

Specialty Care Access for Medicaid Enrollees in Expansion States

Justin W. Timbie, PhD; Ashley M. Kranz, PhD; Ammarah Mahmud, MPH; and Cheryl L. Damberg, PhD

Community health centers (CHCs) in the United States provide a primary care safety net to 25 million low-income patients annually,¹ many of whom have complex health and social needs. CHCs predominantly deliver primary care and historically have reported challenges referring their patients for specialty care.² Following expansions to Medicaid eligibility in 26 states and the District of Columbia (DC) in 2014, authorized by the Affordable Care Act (ACA), CHCs in many states treated a greater proportion of Medicaid enrollees and fewer uninsured patients.³

Medicaid eligibility expansions may affect CHCs in a variety of ways. Treating more insured patients may increase CHCs' revenues, enabling investments in technology and staff to promote access to specialty care.⁴ Additionally, specialists may be more likely to accept referrals from insured patients. Conversely, all CHC patients may face barriers to specialty care, including shortages of specialists or their reluctance to accept Medicaid. Although some states have reported improved specialty access for Medicaid enrollees in recent years,⁴ a federal report from 2014 found that more than 40% of specialists surveyed did not offer appointments to Medicaid enrollees and the median wait time for specialty visits was twice as long as that for primary care visits.⁵ Overall, evidence on the ACA's impact on access to specialty care is limited, with mixed results.⁶⁻⁸

Given this new policy landscape, in which CHCs located in Medicaid expansion states are providing services to a larger number of Medicaid enrollees who may or may not be able to access needed specialty care, we sought to understand current challenges and strategies used by CHCs to access specialty care for their patients in Medicaid expansion states. We conducted a survey of all CHCs that receive grant funding from the Health Resources and Services Administration (HRSA) in a sample of Medicaid expansion states to determine the specific specialties for which access problems were most acute, document the most common access barriers, and identify the strategies that CHCs are using to expand access to specialty care for their patients.

ABSTRACT

OBJECTIVES: Community health centers (CHCs) historically have reported challenges obtaining specialty care for their patients, but recent policy changes, including Medicaid eligibility expansions under the Affordable Care Act, may have improved access to specialty care. The objective of this study was to assess current levels of difficulty accessing specialty care for CHC patients, by insurance type, and to identify specific barriers and strategies that CHCs are using to overcome these barriers.

STUDY DESIGN: Cross-sectional survey, administered during summer 2017, of medical directors at CHCs in 9 states and the District of Columbia, all of which expanded Medicaid.

METHODS: Surveys were administered to medical directors at 361 CHCs (response rate, 55%) to assess the difficulty of accessing specialty care by insurance type and to identify the specialties for which it was most difficult to obtain new patient visits. The survey also elicited ratings of commonly reported barriers to obtaining specialty care and identified strategies used by CHCs to access specialty care for patients. Descriptive results are presented.

RESULTS: Nearly 60% of CHCs reported difficulty obtaining new patient specialty visits for their Medicaid patients, most often for orthopedists. Barriers to specialty care reported by CHCs included that few specialists in Medicaid managed care organization (MCO) networks were accepting new patients (69.4%) and MCO administrative requirements for obtaining specialist consults (49.0%). To enhance access to specialists, CHCs reported that they entered into referral agreements, developed appointment reminder systems, and participated in data exchange and other community-based initiatives.

CONCLUSIONS: Medicaid patients at CHCs face many barriers to accessing specialty care. Payment policies and network adequacy rules may need to be reexamined to address these challenges.

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TAKEAWAY POINTS

- ▶ Community health centers (CHCs) historically have reported barriers to specialists for their patients. CHCs in 9 states and the District of Columbia that expanded Medicaid eligibility reported challenges accessing specialty care for their patients, particularly for orthopedists, gastroenterologists, neurologists, and psychiatrists.
- ▶ Barriers to specialty care reported by CHCs included that few specialists in Medicaid managed care organization (MCO) networks were accepting new patients (69.4%) and MCO administrative requirements for accessing specialist consults (49.0%).
- ▶ In response to these and other challenges, CHCs are using a wide range of strategies to better integrate primary and specialty care services to provide more coordinated care to their patients.

METHODS

We surveyed medical directors at 361 CHCs in 9 Medicaid expansion states and DC during summer 2017 (response rate, 54.6%). CHCs, a type of federally qualified health center, are nonprofit, community-focused primary care providers that are located in medically underserved areas and provide services to all patients, regardless of ability to pay.⁹ Most CHCs receive grant funding from HRSA. CHCs with and without federal funding collectively serve 1 in 6 Medicaid enrollees.¹⁰ The study sample included California, Colorado, DC, Illinois, Louisiana, Minnesota, New Jersey, Oregon, Vermont, and Washington (average state-level response rate, 58.9%; range, 26.3% [New Jersey] to 78.6% [Minnesota]). The survey was fielded as part of a larger effort to describe the landscape of care integration activities involving CHCs, specialty practices, hospitals, and social service organizations in 12 states and DC. The study was approved by RAND's Institutional Review Board.

The web-based survey was completed by the medical director or a designee at each CHC. The survey included items that solicited ratings of difficulty for their patients to access timely initial visits with specialists outside of CHCs, by payer, using a 5-point Likert-type response scale with the options of very difficult, somewhat difficult, neither easy nor difficult, somewhat easy, or very easy. Timely access was not explicitly defined because states often use different standards.¹¹ Respondents reporting that it was very difficult or somewhat difficult were asked to report, by payer, the 1 specialty for which it was most difficult to access new patient visits. Respondents were provided a drop-down menu of 16 specialties and were given the option to write in a specialty not listed.

CHCs also responded to questions about 12 barriers to obtaining specialty care (not specific to payer), identified from both a review of the literature and discussions with 15 stakeholders during an earlier phase of the project.^{2,12-16} Survey respondents also answered 17 questions about strategies that might be used to access specialty care for patients (not specific to payer) related to alternative care delivery models (eg, telemedicine), data-sharing arrangements, and participation in activities that are likely to strengthen linkages with specialists. The items were measured using a 6-point Likert-type response scale with the options of not applicable, never, rarely, sometimes, often, or always. CHCs responding “not

applicable” were not included in the results for that item. Based on the distribution of survey item responses, results are presented with responses dichotomized to often/always versus never/rarely/sometimes (or, for some items, very difficult/somewhat difficult vs neither easy nor difficult/somewhat easy/very easy).

RESULTS

Difficulty obtaining new patient specialty visits reported by CHCs varied by insurance type, with most respondents reporting difficulty

for patients with no insurance (168 CHCs; 85.3%) or Medicaid (113 CHCs; 57.3%), and a lower share of respondents reporting difficulty for patients dually eligible for Medicaid and Medicare (69 CHCs; 35.0%), with only Medicare (47 CHCs; 23.9%), or with private insurance (28 CHCs; 14.4%).

CHCs identified a range of specialties to which they had difficulty referring their Medicaid patients, with visits to orthopedists reported as the most challenging by 16% of respondents who reported difficulty (**Figure**). Other specialties with commonly reported access problems included gastroenterology (12%), neurology (12%), psychiatry (12%), dermatology (11%), and cardiology (5%). CHCs also reported the greatest access problems for these same 6 specialties for their uninsured patients.

CHCs that reported difficulty obtaining specialty care for their Medicaid patients rated several barriers as often or always contributing to poor access. The most common barriers were related to payment, coverage, and availability of appointments, including low Medicaid payment rates for specialists (78%), few specialists in Medicaid managed care organization (MCO) networks accepting new patients (69%), lack of Medicaid coverage for telemedicine (49%), and Medicaid MCOs' administrative requirements for obtaining specialist consults (49%) (**Table**). More than half of respondents also rated long distances or travel times required to reach specialists (60%) and patients' out-of-pocket cost burden associated with specialty care (56%) as contributors to poor access. More than one-third of CHCs reporting access problems cited difficulty establishing referral agreements with specialists (38%) and finding specialists that met the cultural or linguistic needs of their patients (38%).

CHCs reported difficulty with specialty referrals even though they deployed strategies that sought to improve access, either directly or indirectly (**Table**). Nearly two-thirds of CHCs reporting access problems had established agreements with specialists relating to the terms of referrals. More than 80% of CHCs reporting access problems provided at least some specialty care on-site, whereas nearly half reported using e-consults (45%) and less than one-third reported using telemedicine (27%) to interact with specialists. Most CHCs made specialist appointments on behalf of patients (61%), although fewer CHCs regularly reminded patients about upcoming

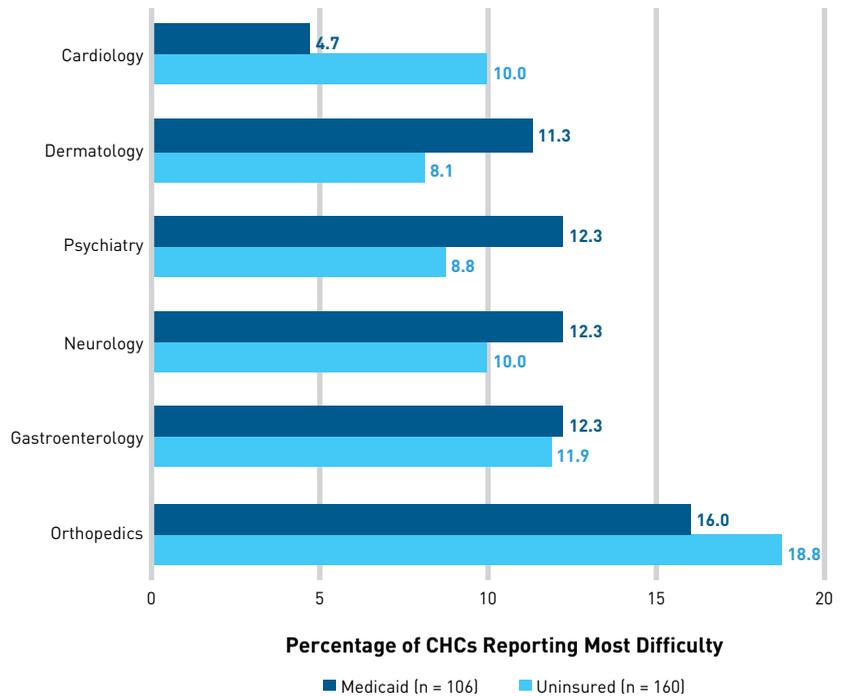
appointments (40%). CHCs reported moderate levels of data sharing with specialists, including 43% that consistently shared health information electronically with specialists. By contrast, only 13% of CHCs were able to implement systems permitting real-time “read” access to the medical records of specialty practices. More than half of CHCs reported some form of collaboration with specialists, including participation in health promotion initiatives (66%) or quality improvement projects (57%) with local specialty practices.

DISCUSSION

Consistent with past reports of significant access problems,² 85% of CHCs reported difficulty obtaining specialist visits for their uninsured patients. Despite the ACA's expansion of Medicaid eligibility, which led to nearly 12 million adults across the United States becoming newly eligible to gain Medicaid coverage,¹⁷ almost 60% of CHCs in our sample of Medicaid expansion states reported difficulty accessing new specialty visits for their Medicaid patients. Although insurance expansions may facilitate access to specialty care by reducing some financial barriers to care, other barriers remain outside of CHCs' control. In particular, the impact of insurance expansions will ultimately depend on the degree to which payment and delivery systems are aligned to ensure that patients gain access to appropriate and timely specialty care. Data available as of July 2016 suggest that Medicaid pays only 72% of Medicare's rates for specialty services,¹⁸ and these payment differentials are likely to persist as the federal share of funding for the expansion population decreases over time. Thus, specialists face strong disincentives to treat patients insured by Medicaid compared with other payers.

Most Medicaid enrollees in most states included in the study receive their insurance coverage via comprehensive Medicaid MCOs,¹⁹ which means that both MCOs and the states play a large role in determining access to specialty care for the majority of Medicaid enrollees. CHCs in our study, in which 7 of 9 states plus DC had a Medicaid MCO penetration rate exceeding 70%,¹⁹ commonly reported narrow MCO networks as a challenge to obtaining specialty care for patients. Although the Medicaid and CHIP Managed Care Final Rule of 2016 required new minimum standards for ensuring the adequacy of Medicaid MCO networks, it remains unclear whether states will define standards for individual specialties, go beyond time and distance standards to include appointment or office wait times, or begin to rigorously enforce the new standards.¹¹ For sponsors and administrators of MCOs, our results suggest that Medicaid MCO

FIGURE. Specialties Reported as the Most Difficult for Accessing New Patient Visits, Among CHCs Reporting Difficulty for Patients With Medicaid or No Insurance



CHC indicates community health center.

networks in our sample of 9 states and DC may lack a sufficient number of specialists to care for Medicaid patients, which may reflect specialists' reluctance to accept referrals for Medicaid patients. As such, administrators may want to consider reassessing both the number and type of specialists available for new patient visits and encouraging the use of strategies that can promote more efficient use of specialists.

CHCs reported difficulty accessing similar types of specialty care for both uninsured patients and Medicaid enrollees. Notably, substance use disorder (SUD) treatment specialists and dentists, whose services have historically been in high demand at CHCs, were rarely reported as the specialists who were most difficult to access through referrals, which others have speculated may be due to increased funding and attention for SUD treatment and Medicaid expansions, respectively.^{20,21}

Among CHCs that reported specialty access problems, the majority had implemented strategies to access specialty care for their patients and help their patients make those appointments. To obtain specialty care for patients, most CHCs reported entering into agreements that specified the terms and expectations regarding referrals and engaging with specialty practices in health promotion and quality improvement initiatives, with fewer CHCs reporting use of e-consult systems and participation in data exchange with specialists. These findings highlight the range of strategies CHCs

TRENDS FROM THE FIELD

TABLE. Common Barriers to and Strategies for Accessing Specialty Care Identified by CHCs That Report Access Problems for Their Medicaid Patients

	%	Total CHCs Responding to Item ^a
Common Barriers to Specialty Care		
Payer factors		
Low Medicaid specialist payment rates	78.0	109
Few specialists in Medicaid MCOs accept new patients	69.4	108
Medicaid MCO administrative requirements for obtaining specialist consults	49.0	104
Lack of Medicaid telemedicine coverage	48.8	82
Patient factors		
Patient long travel distance/time to specialists	59.8	112
Patient out-of-pocket costs for specialty care	56.3	112
Few specialists meet cultural/language needs of patients	37.5	112
Provider relationships		
Difficulty establishing formal referral agreements	37.5	104
Few personal relationships with specialists	30.2	106
Few affiliations with local hospitals/health systems	24.1	108
Regulatory factors		
Difficulty expanding health center scope to include on-site specialty care	31.2	93
Difficulty obtaining malpractice insurance for specialists through the Federal Tort Claims Act	15.1	73
Common Strategies for Accessing Specialty Care		
Alternative delivery models		
On-site provision of specialty care for any patients in last 6 months	84.1	113
Use of e-consults for any patients in last 6 months ^b	45.1	113
Use of telemedicine for any patients in last 6 months ^b	26.6	113
Referral agreements		
Has agreements with specialists about either the types of referrals specialists will accept or information the health center will provide when making referrals	64.6	113
Has agreements with specialists about the type of information specialists will provide to the health center following visits	41.6	113
Has agreements with specialists about the types of patients to be referred	18.6	113
Has agreements with specialists about testing to be conducted prior to referrals	17.7	113
Has agreements with specialists about the time frame by which specialists should send information to the health center following the specialist visit	15.9	113
Providing patient supports		
Often or always makes appointments on behalf of patients	61.1	113
Often or always reminds patients about appointments	39.8	113
Data sharing		
Often or always sends health information electronically to specialists	43.4	113
Often or always receives health information electronically from specialists	28.3	113
Often or always reads medical records of specialty practices	13.3	113
Community partnerships		
Participated in health promotion initiatives with specialists in last 2 years	65.8	111
Participated in quality improvement projects with specialists in last 2 years	56.8	111

CHC indicates community health center; MCO, managed care organization.

^aIncludes only CHCs reporting difficulty obtaining new patient visits with specialists for their Medicaid patients. Denominators for barriers and strategies may differ due to item nonresponse and differences in the numbers of CHCs responding "not applicable," which were excluded from the denominators.

^bE-consults refer to asynchronous electronic interactions between primary care and specialty care providers; telemedicine refers to real-time videoconferencing or "store-and-forward" applications in which digital content is transmitted to specialists for review at another time.

are pursuing, which are timely findings in light of HRSA's August 2018 updated requirements that CHCs collaborate with specialists and document these efforts.²² Additionally, to promote patient attendance at appointments, many CHCs reported making appointments on behalf of patients, with fewer CHCs reporting use of reminder systems to help prevent their patients being "no-shows" to their specialty appointments. Because evidence suggests that patient reminders via phone or text message can help promote visit attendance,²³ more CHCs should consider pursuing this strategy.

Limitations

This cross-sectional survey did not include items about changes since Medicaid expansion and cannot make any causal conclusions about the impact of Medicaid expansion on changes in access to specialty care. Additional study limitations include nonresponse bias, which may have led us to either over- or understate actual levels of difficulty accessing specialty care. In addition, we may not have captured the full breadth of strategies that CHCs are using to secure specialty care for their patients. Additionally, further research is needed to determine if these findings differ for CHCs in states that did not expand Medicaid. Finally, although our survey did not include all Medicaid expansion states, we designed the sample to be geographically diverse.

CONCLUSIONS

Obtaining specialty care is a significant problem for uninsured patients and Medicaid patients seeking care from CHCs, the entry point to the US healthcare system for tens of millions of low-income patients. Despite using a wide range of strategies to achieve integrated systems of care with specialists in their communities, CHCs report few available specialists, low Medicaid payments, long travel times, and high cost-sharing burdens for patients as the greatest barriers to obtaining specialty care for their patients. Payment policies and network adequacy rules may need to be reexamined to reduce long-standing inequities in access to specialty care for our nation's most vulnerable residents. ■

Author Affiliations: RAND Corporation, Arlington, VA (JWT, AMK, AM), and Santa Monica, CA (CLD).

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Address Correspondence to: Ashley M. Kranz, PhD, RAND Corporation, 1200 S Hayes St, Arlington, VA 22202. Email: akranz@rand.org.

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