CHI SNAC LABS 2013-14

# Food for Thought

Updates from the Safety Net Advisory Committee (SNAC)

# The Special Case of Specialists:

## *Challenges and Opportunities in Colorado Medicaid's Accountable Care Collaborative*

APRIL 2013

Leaders from a variety of groups that serve vulnerable Coloradans – including representatives from patient advocacy organizations, safety net clinics, the Regional Care Collaborative Organizations and the Colorado Department of Health Care Policy and Financing (HCPF) – participated in the SNAC Lab on April 25, 2013.

This report of the learning lab has two sections: Background information provided by the Colorado Health Institute and a summary of the discussion.

### *Primary Themes*

- **Accessing specialty care** is often difficult for Medicaid patients due, in part, to a shortage of specialists. Pain management care is a significant need across the state.
- **Payment reform,** including models that reward good outcomes, could help address Medicaid reimbursement rates that are widely considered to be too low.
- **New "non-visit based" approaches** to specialty care are promising ways to improve patient access and communication between primary care providers and specialists.

### *Background: The Need for Specialty Care*

Specialty care is a critical part of the health care continuum. Most people do not need specialty care in any given year, but when they do it is often an urgent need for a serious condition. Adults tend to see specialists more often than children, according to the 2011 Colorado Health Access Survey (CHAS). As more adults enroll in Medicaid, it is important to look at how specialists fit into Colorado Medicaid's Accountable Care Collaborative (ACC), a program with the triple aim of improving health, enhancing the patient experience and controlling costs.

Vulnerable Coloradans, even those with Medicaid coverage, often lack access to specialty care. A 2010 survey conducted by the Colorado Health Institute for Kaiser Permanente asked safety net providers a number of questions, including their experiences trying to make referrals for their patients.

This table shows the most difficult and the least difficult referrals to successfully complete for Medicaid patients:

| Five Most Difficult Specialties | Five Least Difficult Specialties |
|---|---|
| Pain Management | Radiology |
| Endocrinology | Oncology |
| Elective Surgery | Cardiology |
| Reproductive Endocrinology | Chemotherapy |
| Physiatry | Diagnostics |

Source: 2010 Colorado Safety Net Specialty Care Assessment

The 2011 CHAS asked respondents if they had health insurance for all of the previous year and what kind of coverage they currently had. Of respondents currently covered by Medicaid and who had some form of health insurance throughout the previous year, 12 percent said they had gone without needed specialty care during the past year due to cost. By comparison, 6.6 percent of respondents covered by private insurance reported going without needed specialty care due to cost. About a third (33.1 percent) of uninsured respondents said they went without needed specialty care during the previous year due to cost.

There are several possible explanations for the findings. Some Medicaid clients may have thought they couldn't afford a co-payment for specialty care even though out-of-pocket expenses are usually a few dollars. Also, there could have been travel costs associated with visiting a specialist that discouraged Medicaid patients. And, it is possible that Medicaid clients had different insurance in the past year that required higher out-of-pocket co-pays.

Cost isn't the only variable. Nearly half of safety net medical directors reported there is often not a specialist available in the community to meet certain needs and half said that long wait times to get an appointment are a major barrier, according to the 2010 specialty care assessment.[1]

## *The SNAC Lab Discussion*

Colorado has decided to expand Medicaid, and as more people enroll there will be increasing pressure to

make specialty care more efficient and more accessible. Currently, Colorado Medicaid's Accountable Care Collaborative focuses on primary care and does not have a defined role for specialists. As the program grows, some SNAC Lab participants said that should change.

## *Terms to Know*

**Specialty care:**
Medical care provided by a board-certified specialist with advanced training and focused clinical expertise. Sometimes oral health and behavioral health are treated like specialties because many safety net clinics do not provide these services and must refer patients to other providers. The SNAC lab discussion primarily focused on specialties such as pain management or endocrinology given the challenges that vulnerable Coloradans face in gaining access to this care.

**ACC:**
The Accountable Care Collaborative, which is a central part of Colorado Medicaid reform, aims to improve health while reducing health care spending by rewarding positive health outcomes rather than a high volume of service. The ACC has three building blocks; regional care collaborative organizations (RCCOs), primary care medical providers, and a statewide data and analytics contractor (SDAC).

**RCCO:**
Regional Care Collaborative Organizations help coordinate care for Medicaid patients enrolled in Colorado's Accountable Care Collaborative, which is broken down into seven regions.

The conversation included the following points:

- ***Barriers to Access Vary***

The need for – and access to – specialty care is generally different for adults than for children. SNAC Lab participants report that pediatric specialists often view Medicaid as part of their payer mix while specialists who serve adults are more likely to consider Medicaid clients as pro bono and therefore limit the number of Medicaid patients they see. In particular, few dental specialists in private practice accept Medicaid.

The discussion also identified pain management as a particular challenge. It was generally agreed that many areas of the state do not have enough pain management specialists. This is due, in part, to the perceived increased risk in dispensing opioids, which can lead to dependency and substance abuse. Alternative approaches to helping people in pain, such as group visits and behavioral health intervention, are used less often because of payment difficulties.

- ***Payment Reform Holds Promise***

Insufficient reimbursement is a barrier for Medicaid patients who need to see a specialist. Initiatives such as the ACC payment reform pilot projects required by HB12-1281 and possible payment model changes in the RCCO re-bid may help primary care providers and RCCOs develop new kinds of relationships with specialists. For example, one RCCO's proposal for an alternate payment structure targets people enrolled in both Medicare and Medicaid, many of whom have significant needs for specialty care. State leadership on payment and delivery system reform within the Medicaid program could also support non-visit based reimbursement for consulting with a specialist.

- ***New Approaches are Emerging***

SNAC Lab participants cited several alternatives to office-based visits that can increase access to specialty care and consultation. Among them: telemedicine, telepharmacy and consultations with providers and/or patients via phone, text message or Skype. Kaiser Permanente Colorado is working on a pilot program in which clinicians at some federally qualified health centers use secure email to seek guidance from Kaiser specialists. Such alternatives to office visits are particularly useful in rural areas. Challenges to implementing these mechanisms include questions and concerns about liability, payment and how patients and providers respond to the use of technology. Identifying effective methods of referral and/or consultation between primary care providers and specialists is a key concern.

- ***Integrating Care Requires Collaboration***

HCPF is actively discussing the integration of behavioral health services with primary care. Behavioral health services can improve health in a variety of ways, reducing the need for specialist services. On another front, it is important that specialists and primary care physicians work together when they share a patient. Some patients might see a specialist – an oncologist or rheumatologist, for example – for most of their medical needs. But these patients might also require basic primary care that the specialist is not necessarily equipped to provide. So, close collaboration between the two is essential, even in situations where the specialist is providing most of the care.

- ***Change Brings New Questions***

The health care system is undergoing significant changes that will require answers to a number of questions. Once Coloradans can purchase health insurance through Connect for Health Colorado, might the higher numbers of those with private coverage make it even more difficult for Medicaid patients to see a specialist? What models might help a particular community better serve patients needing specialty care? SNAC Lab participants suggested that local or regional needs assessments, which use information from a variety of sources to determine what a community needs, could help answer these questions.

## *Conclusion*

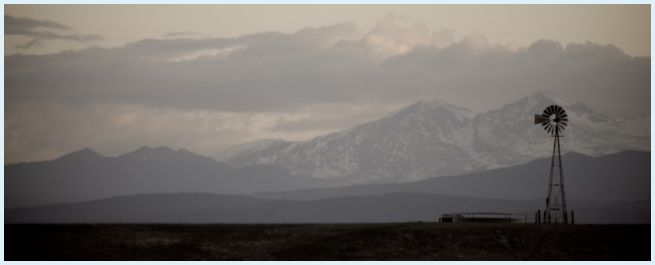
Vulnerable Coloradans often have difficulty accessing specialty care. Colorado's Medicaid expansion will increase the number of adults enrolled in Medicaid, likely making specialty care access a greater challenge for the Accountable Care Collaborative (ACC). Changes in how care is provided and paid for are being explored to help people get the care they need when they need it. While the ACC is currently focused on primary care, many consider upcoming ACC payment reform pilot programs to be an opportunity to engage specialists and improve access to specialty care.

[1] Colorado Health Institute. (2011). 2010 Colorado Safety Net Specialty Care Assessment. Available at: http://www.coloradohealthinstitute.org/uploads/downloads/2010_SpecialtyCare.pdf

# Reporting from the Field

**Donna Mills** sees unique challenges with specialty care in her corner of Colorado. As the chief executive officer of Integrated Community Health Partners (ICHP), she oversees RCCO Region 4 – an area covering 19 counties in southeast Colorado, including the San Luis Valley, Pueblo and the vast rural areas all the way to the Kansas border.

Most of the area's providers already serve Medicaid patients. The challenge is not so much in finding willing specialists, but the fact that there are so few of them. ICHP has worked creatively to leverage existing relationships with specialists. Mills relies



on connections she made with specialists in previous jobs. She also emphasizes the importance of explaining the ACC model to specialists. She believes that once they understand it, getting them to work with the program is not a hard sell. Many specialists are reassured to know that a Medicaid patient is connected with a medical home that addresses the patient's primary care needs, she said.

# What to Watch

## Events Affecting Specialty Care and the ACC

### May 1, 2013:
Medicaid expansion in Colorado approved by the legislature.

### May 13, 2013:
Governor John Hickenlooper signs Medicaid expansion into law. Coloradans who will be newly eligible for Medicaid starting January 1, 2014, are mostly working age adults with annual incomes up to 133 – effectively 138 – percent of the federal poverty level (FPL).

### July 2013:
The Colorado Department of Health Care Policy and Financing will select at least one Medicaid payment reform pilot project under HB12-1281.

**Gov. John Hickenlooper** signs Senate Bill 200, Medicaid Expansion, into law at the State Capitol on May 13.

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