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Improving Access to Specialty Care for Medicaid Patients: Policy Issues and Options

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Overview

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.

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.

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