



“It’s been like a miracle”: Low-income Arkansans and access to health care services following Medicaid reform

INQUIRY: The Journal of Health Care Organization, Provision, and Financing
Volume 57: 1–10
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DOI: 10.1177/0046958020981169
journals.sagepub.com/home/inq



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Abstract

This article reports qualitative results from a mixed-methods evaluation of the Arkansas Health Care Independence Program. Qualitative data was collected using telephone interviews with 24 low-income Arkansans newly enrolled in Medicaid or a Qualified Health Plan in 2014. We used methods developed for rapid qualitative assessment to explore a range of general barriers and facilitators to accessing health care services. Secondary analysis guided by the most significant change technique aided in the construction of case summaries that permitted insights into participants’ experiences of managing their health over time. Barriers to accessing health care services included treatment costs, beliefs and values related to health, limited health literacy, poor quality health care, provider stigma, and difficulties that made travel challenging. For 1 participant who was no longer eligible for Medicaid or a QHP, lacking health care coverage was also problematic. Facilitators included having health care coverage, life experiences that re-enforced the value of prevention, health literacy, and enhanced health care services. Low-income Arkansans experiences accessing health care elucidate access as multi-dimensional, involving not only the availability of affordable services, but treatment effectiveness and patient experiences interacting with providers and clinic staff. We use these findings to formulate recommendations for programs and policies aimed at further increasing access to high-quality health care as a strategy for reducing health disparities.

Keywords

access to health care, qualitative evaluation, healthcare disparities, Medicaid reform, qualitative program evaluation

What do we already know about this topic?

Following enactment of the Health Care Independence Program in Arkansas, the rate of uninsured, non-elderly adults in Arkansas was reduced almost by half, from 27.5% to 15.6%.

How does your research contribute to the field?

To reduce disparities in access to healthcare, an insured population must be able to obtain high-quality, effective treatment, and know how to obtain the information they need to make informed decisions about health. Encounters with health care professionals must be non-stigmatizing to ensure continued engagement in care.

What are your research’s implications towards theory, practice, or policy?

Qualitative findings from this evaluation emphasize a multi-dimensional conceptualization of access that incorporates not only the accessibility of services, but treatment effectiveness and patient experiences during interactions with providers and clinic staff.

Introduction

In 2010, a ruling by the United States (US) Supreme Court allowed individual states to use a Section 1115 demonstration waiver to expand Medicaid benefits to those who qualify under the Patient Protection and Affordable Care Act (ACA).

Unlike other states, Arkansas did not have an established Medicaid managed care system when the ACA was signed into law, and many doubted that the existing fee-for-service network could withstand an influx of new Medicaid enrollees. Expanding coverage through private health insurance



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plans, or Qualified Health Plans (QHPs), was therefore proposed as a strategy for ensuring access to quality health care.¹

In 2013, the state of Arkansas signed the Health Care Independence Program (HCIP) into law, creating the “Private Option.”² Unlike those enrolled in Medicaid through the ACA, the HCIP enrolled Arkansans 19 to 64 years old without income at or below 138% of the federal poverty level in private health insurance (i.e., QHPs) through the federal health insurance marketplace. Medicaid paid the monthly premiums for enrollees, who received a private health insurance card. Low-income Arkansans who scored high on an exceptional healthcare needs screener were retained in Medicaid rather than having been enrolled in a QHP.^{1,3} Following enactment of the Private Option in 2014, the rate of uninsured, non-elderly adults in Arkansas was reduced almost by half, from 27.5% to 15.6%.⁴

This article describes qualitative results from a mixed-method evaluation of the HCIP. For the qualitative evaluation, we sought to explore a range of general barriers and facilitators to accessing healthcare among recent Medicaid and QHP enrollees. To achieve these goals, semi-structured telephone interviews were conducted with 24 Arkansans who had enrolled in Medicaid or a QHP in 2014. Rapid qualitative assessment techniques revealed general barriers and facilitators to accessing health care (i.e., experienced by participants regardless of age, gender, race, ethnicity, or residence), even after obtaining health care coverage through the HCIP. The goal was to use insights gained through low-income Arkansans’ individual experiences accessing healthcare before and after enrollment in Medicaid or a QHP to develop pragmatic recommendations for improving clinical practice and policy.

Materials and Methods

Study Setting

Arkansas is a predominantly rural state with a population of approximately 3 million people. In 2019, Arkansas ranked 48th in overall health in the US.⁵ The state furthermore ranked 10th nationally in health care disparities and had a greater reported frequency of physical and mental distress compared to the national average.⁵ Immediately prior to enactment of the ACA, Arkansas fell within the top 75th percentile of states in which non-elderly residents devoted a

greater proportion of their income to out-of-pocket medical expenses.⁶

Participants and Recruitment

We used Medicaid enrollment rosters to recruit participants. The rosters included the names and telephone numbers of Arkansans previously eligible and newly enrolled in Medicaid (aid categories 20, 25) or newly eligible and assigned to a QHP (aid category 06) under the HCIP in 2014. Two schedulers made initial contact with potential participants by telephone. The schedulers described data collection procedures and the rationale for the qualitative evaluation, then invited newly enrolled Arkansans to participate in a 60-min telephone interview. Of the 135 Arkansans contacted, 54 volunteered to participate in a telephone interview. Twenty-four ($N=24$) of those recruited were interviewed before data saturation was achieved, per guidelines for maximum variability sampling.⁷ The researcher determined that saturation had been achieved when 5 consecutive interviews failed to produce data that substantially altered how the phenomenon under investigation was understood (i.e., participants repeated the same information reported during prior interviews).

Data Collection Procedures

Data was collected by telephone from July to September of 2018. The aim was to elicit a range of experiences accessing health care to evaluate the impact of the HCIP from the perspective of Arkansans newly enrolled in traditional Medicaid or a QHP. At a date and time selected by each participant, a PhD-level anthropologist with expertise in program evaluation called participants, summarized project goals, and obtained verbal consent to audio record the interviews. A semi-structured interview guide with questions informed by the State of the Art (SOTA) Access Model⁸ was used to ensure that all access domains were consistently explored during data collection. The SOTA model contains 5 broad domains of access, encompassing the digital, geographic, temporal, financial, and social contexts of access. It was moreover specifically developed to facilitate the translation of research findings into recommendations for improving healthcare practice and policy, and was thus well-suited to the pragmatic goals of this evaluation. The interviews ranged

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Received 6 August 2020; revised 27 October 2020; revised manuscript accepted 16 November 2020

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from approximately 25 to 60 min in length and were transcribed verbatim. Participants were not compensated for completing an interview. Interview audio files are accessible upon request by the lead author.

Analyses

Rapid qualitative assessment techniques were used to analyze the transcripts,^{9,10} based on the potential of these methods to focus analysis on pragmatic goals and to minimize interpretation. In the first analytic phase, the PhD-level anthropologist who led the interviews summarized content from each transcript in a summary template.⁹ The templates were organized using broad domains from the SOTA Access Model to facilitate the translation of findings into practice and policy recommendations. The templates also contained domains for demographic characteristics, primary health concerns, and analytic insights. In the next phase, the anthropologist synthesized content from the 24 templates into 1 participant-by-domain matrix,¹¹ using constant comparison to identify a range of general barriers and facilitators, as well as differences between participants that revealed nuances in experiences accessing healthcare.¹²

In separate analyses, the most significant change technique was used to construct 24 case summaries.¹³ The anthropologist re-read each transcript, taking notes regarding the most significant change described by participants in relation to managing their health over time. These notes formed the basis for case summaries describing participant experiences of health and health care use before and after having enrolled in Medicaid or a QHP. This complimentary analysis allowed a more holistic understanding of individual experiences to emerge than templates or matrices, which fragment participant accounts into domains and categories. Case summaries presented below were selected based on their ability to vividly illustrate participants' individual experiences managing their health through time. All names are pseudonyms.

Rigor was established while analysis was ongoing. To control analytic drift, the anthropologist developed a rubric containing parameters for each template domain and category. Additionally, 25% ($n=6$) of templates were audited for accuracy and completeness by a PhD-level psychologist trained in template analysis. Finally, the anthropologist used negative case analysis to compare consistency across the case summaries and matrix.¹⁴

Results

We first characterize participants' health care coverage, demographic characteristics, and health-related concerns. Most participants (23/24) described long-standing conditions, permitting valuable insights into how their health was managed over time (i.e., prior and subsequent to enrollment in Medicaid or a QHP). We then describe the range of general

barriers and facilitators described during the interviews, illustrated through excerpts and case summaries conveying participants' experiences managing their health through time. As the contribution of these findings lie in their ability to convey a range of experiences, rather than to produce generalizable results, we have not reported frequencies.

Healthcare Coverage

As the interviews were conducted in 2018, and enrollees were identified using rosters from 2014, not all participants were enrolled in Medicaid or a QHP at the time of the interviews. Eight ($n=8$) Arkansans were enrolled in Medicaid, 7 ($n=7$) were enrolled in a QHP, and 3 ($n=3$) were dually enrolled in Medicaid and Medicare. Additionally, 5 ($n=5$) participants were previously enrolled in Medicaid, but enrolled only in Medicare at the time of the interview, and 1 ($n=1$) was previously enrolled in Medicaid, but had no form of health care coverage at the time of the interview. Although in some cases not all participants were enrolled in Medicaid/a QHP, all had nevertheless accessed health care through Medicaid or a QHP in the past. This variability allowed a spectrum of experiences accessing health care to emerge from analysis.

Participant Demographic Characteristics and Health Related Concerns

Newly enrolled Arkansans who agreed to participate in telephone interviews were largely female (14/24) and non-Hispanic White (22/24). Nearly all participants (23/24) described having been diagnosed with a chronic condition and mental health concerns were common (11/24). To provide a sense of the complexity and severity of participants' health-related concerns, Table 1 presents diagnoses described during the interviews, as well as some participant demographic characteristics.

Barriers to Accessing Health Care Services

Treatment Costs. Participants most consistently described out-of-pocket costs as having posed a barrier to accessing health care. Moreover, although concerns about cost diminished following Medicaid or QHP enrollment, some participants still reported having factored cost into their decisions about health care. For example, 1 participant (P054) enrolled in a QHP described having delayed treatment for tumors on her feet and cataracts because she was unsure if the plan would cover the cost of services. Participants also described gaps in coverage, particularly dental and eye care, that made it difficult to afford treatment even after enrolling in Medicaid or a QHP. "I need to see a dentist badly and I can't afford it," stated 1 man enrolled in Medicaid. "I don't have the gum base to support my roots and my teeth are slowly falling out." (P383).

Table 1. Gender, race/ethnicity, and health-related conditions described by participants during the interviews.

ID #	Condition(s)	ID#	Condition(s)
P234 Female White, non-Hispanic	Diabetes	P200 Female White, non-Hispanic	Bipolar disorder
P248 Male White, non-Hispanic	Hypertension High cholesterol	P455 Female White, non-Hispanic	Autoimmune disorder Polycystic ovary syndrome
P075 Female White, non-Hispanic	Anxiety Colon cancer Diabetes	P305 Male White, non-Hispanic	Anxiety Depression SUD (heroin)
P177 Female White, non-Hispanic	High blood pressure Pre-diabetes Unspecified "heart condition"	P309 Male White, non-Hispanic	Cirrhosis of the liver Schizophrenia SUD (alcohol)
P193 Female African American	Diabetes Hypertension Thyroid disease	P338 Male White, non-Hispanic	Hypertension Tachycardia Unspecified "disorder of the central nervous system"
P208 Female White, non-Hispanic	CNCP Hypertension Neuropathy in legs and feet Unspecified "stomach issues"	P379 Male White, non-Hispanic	Cancer Mental health disorder (unspecified) Thyroid disorder Substance Use Disorder (unspecified)
P054 Female White, non-Hispanic	Cataracts CNCP Deafness, partial Osteoarthritis Tumors on feet	P037 Female White, non-Hispanic	Anemia CNCP Compressed spine Migraines Unspecified "heart problems"
P240 Male White, non-Hispanic	Anxiety Chronic lymphoma leukemia High cholesterol Hypertension	P125 Male White, non-Hispanic	Aortic Valve Disease Bipolar Disorder CNCP Hypertension PTSD
P370 Female White, non-Hispanic	Depression Generalized anxiety disorder Hypertension Irritable bowel syndrome	P385 Female White, non-Hispanic	Anxiety COPD Unspecified "heart problems" Unspecified "intestinal problems"
P085 Female African American	Exhaustion Graves' disease Meniere's disease Overactive thyroid Type I diabetes	P218 Female White, non-Hispanic	Depression CNCP Hypertension Migraines Obesity
P383 Male White, non-Hispanic	Anxiety Gum disease Major depressive disorder Schizophrenia SUD (unspecified, likely heroin)	P329 Male White, non-Hispanic	CNCP Herniated spinal disks High cholesterol Hypertension Spinal Spinozism Tachycardia
P143 Female White, non-Hispanic	Arthritis COPD Cystic fibrosis Degenerative joint disease Emphysema Hypertension Lung cancer Scoliosis Tachycardia	P230 Female White, non-Hispanic	Agoraphobia Bipolar disorder Depression Gall bladder disease Hypertension PTSD Schizophrenia SUD (unspecified)

Beliefs and Values Related to Health. Some participants expressed the belief that illness or injury must interfere with everyday functioning to warrant medical attention, and thus often did not immediately attempt to obtain treatment for health-related concerns. One woman admitted: “Sometimes things have to get pretty bad before I realize that, yes, I need to go [for treatment]. I just kind of put it off and say, ‘It’ll get better,’ when I really should go” (P200). The effects of this belief on health care utilization were reinforced by the value placed on stoicism and self-reliance, which some participants admitted had led them to delay treatment. One man who had managed chronic non-cancer pain (CNCP) from 2 herniated disks and spinal stenosis on his own for years explained his refusal to seek treatment thusly: “We all try to be tough soldiers at times” (P329).

Limited Health Literacy. Most participants demonstrated limitations in their ability to obtain, process, and understand basic health information, which sometimes resulted in delayed treatment. In this regard, participants described difficulty understanding which services were available to them through Medicaid or a QHP, or not knowing where to access the information they needed to make informed decisions about health. Limited health literacy also made it difficult for participants to understand their providers and to follow treatment recommendations. Low-income Arkansans who expressed limited health literacy also had difficulties advocating for their health. For example, 1 man with limited health literacy stated: “They’re talking about cutting [my medication] out on me. I don’t know where to go to talk with people, what to ask them” (P125).

Poor Quality Health Care. Participants also expressed concerns regarding the quality of health care available to them that hindered their access to effective treatments. “I wish things were better here,” stated 1 woman. “Not just for me, but for a lot of people. I worry about not being able to have the best health care” (P208). Low-income Arkansans described various factors which they perceived reduced the quality of health care, including having rarely or never had face-to-face contact with a primary care physician (PCP). “I’ve never met the man,” stated 1 woman about her PCP. “He stays in the office” (P177). Using Medicaid to access health care was also perceived as affecting the quality of services. One woman who had at various intervals been without coverage, enrolled in Medicaid, and enrolled in a QHP explained: “When you go to the doctor and you don’t have health insurance, they just try to treat the symptoms. They don’t find the underlying cause because you can’t afford it” (P455).

Poor quality health care was particularly problematic for participants with CNCP, who reported having undergone invasive procedures that were either unsuccessful, resulted in further impairment, or led to long-term opioid use. Other low-income Arkansans had not received any treatment for

CNCP, despite having been diagnosed by a physician. To illustrate, 1 woman diagnosed with scoliosis, degenerative joint disease, and arthritis stated: “I ain’t got nothing done about my back yet and it’s in really bad shape” (P143). Mental health treatment was also largely described as ineffective and limited to psychopharmacotherapy.

The consequences of ineffective, poor quality health care are apparent in the case summary below, constructed from the interview with “Roger” (P383):

Although he had been “hearing voices” since 1993, Roger could not afford the cost of mental health treatment and attempted for years to manage his symptoms through illicit substances. Once he gained access to health care coverage through a QHP, Roger immediately sought treatment at a mental health facility within walking distance of the home he shared with his mother. He was diagnosed with major depressive disorder and anxiety, and prescribed medicines to help control his symptoms. Roger spoke in a monotone during the interview and described experiencing debilitating anxiety attacks despite undergoing pharmacological treatment, stating about his newly accessed mental health care: “I don’t think it seems to be working too good.” Although his mother supported Roger as best she could, she lacked the knowledge and skills to manage his anxiety attacks. As a result of poorly managed mental health, Roger described “just riding out” and “suffering through” debilitating attacks that made it challenging for him to manage day-to-day life, including maintaining steady employment.

Provider Stigma. Low-income Arkansans described provider stigma and de-humanization of patients that affected both their experiences of care and willingness to seek medical attention. In this respect, Medicaid enrollees described having experienced degrading and de-humanizing treatment at the hands of providers and clinic staff. “I felt less of a person,” noted 1 woman about her interactions. “That’s the way some people made me feel.” (P218). Medicaid enrollees also reported difficulties scheduling appointments. For example, 1 woman described the following interaction: “I mentioned being on the expanded Medicaid, and the secretary started to hang up on me! And I said: ‘Wait! It’s gonna be Blue Cross Blue Shield!’ And I finally got her to not hang up” (P054). Another observed that: “When I had Blue Cross and Blue Shield, it seemed like whenever I just showed the card, things moved faster. I mean, the attitude was different. But with the Medicare, it’s like I’m being treated differently” (P193). The effect of this barrier on health care utilization is evident in a statement from 1 woman who recounted: “I was supposed to get a colonoscopy, and when I went to the doctor and they said, ‘We don’t take Medicaid,’ I left. And still haven’t had a colonoscopy” (P370).

Provider stigma was also reported by participants diagnosed with substance use disorder (i.e., SUD). “As soon as they see that I have a history—or a past—with substance abuse, I feel as if I’m treated differently,” related 1 man. “Even though I’ve got help and I’m clean for 7 years, I’m

automatically treated as if I'm just human garbage" (P305). A final form of stigma that impeded access was directed at participants prescribed opioids for CNCP. One woman who experienced daily migraines from a compressed spine described having been "afraid" to request a refill for Percocet from her provider because "they are looked down upon so much now" (P037). As a result, she managed chronic and debilitating pain on her own.

Difficulties that Made Travel Challenging. An additional impediment that delayed treatment were difficulties that made travelling to medical appointments challenging. In this respect, participants described debilitating conditions (i.e., CNCP, anxiety, neuropathy, cancer) that made it difficult to withstand travel. "I get tired really easy," explained 1 woman in describing why she sometimes canceled medical appointments. "Especially when I'm on chemo" (P075). Treatment was also delayed when critical sources of social support (e.g., sisters, sons-in-law) were unable to obtain time off work or were too ill to drive those without a personal source of transportation.

Lacking Health Care Coverage. For 1 participant (P248) who was no longer eligible for Medicaid at the time of the interviews, not having a source of health care coverage posed a significant barrier. This participant described having experienced the most difficulty accessing services relative to other low-income Arkansans who participated in the evaluation. Lacking health care coverage was therefore the least reported, but most qualitatively significant, barrier.

The consequences of lacking health care coverage are illustrated well by the case summary below, constructed from the interview with "Paul" (P248):

Employed as a pharmacist for many years, Paul once had a steady income and health care coverage. When the pharmacy chain he worked for downsized, he was laid off. During the 5-years in which he was unemployed, Paul developed kidney stones, carpal tunnel, and a hernia. As he could not afford to pay out-of-pocket for treatment, he coped with these conditions as best he could on his own. Although briefly gaining access to medical treatment through "Obamacare," shortly thereafter Paul became a full-time caregiver for his mother, who was disabled by dementia. The income he earned as a caregiver disqualified him from Medicaid, and he stated that: "Any idea of me affording insurance right now is completely out of the question." Unable to access preventive care, Paul developed high cholesterol and hypertension, and he was preoccupied with what might happen to him in the future. "I'm really having problems with this not having insurance coverage," he confessed. "If anything happens, I'm one step away from bankruptcy."

Facilitators to Accessing Health Care Services

Health Care Coverage. Possessing a source of health care coverage was the most consistently reported facilitator to

accessing health care services. In this regard, participants repeatedly stated that enrolling in Medicaid or a QHP permitted unprecedented access to much-needed services. One woman recalled that before enrolling in a QHP: "I couldn't get any health care, really. I just had to get super-sick and then just go to a general practice doctor to just get an antibiotic or something" (P054). Additionally, nearly all participants described having sought mental health treatment only after enrolling in Medicaid or a QHP. In 1 extreme case, a man struggled with debilitating mental health concerns for more than 20 years before accessing treatment through a QHP (see the case summary for "Roger," above).

The impact of gaining access to health care coverage is vividly illustrated by the case summary below, constructed from the interview with "Patricia" (P370):

Patricia had been self-employed as a freelance writer and photographer for 30 years. Despite having been diagnosed with Generalized Anxiety Disorder, Post-traumatic Stress Disorder, depression, hypertension, and Irritable Bowel Syndrome, she recalled: "I didn't have health insurance. And then for years I had health insurance and didn't pay for anything. You know, you had a big deductible or whatever." Thus, the cost of care made Patricia reluctant to seek treatment, resulting in a worsening of health-related conditions. Patricia's life changed dramatically when she became eligible to enroll in Medicaid. "It's been like a miracle," she stated. "I've been very sick and I'm very fortunate that I've been able to get the health care that I need." Gaining access to health care allowed Patricia to manage her mental health which, in turn, enabled her to continue practicing photography and writing. "I actually find the work I do useful because it gives me a sense of purpose and also distracts me from my misery," she explained.

In comparing participants' experiences, those enrolled in a QHP more often reported having been able to schedule an initial appointment with a provider than Medicaid enrollees. One participant who had used different sources of coverage to access health care explained: "If you call a doctor's office and you have Blue Cross Blue Shield, yeah they can take you. But if you have Medicaid, you can't get a doctor" (P455).

Life Experiences that Re-Enforced the Value of Prevention. A less common facilitator that was nevertheless significant in its impact was life experiences that re-enforced the value to prevention. Participants who were diagnosed with a chronic condition early in life, had children diagnosed with a chronic condition, and were once employed in the health care industry were notably more prevention-oriented. Illustrating how early life experiences can shape attitudes toward managing health, 1 woman diagnosed with juvenile diabetes at the age of 19 expressed: "I make sure to go see my PCP every 3 months. This is just 1 body that I have, and I want to make sure it can go on as long as possible" (P085). Participants possessing a pro-active attitude toward health furthermore less often described the cost of services as having deterred

them from seeking health care. Thus, 1 woman diagnosed with high blood pressure at the age of 15 stated: “When it comes to my health, I worry about the cost later” (P193).

Health Literacy. Inter-related with life experiences, health literacy also emerged as a facilitator to accessing health care. Participants who expressed health literacy knew how to obtain information about health and health care and were thus able to strategize around barriers to obtain treatments. To illustrate, 1 participant lacking health care coverage used the knowledge he had gained as a pharmacist to obtain affordable medications from Canada. “Your normal citizen would not know how to do that,” he noted (P248). Technological proficient emerged as another form of health literacy. Participants with health literacy possessed the skills to navigate online portals and connect with services by, for example, soliciting answers to health-related questions from providers or requesting refills for medications.

Enhanced Health Care Services. Participants also described enhanced services that facilitated access to timely treatment. Services described as having facilitated access included coordination among health care providers, the availability of automatic refills for prescription medications, and appointment reminders. These services were particularly critical for participants who lacked health literacy and thus experienced difficulties managing their health and health care.

Discussion

This qualitative evaluation used a multi-faceted analytic approach combining summary and matrix analyses with the most significant change analysis to understand access to quality health care among 24 low-income Arkansans newly enrolled in Medicaid or a QHP. In the first phase, template analyses revealed that having health care coverage, life experiences that re-enforced the value of prevention, health literacy, and enhanced health care services facilitated access. Barriers included treatment costs, beliefs and values related to health, limited health literacy, poor quality health care, provider stigma, and difficulties that made travel challenging. For 1 participant who was no longer eligible for Medicaid or a QHP, lacking health care coverage also posed a barrier. These findings help explain why, although 250 476 Arkansans had accessed health care services through the HCIP by February 2020,¹⁵ health disparities persist in Arkansas.^{16,17}

In the second phase, matrix analysis revealed that participants enrolled in a QHP reported fewer barriers to accessing quality health care than Medicaid enrollees. Medicaid enrollees reported difficulties scheduling an initial appointment with providers and described experiencing dehumanizing treatment during encounters with providers and clinic staff. Moreover, participants expressed the perception that the services available through Medicaid were of poorer quality. Thus, enrolling in a QHP was described as a more consistent

facilitator than having enrolled in Medicaid. Participants’ experiences and perspectives align with quantitative results from the larger mixed-method evaluation indicating that, compared to Medicaid enrollees, Arkansans with QHP coverage had better access to services and obtained higher quality care.³

The most significant change technique was used to construct case summaries which permitted a more holistic understanding of participants’ experiences through time. In nearly every case summary, gaining (and sometimes, losing) access to health care coverage emerged as the most significant change in respect to managing health. Case summaries thus supported results from template and matrix analyses indicating that gaining a source of health care coverage was the most qualitatively significant facilitator to accessing health care among participants.

Our findings highlight the role of social determinants (i.e., economic insecurity, caregiver stress, unstable housing) in the onset of chronic conditions. For example, the case summaries revealed that participants largely did not seek medical attention during the years in which chronic conditions developed, often due to concerns about cost, choosing instead to seek care only when they could no longer function. These qualitative findings align with results from large-scale surveys which have found increased utilization of primary care, increased outpatient visits, and increased engagement in care for chronic conditions following enactment of the HCIP.^{1,18,19} Although cost was most often cited as the reason for delayed treatment, some participants did not utilize health care even when affordable treatment was available. In these instances, the value placed on self-reliance and stoicism, and the inter-related belief that illness must result in functional impairment to warrant medical attention, delayed treatment. These barriers resulted in costly delays, both in terms of medical expenses incurred and consequences to participants’ health. Once able to access care through Medicaid or a QHP, poor quality health care and negative interactions with providers exacerbated the effects of economic and social stressors on many participants’ health.

Among these findings, participant experiences of stigma during encounters with providers and clinic staff present opportunities to further increase access to quality health care for low-income Arkansans. Participants enrolled in Medicaid, diagnosed with SUDs, and prescribed opioids for CNCP described de-humanizing treatment by providers and/or staff that made them reluctant to initiate or continue treatment, as well as difficulties scheduling appointments. Vivid descriptions of how experiences of stigma shaped decision-making about health are supported by findings from multiple studies documenting provider stigma^{20,21} and the negative effects of provider stigma on access.^{22,23} For example, 1 quantitative study associated provider stigma of patients enrolled in Medicaid with unmet health needs, perceptions of poor-quality care, and worse health across several self-reported measures.²⁴

Despite evidence that provider stigma impedes access to quality health care, few rigorous studies have evaluated the long-term impact of interventions to reduce provider stigma.²⁵ Intervention development has likely been hindered by the wide diversity of patients who report experiencing provider stigma, including immigrants, ethnic/racial minorities, and patients diagnosed with mental health concerns, SUDs, and the human immunodeficiency virus, to name a few. Patient-centered treatment approaches may thus represent a more realistic strategy for improving patient experiences. For example, trauma-informed care, which promotes patient safety and empowerment, peer support, cultural competency, and collaboration in decision making during clinical encounters, has shown promise as a treatment approach for underserved and vulnerable populations,^{26,27} including Medicaid patients.²⁸

Also noteworthy is how beliefs and values delayed treatment, even when participants possessed access to affordable health care. As culture evolves to help individuals cope with problems, findings regarding common beliefs and values can be drawn upon to develop more effective public health messages aimed at reducing health disparities in Arkansas.²⁹⁻³¹ For example, the value placed on self-reliance and stoicism could be leveraged to promote the message that being proactive about health prevents development of financially costly and physically debilitating conditions.

The use of community health workers (CHWs), which aligns with the tenants of patient-centered health care,³² could also reduce barriers described by participants (i.e., provider stigma, limited health literacy, beliefs and values related to health). In prior studies, CHWs have increased utilization of preventive services³³ and enhanced patient management of chronic conditions and treatment adherence³⁴ in poor, underserved and diverse communities.³⁵ Evidence for the effectiveness of CHWs in Arkansas comes from the Community Connector Project, which effectively used CHWs to connect low-income Arkansans with unmet health-related needs to services,³⁶ resulting in a 23.8% average reduction in annual Medicaid spending per participant for 2005–08.³⁷ Findings from our project suggests that CHWs could be used to increase uptake of preventive care by explaining how the benefits of prevention outweigh the costs of managing chronic conditions. They could also connect people with limited health literacy to services by describing how to use online portals. Our findings suggest that Arkansans possessing life experiences that have taught them the value of prevention would be well-suited to the role of CHWs.

Finally, as evidence indicates that mental health prevalence rates are higher in federally qualified health centers than in private practice,³⁸ findings suggesting that the mental health services available to low-income Arkansans are largely ineffective is troubling. Although some authors have proposed using telemental health, such as videoconferencing, to connect underserved and vulnerable people in

resource poor areas to evidence-based psychotherapies (EBPs),³⁹ findings regarding health literacy as a barrier suggest that this strategy would not be acceptable and/or feasible for all low-income Arkansans. An alternative strategy is to further expand the integration of mental health treatment in primary care (i.e., PCMH). Some evidence indicates that treatment effectiveness increases, patient and staff satisfaction increases, and treatment and medication costs decrease with PCMH.^{40,41} PCMH may also reduce experiences of stigma.⁴² However, our findings regarding the poor quality of mental healthcare available to Medicaid and QHP enrollees suggests that mental healthcare providers will require additional training in EBPs for PCMH to reach its full potential in Arkansas.

Limitations

Data collection relied on retrospective participant accounts of their experiences, which increased the potential for recall bias to compromise the validity of results. Additionally, racial and ethnic minorities were under-represented in our sample. A more diverse sample might have provided additional insights into the effects of stigma on access and/or revealed additional barriers to accessing services.

Conclusion

Our findings suggest that health care coverage was a necessary, but an insufficient, condition for ensuring access. An insured population must be able to obtain high-quality, effective treatment, and know how to obtain the information they need to make informed decisions about health. Following treatment initiation, encounters with health care professionals must be non-stigmatizing to ensure continued engagement in care. These qualitative findings emphasize a multi-dimensional conceptualization of access that incorporates not only the accessibility of services, but treatment effectiveness and patient experiences of care, if the goal is to develop policies and programs that ensure equitable access to health care.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was part of an accepted Centers for Medicare and Medicaid Services (CMS) Section 1115 Demonstration waiver evaluation plan funded by Arkansas Medicaid [CMS-AR Medicaid].

Ethics Approval

As this work constituted an evaluation of an existing program, a non-research determination was sought and granted by the

Institutional Review Board of the University of Arkansas for Medical Sciences (#217751).

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