IMPROVING ACCESS TO SPECIALTY CARE FOR MEDICAID PATIENTS: POLICY ISSUES AND OPTIONS

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Laurie E. Felland, Amanda E. Lechner, and Anna Sommers

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Abstract: In some states and communities, Medicaid programs, health plans, providers, and others are collaborating to improve timely access to medical and surgical specialty services for Medicaid enrollees. This report examines six models—in Connecticut, Illinois, Minnesota, New Mexico, Oregon, and Tennessee—that support innovative ways of delivering specialty care and help ensure specialty referrals for Medicaid patients are appropriate and efficient. Strategies include finding ways for specialty providers to deliver care at primary care facilities, expanding the role of primary care providers to deliver specialty care, and employing staff to communicate and coordinate care across providers. Although resources remain limited, participating organizations report better access to specialty care for Medicaid patients and early signs of improvements in quality and costs of care. However, sustaining, expanding, and replicating these models may require changes in Medicaid payment methods that recognize new types of interactions with patients beyond face-to-face visits.

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EXECUTIVE SUMMARY

Many Medicaid patients face problems finding specialty physicians to treat them in a timely manner. Low Medicaid payment rates typically are the main barrier, although administrative burdens, patients' nonmedical needs and challenges keeping appointments and adhering to treatment plans play a role as well. Lack of timely specialty care can result in adverse medical outcomes and potentially higher costs from avoidable emergency department visits and hospitalizations. Safety-net hospitals, community health centers, specialists, state Medicaid programs and Medicaid health plans are partnering to improve access to specialty care. This report examines six such models in Connecticut, Illinois, Minnesota, New Mexico, Oregon, and Tennessee.

The models deploy staff members and technology in innovative ways, including:

- increasing the availability of specialty care through telehealth, bringing specialists to primary care sites, and using physician assistants (PAs) to deliver specialty services;
- expanding the role of primary care providers—physicians and nurse practitioners (NPs)—to handle more specialized health issues through training and electronic consultations; and
- enhancing communication and coordination among patients, primary care providers, and specialists through broad medical home models and staff—known as access coordinators—dedicated to arranging specialty care.

While these models were selected because they had some external funding, their available resources did not allow them to address all types of specialties or patient needs. In general, public and private grants typically help with start-up costs, particularly for big-ticket items like health information technology tools. Ongoing expenses, such as salaries for additional staff, in many cases are supported through funding from Medicaid programs and health plans, although participating providers absorb many operating costs.

Along with improving Medicaid patients' access to specialty care, participating organizations were interested in improving job satisfaction, ensuring that specialist appointments are appropriate and productive, freeing up specialists to treat more seriously ill patients, and reducing use of expensive services, such as hospital and emergency care. The models rely mainly on specialists who already serve Medicaid patients rather than attracting new specialists. Challenges remain, including bridging different cultures and processes among participating organizations, overcoming provider concerns about patient safety and quality of care, and taking providers away from other patients or activities.

While many of the models are still developing and growing, participating organizations reported some improvements in access to specialty care, and a few have measured improvements in quality and documented cost savings; most hope to demonstrate more concrete improvements through upcoming evaluations. Most models plan to expand to other specialties and patients and show promise for replication by other communities.

While the models have developed under existing state Medicaid policies, long-term sustainability, expansion, and replication may require updates to Medicaid payment policies that recognize and support new types of interactions with patients. Such changes might include: paying providers to consult with other clinicians or treat patients remotely; expanding the scope of federally qualified health centers (FQHCs) to provide more specialty services; funding the training of primary care clinicians in certain types of specialty care; and changing the way nonclinical activities, like coordinating patient care, are paid and accounted for in managed care contracts.

The Affordable Care Act expands Medicaid coverage to millions of Americans starting in 2014 but does not explicitly address the likely increased demand for specialty care stemming from the coverage expansion. Although the law's temporary increase in Medicaid payments for primary care may help support components of these models that rely on a larger role by primary care clinicians, many expect the demand for these providers to exceed supply. Indeed, national health reform likely will highlight and increase the need for health care providers, plans, and policymakers to address problems securing timely, efficient, high-quality specialty services for Medicaid patients.

IMPROVING ACCESS TO SPECIALTY CARE FOR MEDICAID PATIENTS: POLICY ISSUES AND OPTIONS

INTRODUCTION: CHALLENGES ACCESSING SPECIALTY CARE

Many low-income people face problems obtaining timely appointments with medical and surgical specialists with expertise in such areas as cardiology, orthopedics, and neurology, among many others. Compared with referrals for privately insured patients, when a primary care physician (PCP) refers Medicaid patients to specialists, these referrals are less likely to result in appointments[1,2] because of difficulty finding specialists willing to accept Medicaid patients[3] and long wait times for appointments.[4] Lack of timely specialty care can result in adverse medical outcomes, emergency department visits and hospitalizations, and potentially higher health care costs.[5,6] The extent of the access problem varies by specialty and community and is associated with state policy and local health system characteristics, such as the supply and distribution of specialists.[7]

Surveys indicate that physicians' relative unwillingness to serve Medicaid enrollees stems primarily from low payment relative to Medicare and commercial insurer payments and from administrative burdens.[8,9] Also, compared with privately insured patients, Medicaid patients face more socioeconomic and health issues that present challenges for specialists. For example, Medicaid patients are more likely to miss appointments because of lack of transportation or child care and have clinical and nonclinical needs—such as chronic conditions, mental health issues, and language interpretation services—that require more provider time and resources.[10,11]

When Medicaid patients need specialty care, their PCPs typically rely on existing relationships with specialists. These often take the form of a personal favor negotiated on behalf of each patient individually—one recent study referred to this as the "tin-cup method."[12] However, in many communities, specialty services for Medicaid patients are available through safety-net hospitals—public hospitals, academic medical centers (AMCs) and other hospitals with a mission to serve people regardless of their insurance status or ability to pay, but demand generally exceeds supply.[13]

ADDING SPECIALTY CARE IN CREATIVE WAYS: SELECTED MODELS

Safety-net hospitals, community health centers, specialists, state Medicaid programs, and Medicaid health plans are partnering to improve access to specialty care. This report examines six such models in Connecticut, Illinois, Minnesota, New Mexico, Oregon and Tennessee. The models deploy staff members and technology in innovative ways, including:

- increasing the availability of specialty care through telehealth, bringing specialists to primary care sites, and using physician assistants (PAs) to deliver specialty services;
- expanding the role of primary care providers—physicians and nurse practitioners (NPs)—to handle more specialized health issues through training and electronic consultations; and
- enhancing communication and coordination among patients, primary care providers, and specialists through broad medical home models and staff—known as access coordinators—dedicated to arranging specialty care.

This study identified six models that arrange for specialty care in various, systematic ways and that obtain funding outside of regular Medicaid payments. (For details on selection criteria, see the Methodology). The six models are:

- ACCESS Community Health Network, partnered with University of Chicago Medical Center;
- CareOregon, partnered with Legacy Health and the Neighborhood Health Center;
- Community Health Centers, Inc., partnered with Yale Medical Group and the University of Connecticut;

- Project ECHO (Extension for Community Healthcare Outcomes) at the University of New Mexico;
- UnitedHealthcare Community Plan, partnered with Tennessee Primary Care Association, Community Health Network, and Meharry Medical Group; and
- Health Care Homes in Minnesota.

(For more details about each model, see the Appendix.)

Each of the models represents collaboration across providers, with varied levels of involvement from state Medicaid programs and health plans. These models were initiated during the past decade by safety-net providers (i.e., hospitals or community health centers) or Medicaid managed care plans. In some cases, the same types of organizations serve as partners in the models; for example, Project ECHO is led by an AMC that partners with federally qualified health centers (FQHCs), a managed care plan, the state legislature, and the state Medicaid agency.

Some models started in response to a problem with a particular specialty, while others took on specialty care more broadly. For instance, Project ECHO began because of a hepatologist's frustration with patients having to wait eight month to see him and to travel long distances for hepatitis C treatment. Generally, the targeted specialties relate to conditions with a high prevalence, including cardiology, neurology, and rheumatology. Many models added specialties over time. Today, Project ECHO and the UnitedHealthcare Community Plan initiative both include approximately 10 specialties, while ACCESS includes more than 20.

The goal is to improve access by providing the needed specialty service, consult, or procedure more efficiently. This also creates the potential to reduce the total cost of specialty care and to free up resources to care for more people. The models use one or more of three main approaches to achieve this goal: increasing the availability of specialty practitioners, expanding the role of primary care providers, and enhancing communication and coordination (Exhibit 1).

Increasing Availability of Specialty Practitioners

One key strategy used by some models is telehealth, which is defined as video or other imaging technology that allows specialists to diagnose and treat patients remotely. Study sites use telehealth to address shortages of specialists in two ways. UnitedHealthcare uses videoconference appointments with a variety of specialists; Community Health Centers, Inc. (CHCI) uses store-and-forward technology that collects images for later review by an ophthalmologist to screen for early signs of blindness in diabetic patients.

Another strategy is to increase access to specialty care at primary care sites, either with specialty physicians or midlevel providers. ACCESS contracts with University of Chicago Medical Center (UCMC) specialists to treat patients at its FQHC and has added midlevel providers to focus on care coordination. CareOregon employs physician assistants to screen patients with orthopedic conditions and treat those who do not need surgery, as well as provide pre- and postoperative care to surgical patients.

Expanding Role of Primary Care Providers

Another approach is to expand the role of primary care providers to handle more specialized health issues, reducing the need for specialty referrals. Via videoconferencing, Project ECHO specialists at the University of New Mexico guide and train primary care providers elsewhere to treat patients with certain conditions. Over time, the providers gain sufficient knowledge to treat specialized problems independently.

Web-based communication technology—including two tools known as eReferral or eConsults—can help primary care providers secure an expert consult and prevent inappropriate or premature referrals. First developed by a physician at San Francisco General Hospital, eReferral allows specialists to review primary care providers' requests for a referral electronically—typically supported by access to electronic health records (EHRs) or other patient records.[14] Similarly, CHCI's eConsults uses secure peer-to-peer electronic

EXHIBIT 1. KEY APPROACHES USED TO IMPROVE ACCESS TO SPECIALTY CARE

Model	Increasing availability of specialty practitioners	Expanding role of primary care providers	Enhancing communication and coordination
CareOregon	Physician assistants handle routine, nonsurgical orthopedic needs		Care coordinators recruit and coordinate care with orthopedic surgeons
ACCESS Community Health Network	Hospital-based specialists treat patients at FQHC sites		Nurse practitioners and medical assistants determine severity of condition and where patient should be seen; support specialists' work at FQHCs
UnitedHealthcare Community Plan	Telehealth technology allows Nashville-based specialists to treat patients throughout the state at primary care provider sites		Staff at primary care and health center associations recruit and train physicians on telehealth and schedule appointments
Project ECHO (Extension for Community Healthcare Outcomes)		University-based specialists remotely consult and train primary care providers to treat their patients' specialty needs themselves	
Community Health Centers, Inc.	Diabetic retinopathy screening performed at FQHC sites and evaluated remotely by ophthalmologists with store-and-forward technology	Primary care providers learn how to treat hepatitis C and HIV through Project ECHO clinics University-based specialists advise primary care providers on cardiology cases through eConsults	
Minnesota Health Care Homes		Primary care providers serve as medical homes and coordinate services beyond the medical home	Access coordinators serve as point of contact and conduit among patients, primary care providers, and specialty providers

Note: FQHC = federally qualified health center.
Source: Authors' analysis of respondent interviews.

messages to present the consult question and relevant patient notes, labs, and diagnostic images to cardiologists at the University of Connecticut. These physicians provide the PCP with either specific guidance on how to manage the patient or recommendations for urgent or routine specialist follow-up.

These strategies do not represent a complete shift of specialty care to primary care settings. In Project ECHO and CHCI's eConsults, the specialists involved agree to see and treat the patients deemed complex. The specialist becomes familiar with the patient's case and comfortable that the patient requires follow-up or is ready for a procedure. For example, cardiologists working with CHCI agree to respond to an eConsults request within two days and to see any patient needing an in-person visit within a week.

Enhancing Communication and Coordination

A third approach is to improve communication and care coordination among the patient, primary care providers, and specialists. Minnesota Health Care Homes (HCH) broadens the medical home concept to a "medical neighborhood" that includes a wider team of clinicians and support staff to coordinate care and form relationships and improve communication with medical and surgical specialists.

To enable better communication and coordination, most of the models have created a new clinical and

administrative position. Often called access coordinators, these staff members serve as a point-of-contact for patients and facilitate communication between primary care and specialty care providers. They also gain a more thorough understanding of patients' needs, which reportedly helps secure appointments with specialists. One access coordinator explained the value of the new relationships formed with specialists: "It used to be a flat-out 'no' [from specialists], whereas now we have opened the door [to getting patients appointments]."

DIVERSE FINANCIAL SUPPORT

Shifting how and where specialty care is provided requires resources, and may include implementing new technology and training primary care providers and other staff. The models studied in this report incur various capital and operational costs, such as facility expansions, health information technology (HIT), and increased labor. HIT is typically the largest start-up cost. Telehealth equipment is expensive because it requires high-resolution video capabilities, among other features. For example, respondents reported that the equipment and installation costs for each telehealth unit at UnitedHealthcare was approximately $30,000 to $40,000. Videoconferencing equipment for Project ECHO and the software, portals, and interfaces with EHRs and other systems for eConsults were typically less expensive. Maintenance and staff HIT training is an ongoing cost. Employing and training primary care providers, PAs, and access coordinators are new and ongoing operational costs. Plus, there is an opportunity cost when primary care providers spend time on tasks other than billable patient visits.

In models that bring specialists to the primary care site, the primary care organization receives Medicaid payment for the services provided and pays specialists as employees or on a per-visit basis or the specialist bills Medicaid directly. However, because many of the models' activities do not involve face-to-face appointments, they are not covered by Medicaid.

Resources tend to come from an array of sources, including government, health plans, foundations, and the participating providers themselves through their own revenues, supplies, and staff time. Many participating community health centers are FQHCs, which receive federal grants and enhanced Medicaid payments—that is, an all-inclusive encounter rate intended to support the broad range of services an FQHC provides. This support has been particularly helpful in covering the general costs of providing services compared with regular Medicaid fee-for-service rates.[15] Additionally, ACCESS was able to modify its FQHC scope-of-project designation, which determines what services can be supported with federal grant funding, to include many medical specialties. Still, a respondent discussing ACCESS reported the need for "financial gymnastics to support the program."

Some state Medicaid agencies help fund the models. Although Minnesota providers must cover the costs of obtaining Health Care Homes (HCH) certification, the state pays an amount (through Medicaid managed care plans) to certified providers for each chronically ill patient, tied to the patient's conditions and socioeconomic barriers.

In some cases individual Medicaid managed care plans fund up-front or ongoing components of the models. One of New Mexico's four Medicaid managed care plans pays primary care providers for their involvement in Project ECHO, CareOregon pays a portion of the new staff at the FQHC, and the UnitedHealthcare Community Plan paid for installation of telehealth equipment and reimburses specialists and providers for telehealth appointments.

VARIED MOTIVATIONS FOR PARTICIPATION

Respondents reported several motivations for primary care providers, specialists, Medicaid programs, and health plans to participate. Because they serve as medical homes for Medicaid enrollees, many primary care providers want to avoid the time and frustration of a scattershot approach to specialist referrals. One primary care respondent explained: "We need to step into our responsibility of being an air traffic controller and make referrals seamless for the patient." Some primary care providers assumed partial responsibility for the specialty

care problem. One said, "I will start by blaming ourselves. We don't have robust standards for referrals. The first part is to create appropriate referral criteria that are shared." Many of the models focus on reducing the need for referrals to specialists and, for those patients who are referred, reducing the time and resources the specialist needs to treat them.

Indeed, specialty physicians and hospitals value the models as a way to treat low-income patients more efficiently and effectively. Specialists gained confidence that referred patients have conditions that warrant consults, that patients are ready for their appointments or procedures, and that relevant information about the patient is available. For example, CareOregon and UnitedHealthcare surveyed specialists to understand the specific information and tests needed to accept Medicaid patients—information that varies across providers—and then created systems to meet the criteria.

In addition, the models help manage specialists' concerns about Medicaid patients' nonmedical needs that can waste an appointment slot or render the visit unproductive. The coordinators spend time understanding patients' barriers to getting care—for example, that a patient only has child care on certain days—and ensuring they can get to their appointments and adhere with care plans.

Some models pay specialists for participation, but it is difficult to know how much of an incentive these payments provide. ACCESS is able to pay the UCMC specialists a negotiated payment that is higher than what they would receive by directly billing Medicaid and CHCI pays specialists a small fee for each telehealth and eConsults interaction.

Primary care and specialty providers alike value the professional growth opportunities the models provide. For instance, respondents involved with Project ECHO and CHCI said that increasing PCPs' skills and responsibilities has boosted job satisfaction.

Still, instead of significantly expanding the pool of specialty physicians willing to treat Medicaid patients, the models mostly involve specialists who already treat a substantial number of Medicaid patients. This reflects the established working relationships and referral patterns among safety-net organizations, as well as continued problems gaining participation from specialists in private practice. Some participating safety-net hospitals limit the participation of their own specialists for financial reasons: ACCESS would like to use more UCMC specialists, but the time specialists spent in the FQHC in lieu of the hospital represents a loss in revenues for UCMC, particularly for higher-paid surgical specialists.

Some state Medicaid programs and Medicaid managed care plans are attracted to the potential cost savings the models could generate. They assume that improved coordination will reduce unnecessary patient visits and, in some cases, transportation costs, and that improved access to specialty care when appropriate will prevent more expensive emergency care and hospitalizations. One Medicaid agency respondent said the state saw the model as a "needed expense that . . . should have downstream benefits."

IMPLEMENTATION CHALLENGES

Implementation takes considerable time and trial and error, particularly to gain provider buy-in and to iron out differences across providers. As one respondent said about primary care and specialty providers working together, "We have two different cultures and different ways of doing business." For instance, it took ACCESS more than a year to ramp up because of challenges setting up protocols for scheduling specialty appointments between the health center and UCMC. CHCI's eConsults took several years—considerably longer than participants expected—to resolve information technology and process issues.

Also, providers reported some concerns about patient safety and quality of care. Some Tennessee primary care providers in the UnitedHealthcare model have not used their telehealth equipment because of quality concerns generally and are wary of working with specialists they do not know. Cardiologists in the CHCI eConsults pilot feared PCPs would submit patients with overly urgent and complex conditions, resulting in delayed, substandard care, and potential exposure to malpractice liability. However, these problems did not

materialize, and one respondent stated that eConsults worked well as a "structured, electronic water-cooler conversation" among physicians.

In addition, the models often hinder overall productivity. A respondent reported that Project ECHO specialists spend an estimated 15 percent or more of their time training and consulting with primary care providers, which takes away from time to treat their own patients.

INCREMENTAL IMPACT

Many of the models are still new, operate on a small scale, and face ongoing challenges. For instance, at the time this research was conducted, eConsults at CHCI were in the pilot phase, with cardiologists consulting on approximately a dozen cases. UnitedHealthcare's telehealth program reportedly handles 20 medical specialty cases a month, with specialists reporting problems with underutilization of their sessions and no-shows.

The models reportedly have improved the availability of specialist appointments, although respondents stressed that demand continued to exceed supply. CHCI increased the percentage of diabetic patients receiving retinopathy screening from 10 percent to 40 percent. According to a respondent, waits for rheumatology appointments at UNM declined from six months to one month after Project ECHO's implementation. An access coordinator in Minnesota reported the benefits of better preparation and communication: "As far as specialists outside the clinic, health care homes' patients seem to be prioritized. They can get in quicker than the average person not in a health care home."

Likewise, strategies that give primary care providers more responsibility for specialty care can result in fewer specialist referrals. For example, a PCP trained by Project ECHO reported seeking specialty referrals for only 10 percent of rheumatology cases, compared with all such patients before implementation of the project.

Many of the models studied typically work best for chronic, complex medical conditions that can be managed by a primary care physician or nonphysician clinician, although the types of specialties suitable for particular models vary. For example, the CareOregon model focuses on orthopedic problems using PAs. In contrast, respondents indicated that orthopedic issues are more difficult to address through a telehealth model because they typically require hands-on physical examination and assessment. The access coordination role appears useful in managing chronic conditions and procedure-based specialties alike.

Some respondents found quality of care and patient outcomes to be the same, if not better, under the models. For example, CareOregon PAs cast routine broken bones of patients released from the emergency department within two days, while previously many patients could not get appointments with specialists and kept their temporary splints, hindering the bones' ability to heal properly. Also, the PA model reportedly results in many orthopedic patients receiving timely nonsurgical therapy to manage joint pain, which can promote mobility and reduce further joint deterioration and the need for surgery. Respondents reported that care provided by expanding the role of PCPs was on par with specialist care. A study found that patients treated for hepatitis C through Project ECHO had similar outcomes as patients treated directly by UNM specialists.[16]

Cost savings are difficult to estimate, but respondents noted the importance of measuring and demonstrating savings. CHCI published results that found that using telehealth for diabetic retinopathy saves approximately $28 (about 35%) per patient compared with a conventional exam.[17] Full evaluations of Project ECHO, HCH, and CHCI are under way or planned.

EXPANSIONS PLANNED BUT LIMITED

Some approaches, particularly telehealth and eConsults, have been replicated in other states and communities. Replication typically requires well-supported, extensive safety-net capacity, with a critical mass of primary care and specialty providers already treating Medicaid patients. This could take the form of a large FQHC with an AMC or public hospital supplying specialty care. For example, a respondent reported that it is a very daunting process to achieve Minnesota HCH certification and that smaller practices may not receive sufficient

incentive payments to support ongoing costs. Larger providers also tend to have existing EHRs and other IT infrastructure needed to support core activities. For example, the shared EHR between FQHCs and the county hospital in Minneapolis helps access coordinators with scheduling specialty appointments and care coordination.

Many respondents were optimistic about gaining efficiencies to add more specialties, providers, and patients. The models that rely heavily on HIT typically have high up-front costs but low marginal costs, in contrast with models that depend more on additional labor. For example, by using IT, Project ECHO's virtual clinics are now available to other primary care organizations beyond New Mexico, including CHCI, which has implemented Project ECHO for HIV and hepatitis C, and will soon launch one for chronic pain management. In addition, CHCI plans to extend eConsults to more specialties. In contrast, expanding CareOregon's PA model to neurology and possibly endocrinology is planned but will occur more slowly because of the need to hire additional staff.

The lack of Medicaid payment for specialty services provided in new ways could limit the models' expansion and replication. Notwithstanding the funding arrangements among these models, Medicaid programs generally are less likely to pay for strategies involving HIT (e.g., telehealth, eConsults), staff training, access coordination, and other types of interactions beyond in-person visits. While as many as 40 state Medicaid programs report covering telehealth services, many limit coverage to real-time encounters with a patient, inpatient or emergency services, or to certain populations, such as children.[18]

Medicaid programs generally do not pay for providers' ongoing education or training to provide specialty care or care coordination, although some of these activities are covered by Medicaid primary care case management programs (more common in rural areas in lieu of risk-based managed care plans) and disease management programs. In addition, state Medicaid programs typically consider care coordination activities an administrative expense, so money spent on such activities could jeopardize a health plan's ability to meet the state's medical loss ratio requirement—that is, the percentage of premiums spent on medical care compared with administrative costs.

Furthermore, federal and state policies limit the types of specialty services that FQHCs can add and receive payment for—this is known as the "scope of project." The Health Resources and Services Administration (HRSA), which oversees FQHCs, allows FQHCs only to add specialty services that are a logical extension of primary care services and that are in sufficient demand by patients. Such services commonly include consultations and examinations for pulmonology, cardiology, podiatry, and oncology, as well as colonoscopies. After HRSA approval, a state Medicaid program must approve a scope-of-service change for the FQHC to receive enhanced payment rates for the added services.

Many states limit the types of providers and services eligible for enhanced Medicaid payments. For example, ACCESS partners with an outside provider to offer optometry services at the health center, but because the Illinois Medicaid agency deems optometrists ineligible for payment at an enhanced rate, the optometry provider bills Medicaid directly at the lower rate, reportedly limiting the provider's participation. Also, state processes for acquiring scope-of-service changes and payment adjustments can be complex or nonexistent.[19] Further, the majority of state Medicaid programs will not reimburse an FQHC for more than one medical visit per patient per day,[20] requiring a patient to return another day for a specialty care follow-up appointment or for the FQHC to absorb additional cost.

Some of these payment limitations may be historical artifacts: when Medicaid was established in the 1960s, HIT used today did not exist. In addition, payers are concerned about potentially duplicating payment, particularly if a new approach does not address a patient's need and in-person treatment by a specialist remains necessary.

The expansion of Medicaid through the Affordable Care Act could have mixed effects on

specialty care access for Medicaid enrollees. Most of the states studied in this report (Connecticut, Illinois, Minnesota, New Mexico, and Oregon) plan to expand Medicaid, while Tennessee plans to opt out of the expansion, as allowed by the June 2012 U.S. Supreme Court decision. The revenues generated by previously uninsured patients gaining coverage and the two-year increase in Medicaid payment for certain primary care services to Medicare levels might enable greater provider involvement in the specialty models. At the same time, demand for specialty care is expected to rise as more low-income people gain Medicaid coverage. If access to primary care improves, which is a key focus of the health care reform law,[21] more clinical problems requiring specialty care may be detected. However, the law does not explicitly address the challenges of providing specialty care to Medicaid patients, and safety-net hospitals are concerned about the loss of federal subsidies—known as disproportionate share hospital payments—that help provide these and other services for low-income people.

POLICY OPTIONS

Federal and state policymakers wishing to improve the availability of specialty care for Medicaid enrollees could consider several changes in how Medicaid dollars flow to health plans and providers. They will have to weigh the benefits, in terms of improved access and potential cost savings, against the up-front and ongoing costs of paying for specialty care in new ways.

Medicaid programs could consider paying for more specialty services supported or provided through telehealth and eConsults and other HIT tools. State laws could establish appropriate use and standard billing procedures for physician-to-physician consults and physician-to-patient encounters that may or may not require a physician be physically present with the patient. They also could incorporate new types of technology as they become available. For instance, many Medicaid programs now reimburse for mental health services provided through low-tech and less-expensive visual platforms like Skype, which could free up more complex and expensive telehealth equipment for specialties that need higher resolution images to diagnose and treat patients.

Respondents indicated that commercial health plans' coverage of telehealth and eConsults could pave the way for broader adoption for Medicaid enrollees. As of 2011, only 12 states required commercial insurers to pay for telehealth services and not all require payment at rates equivalent to traditional face-to-face visits.[22,23] Connecticut passed legislation in 2012 that requires private insurers to cover telehealth services; respondents involved in CHCI expect this to encourage a similar requirement for the Medicaid program. To the extent that private practice physicians invest in such equipment for privately insured patients and reap efficiencies, it could open the door for them to treat Medicaid patients in the same way.

Additionally, states could consider ways to support clinician education and training, as well as care-coordination activities. As more state Medicaid programs adopt patient-centered medical home models that pay providers extra for handling complex patients, more access coordinator positions could be supported. Also, states may want to consider care coordination a medical expense, rather than an administrative cost, in managed care contracts.

While FQHCs mainly focus on preventive and primary care, findings from this study show that primary care providers can serve as a useful bridge to certain specialty services that are difficult to obtain otherwise. With more FQHC funding available through the Affordable Care Act, HRSA might consider allowing certain FQHCs to add specialties under their scope-of-project definition. In areas where single FQHCs have insufficient patient volumes or capacity to support a particular specialty, providers could be encouraged to share specialty services across multiple sites. For example, other Portland health centers refer patients to the FQHC with the CareOregon PA.

For FQHCs that are adding specialties, states might consider increasing payments per encounter to FQHCs to account for the additional cost of providing a specialty service or paying for two medical visits in one day. This would allow FQHCs to optimize the

convenience of colocating primary and specialty care services for patients.

One alternative to direct payments for various strategies is to move toward fixed payments for patients' overall care rather than fee-for-service arrangements. Health care reform encourages development of accountable care organizations (ACOs) and other new payment arrangements designed to improve both the quality and efficiency of care delivery. In the ACO framework envisioned by many, providers take responsibility for caring for a defined group of patients and are rewarded financially for providing care in the least expensive yet appropriate setting.

The specialty models examined here could be important components of ACOs, structured around inpatient and outpatient providers serving a Medicaid population. These models cultivate many of the skills, tools, and linkages needed to improve communication and collaboration across two critical and commonly used parts of care delivery—primary and specialty care—to prevent Medicaid patients from falling through the cracks and potentially needing more hospital admissions and emergency department visits.

Finally, these Medicaid specialty care models could be useful to a broader population. For instance, although Project ECHO mainly serves low-income patients, it was designed to help anyone facing barriers to specialists—a relatively common problem given the rural nature of New Mexico. Medicare and private payers also are interested in improving access to specialty care as a way to reduce costly emergency and hospital care.

METHODOLOGY

Researchers at the Center for Studying Health System Change studied models focused on improving access to specialty care for Medicaid enrollees in six states or communities: Connecticut; Chicago, Illinois; Minnesota; New Mexico; Portland, Oregon; and Tennessee. Each model met five selection criteria: targets Medicaid enrollees; has a financing mechanism to support itself; exhibits strong potential for replication (i.e., not operating in a unique environment); represents efforts by diverse stakeholders; and its future potential is likely linked to legislative or regulatory action. Models were selected with input from an advisory panel of 12 experts on safety-net providers and the Medicaid program. Between January and June 2012, researchers interviewed almost 40 respondents, including hospital representatives, primary care and specialty physicians, community health center executives, and Medicaid agency representatives, among others involved in the models.

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APPENDIX. DETAILS OF SELECTED MODELS AND LIST OF ADVISORY PANEL MEMBERS

ACCESS Community Health Network, partnered with University of Chicago Medical Center Model

ACCESS, a federally qualified health center (FQHC) operating approximately 40 community clinics across the Chicago area, focuses on providing a one-stop shop for patients for both primary and specialty care. In 2008, ACCESS partnered with University of Chicago Medical Center (UCMC), the area's major academic medical center, to host weekly cardiology, neurology, gastroenterology, and infectious disease clinics at the main ACCESS facility. UCMC provided capital funds for ACCESS to almost double its number of exam rooms and add specialty services, although ACCESS absorbs the operating costs of the new expansion. For instance, ACCESS provides a nurse practitioner (NP) and medical assistants to support over 20 specialties and triage guidelines help determine which patients have more serious conditions and should be seen directly at the hospital. ACCESS bills Medicaid its regular prospective payment system (PPS) rate for the specialists' time and, in turn, pays UCMC a negotiated rate to the specialists, who are employed by UCMC. ACCESS has applied for an increase in its PPS rate from the state to account for the cost of including specialty services but has not received it. ACCESS also partners with the Illinois Eye Institute (IEI) to provide optometry services at one of its sites, but because optometrists are excluded from the set of providers FQHCs in Illinois can provide and bill for, the IEI leases the space at the ACCESS site and bills Medicaid directly.

CareOregon, partnered with Legacy Health and the Neighborhood Health Center

CareOregon is a Medicaid managed care plan that has invested in two strategies to address the problems enrollees face in obtaining orthopedic care. About a decade ago, CareOregon partnered with Legacy Health, a hospital system in Portland, to place a physician assistant (PA) specializing in orthopedics at one of Legacy's orthopedic clinics; CareOregon partially subsidizes the PA's salary. In 2010, CareOregon expanded the model with a community clinic it previously owned, Neighborhood Health Center, an FQHC with facilities across the greater Portland area. The health center pays the salary of this additional PA. The PAs screen and triage patients to identify those who do not need or are not suitable for surgery and provide them with more basic orthopedic services or assist them with other options, such as weight loss, diabetes self-management, or physical therapy—a benefit not typically covered or paid for by the state Medicaid program, but that CareOregon is considering covering. The PAs receive payment, although less than a usual physician rate, for their services from the Medicaid health plan. CareOregon also pays the salaries of two access coordinators to locate, develop, and maintain relationships with orthopedists willing to treat patients identified by the PAs as needing surgical care. The access coordinators provide a single point of contact for specialists and patients, assisting the latter with setting up appointments and reminders, as well as educating patients on pre- and postsurgery guidelines.

Community Health Centers, Inc., partnered with Yale Medical Group and the University of Connecticut

Community Health Centers, Inc. (CHCI), is an FQHC operating primary care centers in 13 Connecticut cities, as well as 200 service delivery sites in schools, homeless shelters, and other community facilities throughout the state. CHCI has 130,000 active patients, a research and development center, and the country's first postgraduate nurse practitioner residency program in primary care. CHCI has adopted three main strategies to expand specialty care

access for patients, two-thirds of whom are Medicaid enrollees. In 2009, CHCI implemented a telehealth program to detect early signs of blindness in diabetic patients. Medical assistants at CHCI are trained to take images using retinal cameras. The images are then screened externally, through the California-based EyePACs program and read by ophthalmologists at the Yale Medical Group, to whom CHCI pays a flat rate per screening.

In 2011, CHCI piloted an eConsults system with cardiologists at the University of Connecticut. CHCI pays the practice a small fee per electronic consultation, and the cardiologists agree to treat patients who need in-person appointments in their offices. CHCI plans to expand eConsults to other specialties, such as endocrinology and dermatology.

CHCI started participating in Project ECHO's hepatitis C virtual clinics in 2011. CHCI found the model very effective and replicated it across all its sites for hepatitis C, as well as HIV, and will add chronic pain management virtual clinics in 2013.

CHCI largely relies on its operating margin to cover the ongoing costs of these initiatives because the state Medicaid program does not provide payment for these non-visit-based activities. CHCI has identified ways in which these efforts have improved access to specialty care and has secured research grant funds from the Connecticut Health Foundation and other foundations to conduct a formal evaluation.

Health Care Homes in Minnesota

Health Care Homes (HCH) is a statewide initiative in Minnesota to develop primary care medical homes for all insured patients, established by the state's 2008 health reform law. Primary care organizations, including hospital-based outpatient departments, private physician practices, community health centers, and clinics that meet a host of criteria are certified by the state. To date, the state has certified over 200 health care homes, or almost one-third of all primary care organizations. The primary safety-net hospital in the Minneapolis area, Hennepin County Medical Center, has received certification for many of its outpatient clinics. Three of the largest FQHC organizations in the Twin Cities also are certified. Providers typically absorb the costs of making the capital and process changes to become HCHs, although some safety-net providers received grants to help cover the costs.

As of July 1, 2010, health plans are mandated to pay the HCHs a monthly incentive payment to coordinate care for patients with chronic conditions, commonly asthma and diabetes. Per-member-per-month payments range from $10 to $79. Patients with multiple conditions or language or behavioral health issues will command higher payments. The state covers payments for Medicaid enrollees, while health plans absorb the cost for their privately insured enrollees. Providers commonly use the incentive payments to hire care coordinators to document a care plan for patients; discuss social needs; provide health education; schedule appointments; and facilitate communication among providers. These improvements are intended to help manage specialty care needs and reduce demand for specialty, emergency, and hospital care. Several state efforts are collecting quality and cost data on the initiative and an independent evaluation is planned for 2013 and 2015.

Project ECHO (Extension for Community Healthcare Outcomes) at the University of New Mexico

Project ECHO is a New Mexico videoconference-based program that allows specialty care to be provided in primary care settings. Founded in 2002 at the University of New Mexico (UNM) Health Sciences Center in Albuquerque, the state's only academic medical center, Project ECHO began as an attempt to address significant gaps in treatment for patients with hepatitis C, particularly in the many rural and low-income areas of the state. Multidisciplinary specialty care teams designed training curricula for primary care providers—physicians and NPs—and hold 16 weekly disease-specific sessions, approximately 10 of which are for medical specialties, while others

cover mental health and substance abuse. In these "teleECHO clinics" or so-called "virtual grand rounds," primary care providers present de-identified patient cases to the specialists, who provide advice on the treatment plans. The primary care providers gain expertise to eventually become "mini specialists." Project ECHO has expanded over time and now trains primary care providers in other states as well. Over 1,000 primary care physicians, nurses, nurse practitioners, and physician assistants throughout the state and beyond have participated to date. Project ECHO employs over 40 people to operate the program.

Project ECHO receives diverse funding, including federal and state grants and university support. In addition, the state Medicaid program covers half of the administrative costs of teleECHO clinic services provided to Medicaid patients. Project ECHO services are free to primary care providers, although these providers give up their time to train and prepare, which takes them away from seeing additional patients and bringing in revenues. However, Molina Healthcare, one of the state's four Medicaid managed care health plans, reimburses primary care providers for presenting its Medicaid enrollees to a teleECHO clinic ($150 per patient) and provides $1,500 to some primary care providers to defray the costs of their initial in-person training at UNM.

UnitedHealthcare Community Plan, partnered with Tennessee Primary Care Association, Community Health Network, and Meharry Medical Group

This model represents a partnership among UnitedHealthcare, one of the three health plans participating in Tennessee's Medicaid program; the Tennessee Primary Care Association (TPCA), the state primary care association; and Community Health Network (CHN), a coalition of community health centers. In 2009, UnitedHealthcare set out to develop telehealth infrastructure to increase access primarily to behavioral health services, but also to specialty services, for Medicaid enrollees throughout much of this rural state. Through telehealth units set up at approximately 40 primary care sites throughout the state, patients are treated remotely by specialists in nine medical specialty areas at Meharry Medical Group, a multispecialty faculty practice at Meharry Medical College, an academic medical center in Nashville. CHN's role is largely to install and maintain the equipment and to serve as the scheduling hub for telemedicine appointments across sites. TPCA trains the primary care staff and recruits new primary care sites and providers to participate.

Funding to support the model flows in multiple ways. CHN had received public and private grants to install most of the telehealth units and establish the processes for using them. UnitedHealthcare paid CHN to install and maintain some additional units and reimburses the Medicaid enrollee's primary care provider a small amount for initiating a telehealth appointment. UnitedHealthcare and the primary care providers also pay CHN for their role and UnitedHealthcare pays TPCA an annual amount and reimburses Meharry Medical Group for providing the care. Tennessee's Medicaid program covers services delivered via telehealth.

The Meharry specialists dedicate blocks of time to telehealth visits; reportedly, approximately 20 medical specialty referrals are arranged each month. Still, a number of factors have led to excess capacity in the telehealth network, including a high no-show rate, the cost to primary care providers, and primary care providers' lack of familiarity with the equipment and with specialists outside their community. Some of the extra appointment slots are used by uninsured patients and the prison population.

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