago and was able to “show that for every dollar that Medicaid spent, we were able to save them \$3 to \$4.” However, payers remain unmoved, and the association is partnering with other state and local entities to launch projects to further demonstrate the return on investment.

A provider in Columbia County has found that the success of CHWs can be “community dependent,” with CHWs performing very effectively in some communities while they struggle to “find people to help” in other communities. As of now, stakeholders did not note a significant presence of CHWs in Columbia County. The lack of CHWs can potentially be attributed to a lack of leadership at the state and local levels, as well as inertia hindering practice changes among older primary care practitioners, among other issues.

CONCLUSION

Columbia County is a rural community that is struggling with a dwindling population, poor population health,⁹³ and a shortage of providers, especially those who accept the large proportion of Medicaid beneficiaries in the county. The lack of local medical schools and residency programs reduces the opportunities for the community to attract PCPs to the area. Federal and state programs to improve recruitment and retention of PCPs in areas like Columbia County have not come close to keeping pace with what private hospitals and health systems are willing to pay for them. However, the community expresses hope that the recent legislation expanding the scope of practice for NPs will help make up for the shortage in the physician population.

While FQHCs and SBHCs have played a significant role in providing services for low-income and uninsured populations in other underserved areas around the country, local leaders and providers in Columbia County have yet to open the county’s doors to them. A general air of

competition and mistrust between private practitioners and community health centers in Arkansas and within Columbia County seems to be inhibiting the deployment of the latter. Private practitioners worry that community health centers will encroach on their business, and are critical of how the health centers use the federal funding available to them. Despite these challenges, local leaders in Columbia County were able to open a rural health clinic recently, which has helped fill some access gaps in the region.

As in other rural parts of the country, transportation remains a significant barrier to accessing primary care in Arkansas. Local leaders and providers have not yet invested in interventions like mobile clinics and the purchase of vans. The COVID-19 pandemic has heightened adoption and usage of telehealth, with older patients taking advantage of the ability to get care from their homes. However, a lack of cell phone service and broadband infrastructure as well as a lack of access to smartphones has been a barrier to further expanding the use of telehealth.

Beyond all these barriers related to resources, many residents of Columbia County also lack trust in medical institutions and in their providers. Some local providers have found that hiring clinicians who look like the patients they serve has helped the Black residents of Columbia County feel more comfortable seeking care. In an effort to build connections between providers and patients, the state's CHW association has worked hard to get CHWs integrated into primary care delivery in the state, but the efforts have not yet had significant results in Columbia County.

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