Aurora Health Alliance

SPECIALTY CARE ACCESS NEEDS ASSESSMENT

2021

Aurora Health Alliance Specialty Care Needs Assessment

Table of Contents

1. Project Summary & Key Findings 2
2. Acknowledgements 5
3. Individual Results
   a. Aurora Health Alliance Specialty Care Access Survey 6
   b. CU Medicine Specialty Care Waitlist Analysis 2021 14
   c. Department of Health Care Policy and Financing Regional Accountable Entity Specialty Care Survey 2019 16
   d. Colorado Safety Net Collaborative Specialty Care Survey 2019 17
4. Bibliography 20
5. Appendix 1 – Raw Qualitative Data (Additional Direct Quotes) 21

Project Summary & Key Findings

Aurora Health Alliance Specialty Care Needs Assessment

INTRODUCTION

A National Challenge

Insufficient access to specialty care is a national problem. A large disparity in access to specialty care exists between patients with employer-based insurance and uninsured patients or patients with Medicaid, which is further stratified by differences in socioeconomic status (Alcala et al., 2018). In addition, uninsured patient status is associated with fewer physician visits than patients with Medicaid (Liang et al., 2019). Despite efforts to expand Medicaid, access to specialty care remains a major challenge for patients with Medicaid and those who remain uninsured (Ndumele et at., 2017). In addition to insurance and high cost, common barriers to accessing care include: prolonged wait times to be seen, specialist and referral coordinator shortages, transport and clinic-location factors, lack of clinic-hospital affiliations, and poor communication between primary and specialty providers (Hall, 2013; Levison, 2014; Ezeonwu, 2018).

Becomes a Local Challenge

Lack of access to specialty care is a known challenge in the state of Colorado and the city of Aurora. The Colorado Health Institute conducted a study in 2019 that utilized extrapolated Colorado statewide data to better characterize the unmet specialty need within Colorado. This report identified specialties with the greatest unmet need and ophthalmology and dermatology were at the top of the list for Medicaid patients. The study identified ophthalmology, psychiatry, and geriatrics as the greatest unmet need for patients without insurance (Caldwell et al., 2019). In a Fall 2019 Aurora Health Alliance (AHA) Access to Specialty Care Task force meeting, the group reflected that though the results of the study were insightful, they did not seem to resonate with what the task force had been hearing about top needs in Aurora.

The task force realized that in order enact change, they needed local, reliable data on the priority specialty care needs.

Becomes a Local Opportunity

The AHA Specialty Care Needs assessment initiative was born out of this need. This assessment aimed to characterize and prioritize the unmet need for specialty care among Medicaid and uninsured populations within Aurora, CO as well as assess barriers and potential solutions to provide strategic direction for addressing the unmet need. The task force hopes that with prioritization and strategic direction, change in the specialty care issues in Aurora can be realized.

Aurora Health Alliance Specialty Care Needs Assessment

METHODS

The volunteer team used a mixed-methods approach to achieve its aims, combining existing data with a new survey of providers and care team members caring for uninsured and/or Medicaid-insured Aurorans.

The findings were an overlay, identifying emergent findings from the following assessments:

1. **AHA Specialty Care Access Survey**: Survey of care team members and primary care providers serving Medicaid-insured and/or uninsured Aurorans. Respondents ranked top unmet specialty care needs based on insurance status, least needed specialties and shared narratives describing their challenges and successes in facilitating patient access to specialty care. A web-based survey implemented in another multi-state initiative was adapted from Timbie J, et al. (2020) to collect additional data identifying greatest social barriers and identify potential solutions to the unmet specialty care need. Analysis of quantitative findings included frequencies and a scoring system for analyzing rankings and qualitative findings were analyzed by a group of 5 coders following an inductive approach.
2. **CU Medicine Specialty Care Waitlist Analysis - 2021:** Average wait time to new appointment was assessed for all specialty care clinics over a 6-month period, analyzing average wait times for Aurora residents with Medicaid insurance compared to non-Medicaid/commercial insurance. All specialties with < 100 new patient requests were excluded with the exception that rheumatology was analyzed to provide a comment, as it was a prominent finding in the AHA Specialty Care Access Survey. Two analyses were run: (1) Top 10 clinics with the absolute longest average and median wait times for patients insured by Medicaid. (2) Statistical comparison of average wait time for specialty clinics for patients insured by Medicaid versus commercial insurance, with a resultant ranking of those with statistical differences based on level of disparity.
3. **Health Care Policy and Financing (HCPF) Regional Accountable Entity (RAE) Specialty Care Survey – 2019:** Representatives from each RAE responded to a survey to characterize their highest need specialties by region (providing numerical data, waittimes if able, other data) and challenges. Data prioritizing needs from RAE Region 3 (corresponding to Aurora) was utilized in this AHA Specialty Care Needs Assessment.
4. **Colorado Safety Net Collaborative (CSNC) – 2019 Survey**: A 2019 survey of CSNC members (comprised of non-federally qualified health centers) asked respondents to identify top referral needs. Also asked respondents to share challenges and successes with referrals and the final recommendations provided strategic priorities to the Department of Healthcare Policy and Financing (HCPF).

RESULTS

- **Specialty Care Priorities: emergent priorities for unmet needs aligned across all 4 needs assessments**
  - Specialty care survey was used as the "gold standard" and other analyses affirmed those findings
  - Most of the unmet needs aligned across uninsured and Medicaid patients
  - Among Medicaid patients, <u>every specialty</u> was mentioned at least once as a priority unmet need. There were still emergent priorities.
- **Medicaid & Uninsured Greatest Unmet Specialty Care Need**
    - Neurology
    - Rheumatology
    - Psychiatry
    - Urology
    - Endocrinology
    - Orthopedics (non-operative/operative)
    - Pain Management
    - Substance Abuse Management
  - **Additional Priorities for Uninsured:**
    - Gastroenterology
    - Oncology
    - General Surgery
    - Diagnostic Tests/Procedures: endoscopy & colonoscopy; cardiac testing (echocardiogram, stress testing, cardiac monitoring); MRI & CT scans
  - *Note: Cardiology was identified among the top 10 of the greatest unmet needs and also on top 3 least needed specialties. Cardiology should be a target for further inquiry.*
- **Medicaid and Uninsured Least Needed Specialties**
  - Obstetrics
  - Cardiology
  - Ophthalmology (general)
- **A menu of strategic solutions emerged – with a clear first step, that network transparency is needed.** *This was an emergent finding found in both the AHA Specialty Care Access Survey & CSNC 2019 Specialty Care Survey.*

ACKNOWLEDGEMENTS

Aurora Health Alliance Specialty Care Needs Assessment

Thank you to all who contributed to this project at various points from conception to completion.

- Core Project Team:
  - Allyson Gottsman
  - Angel Surafel
  - Clayton Hoffman (student)
  - Dionisia de la Cerda
  - Eugene Ng (student)
  - Kari Mader
  - Tristan Hall
- Analyst Volunteers:
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  - Denise Denton
  - Emily Larson
  - Maydha Kumar
  - Molly Markert
- Thank you to multiple others who provided outside needs assessments, data from CU Medicine and assisted in distribution of the AHA survey.

AHA Specialty Care Access Survey

Aurora Health Alliance Specialty Care Needs Assessment

Survey Description

- Part 1: Unmet Needs
  - Demographics (clinic, role, patients populations)
  - Top unmet specialty care needs Medicaid; uninsured
  - Least problematic specialty care need for Medicaid; uninsured
  - Free Response (if applicable) – top 3 problematic diagnostic tests or procedures for uninsured patients
- Part 2: Barriers and Solutions
  - Free Response – barriers and solutions that should be considered for Medicaid; uninsured
  - Adapted a list from the literature of common barriers and solutions, asking respondents to rank how often a barrier occurs or that a solution should be utilized (Timbie et all, 2020).

Analysis

- **Quantitative:** frequencies, means, rank assignment of priorities
  - Explanation of Rank Assignment of Priorities:
    - $Score = \sum Rank\ Number\ Multiplier \times Number \times Mentioned$
    - **Example:**

Level of Unmet Need	#1	#2	#3	#4	#5
Multiplier for the Score	5	4	3	2	1
Department: (Frequency) Cardiology (Number of People that said This was the #1, 2, 3… top concern)	5	2	0	1	2

$$Score = (5 \times 5) + (4 \times 2) + (3 \times 0) + (2 \times 1) + (1 \times 2) = 37$$

    - Rank Conclusion: the higher the score, the higher the unmet need in the analysis
- **Qualitative:** thematic analysis utilizing inductive approach, 4 coders

Results

Respondents

- 54 respondents
- 15 clinics represented care for Aurora residents (see Figure 1)
- 59% of respodents from Aurora FQHCs
- Roles: 55% primary care providers, 45% team members (office managers, care managers, referral specialtists, etc.)
- Survey Sub-Sections:
  - 80% of respondents cared for Medicaid patients and answered Medicaid-specific questions
  - 75% of respondents cared for uninsured patients and answered uninsured-specific questions
  - 67% responded to Part 2 of survey, asking about barriers and solutions to specialty care

Figure 1		
Clinic Name	Participant Frequency	Number of Providers per Clinic
Adult Special Care Clinic	1	71
AF Williams Family Medicine - Central Park	9	34 (medical only)
Aurora Community Health	7	7 (medical only), 11 (total)
Colorado Primary Care Clinic	1	4
DAWN	9	~20
Guardian Angels Health Center	2	6
STRIDE CHC – Del Mar	8	6 (medical only)***
STRIDE CHC – East Colfax	1	4 (medical only)***
STRIDE CHC - Englewood	1	Closed permanently
STRIDE CHC – Hampden & Chambers	1	7 (medical only)***
STRIDE CHC – Peoria	3	17 (medical only) ***
STRIDE CHC – Wheat Ridge	1	19 (medical only) ***
STRIDE CHC – unspecified	10	N/A
UCHealth University Internal Medicine	1	37
Young Mother's Clinic	1	9
**** Info collected via phone operator. There is overlap in these providers – some providers travel to multiple locations and are accounted for in both clinic provider #s.*		

Aurora Health Alliance Specialty Care Needs Assessment

Unmet Specialty Need Ranked

Rankings in Descending Order - Medicaid		Rankings in Descending Order - Uninsured	
Top 1-5		Top 1-5	
Department	**Score**	**Department**	**Score**
Neurology	54	Cardiology	55
Rheumatology	48	Gastroenterology	43
Psychiatry	47	Orthopedics- operative	41
Urology	43	Oncology	38
Endocrinology	42	General Surgery	37
Orthopedics- non operative	42	Neurology	32
Cardiology	37	Urology	29
Orthopedics- operative	35	Endocrinology	23
Pain Management	35	Orthopedics- non operative	22
Substance Use Disorder Treatment	33	Pain Management	20
Dermatology	28	Gynecology	18
Gastroenterology	20	Other - please specify	17
Oncology	12	Psychiatry	16
Other - please specify	12	Substance Use Disorder Treatment	15
Nephrology	11	Dermatology	13
General Surgery	11	Otolaryngology	13
Gynecology	10	Rheumatology	12
Pulmonology	9	Pulmonology	10
Ophthalmology- general	5	Nephrology	9
Ophthalmology- retinopathy screening	5	Ophthalmology- retinopathy screening	9
Otolaryngology	5	Ophthalmology- general	6
Obstetrics	4	Obstetrics	0
Podiatry	3	Neurosurgery	0
Neurosurgery	2	Podiatry	0

Aurora Health Alliance Specialty Care Needs Assessment

Easiest Specialties to Access Ranked

Rankings in Descending Order - Medicaid		Rankings in Descending Order - Uninsured	
Top 1-3		Top 1-3	
Department	**Score**	**Department**	**Score**
Obstetrics	45	Obstetrics	33
Cardiology	37	Ophthalmology- general	26
Ophthalmology- general	20	Cardiology	25
Gastroenterology	14	Gynecology	19
Gynecology	12	Dermatology	10
Orthopedics- non operative	11	Neurology	8
Dermatology	6	Other - please specify	8
Oncology	5	Oncology	7
Endocrinology	4	Ophthalmology- retinopathy screening	6
Otolaryngology	4	Substance Use Disorder Treatment	5
Neurology	3	Psychiatry	4
Ophthalmology- retinopathy screening	3	Pulmonology	3
Orthopedics- operative	3	Endocrinology	2
Substance Use Disorder Treatment	3	Gastroenterology	2
General Surgery	3	Otolaryngology	2
Podiatry	2	Podiatry	2
Pulmonology	2	Orthopedics- non operative	1
Psychiatry	2	Neurosurgery	1
Rheumatology	2	Urology	1
Nephrology	0	Nephrology	0
Neurosurgery	0	Orthopedics- operative	0
Pain Management	0	Pain Management	0
Urology	0	Rheumatology	0
Other - please specify	0	General Surgery	0

Aurora Health Alliance Specialty Care Needs Assessment

Barriers to Specialty Care - Ranked Quantitative Findings

Top Barriers for Medicaid Patients		
Barrier	Score	Number of People that Responded (N)
Long call waits when attempting to schedule appointments	110	36
Few specialists in your Medicaid MCO network(s) accepting new patients	76	19
The inability to determine the total out of pocket cost for a specialty care visit/procedure	69	19
Patients' out-of-pocket costs for specialty care	65	19
High incidental/opportunity cost of making a decision to go to the doctor (ex: missed work)	59	19
Few specialists that meet the cultural or language needs of your health center's patients	59	19
Difficulty expanding your health center's scope of project to include on-site specialty services	59	19
Low Medicaid reimbursements for specialists	58	19
Patients' long travel distance/time to specialists	56	19
Few affiliations with local hospitals or health systems among your health center's physicians	55	19
Few personal relationships between your physicians and specialists outside of your health center	54	19
Medicaid MCO administrative requirements for obtaining specialist consultations (e.g., prior authorization for referral)	54	19
Difficulty establishing formal referral agreements between your health center and specialists	50	19
Difficulty obtaining malpractice insurance coverage for specialists through the Federal Tort Claims Act	6	19

Top Barriers for Uninsured Patients		
Barrier	Score	Number of People that Responded (N)
Long call waits when attempting to schedule appointments	105	36
The inability to determine the total out of pocket cost for a specialty care visit/procedure	85	20
Patients' out-of-pocket costs for specialty care	84	19
High incidental/opportunity cost of deciding to go to the doctor (ex: missed work)	76	20
Patients' long travel distance/time specialists	64	20
Patient immigration status	59	19
Few affiliations with local hospitals or health systems among your health center's physicians	57	19

Few personal relationships between your physicians and specialists outside of your health center	56	19
Difficulty establishing formal referral agreements between your health center and specialists	56	19
Few specialists that meet the cultural or language needs of your health center's patients	55	20
Low reimbursements for specialists	44	20

Solutions to Specialty Care Access - Ranked Quantitative Findings

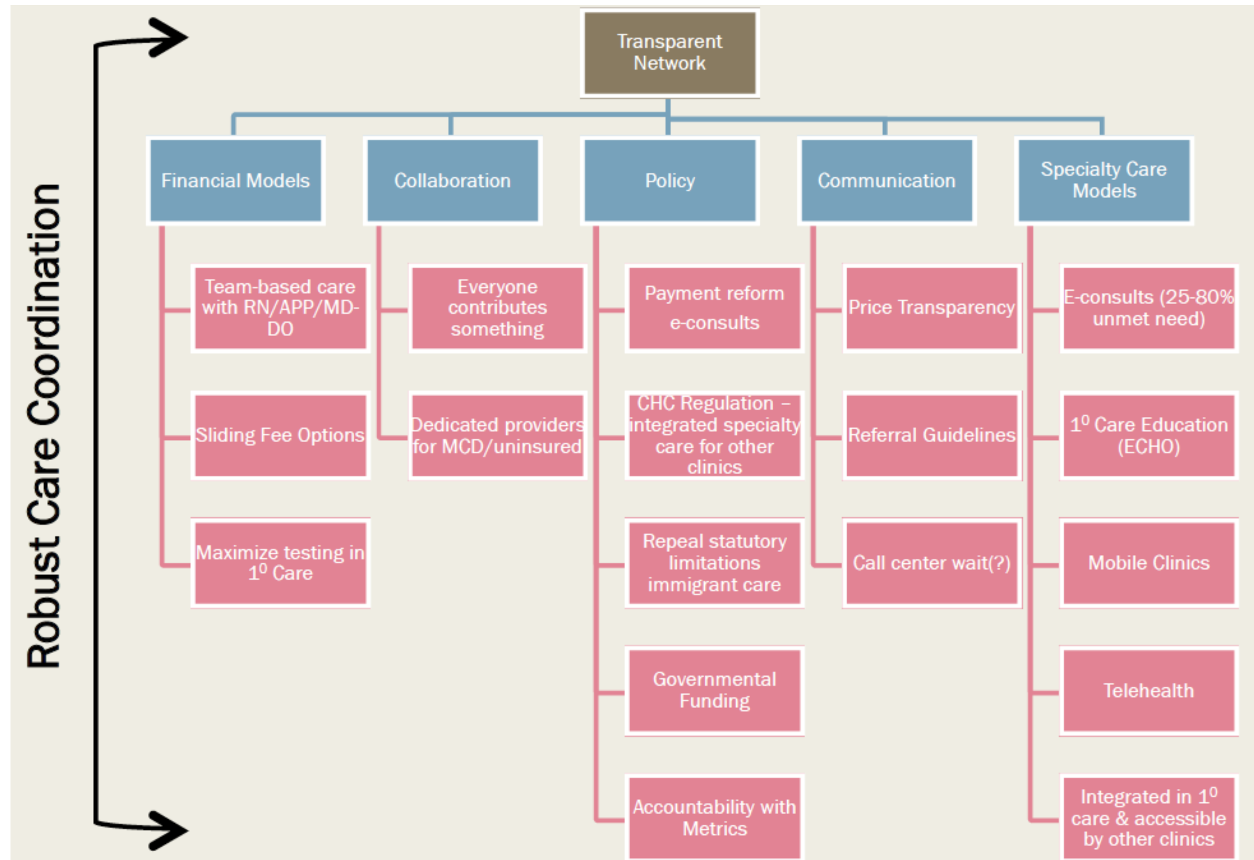
Medicaid Patients Top Solutions		
Barrier	**Score**	**Number of People that Responded (N)**
Exchange electronic health information with specialists	76	19
Use patient navigators/case managers to help navigate specialty care appointments	68	19
Reminding patients about appointments	66	19
Making appointments on behalf of patients	62	19
Use telemedicine for any patients	61	19
Use e-consults for any patients	53	19
Have agreements with specialists about the types of referrals specialists will accept when making referrals	40	19
On-site provision of specialty care for any patients	32	19

Uninsured Patients Top Solutions		
Barrier	**Score**	**Number of People that Responded (N)**
Making appointments on behalf of patients	72	19
Use patient navigators/case managers to help navigate specialty care appointments	68	19
Reminding patients about appointments	65	19
Use e-consults for any patients	58	19
Use telemedicine for any patients	55	19
On-site provision of specialty care for any patients	51	18
Have agreements with specialists about the types of referrals specialists will accept when making referrals	47	19

Thematic Findings

Barrier – Medicaid + Uninsured	Example Quotes
Specialists do not accept Medicaid & uninsured patients.	*“Many specialties are not willing to take uninsured or Medicaid patients”*
For those that accept Medicaid and/or uninsured patients, there is significantly limited access (except for obstetrics).	*“All clinics are full for Medicaid patients for the year. No new patients accepted.”*
The current specialty care environment is unnecessarily complex and challenging to understand and navigate. Several challenges noted included transportation, opportunity cost of missed work, requiring scheduling very far in advance, and language barriers.	*“…having the time to individually advocate for patients to get urgent care when they need it (no time for this type of care coordination), helping patients address their barriers to getting the appointment scheduled and physically going to the appointment (they don't know how to navigate the complex system to get an appointment and often have transportation issues getting there)…”*
Dominant theme for Medicaid	
For specialists that accept Medicaid, there is cap on the number that limits access. This cap was noted multiple times to be confusing and lack of transparency makes it hard to help patients access care.	*“…sets caps on how many Medicaid patients they can see for each specialty and it isn't very transparent. It is very difficult for us to know if someone is accepting Medicaid or not as it often changes and it is difficult to find out. Also, some greatly limit access”*
Dominant theme for Uninsured	
Cost is the major barrier for uninsured populations. Transparency around this cost is a primary issue and patients forego care due to not knowing the cost. This barrier contributes to specialty care access at each step in the specialty care referral process, preventing patients from obtaining the basic screening and/or testing that is needed before seeing a specialist.	*“The largest barrier is….cost and lack of cost transparency. My patients can't afford to go to *** if they are uninsured and I can't even tell them the cost if they want to”* *“…patients being referred out for MRI/CT scan and have no insurance end up canceling procedure due to cost of test”*

Prioritized Map of Solutions – *from qualitative + quantitative findings*



Aurora Health Alliance Specialty Care Needs Assessment

CU Medicine Specialty Clinic Waitlist Analysis - 2021

Detailed Methods

- Comparing average time to appointment between Medicaid patients and all others (minus uninsured)
- Limited to "new patients" and first appointment request
- Limited to patients w/ an Aurora address to evaluate specialty needs and access disparities in that area
- Timeframe: 1st two quarters of calendar year 2021
- Grouped appointment waits by specialty
    - Originally grouped into 61 specialties
    - Limited to 27 specialties for this analysis – criteria: >=100 Medicaid patient appointment requests (evaluated prior to outlier removal)
        - *Note: Rheumatology additionally analyzed as was an emergent finding in AHA Survey; had 74 unique Medicaid referrals in study period*
- Outliers were removed from the data if they were more than 1.5 times the interquartile distance above the 3rd quartile or below the 1st
    - Outliers were identified and removed on a per specialty basis
- Upon data visualization & quantile plotting, the wait time data is non-normally distributed
- Performed 27 one-tailed Mann-Whitney (non-parametric) tests to determine if wait times for Medicaid patients were significantly longer than non-Medicaid patients per specialty
- Determined effect size (Vargha & Delaney's A) for all significant results, which gives the relative magnitude of the disparities
- Significance set at $p<0.025$ due to all tests run as single-tail tests (note resetting to $p<0.05$ did not change results)

Results

Aurora Health Alliance Specialty Care Needs Assessment

Top 10 in Descending Order – Longest Days to Appointment Medicaid (Mean)		Top 10 in Descending Order – Longest Days to Appointment Medicaid (Median)	
Specialty Clinic	**Mean Days**	**Specialty Clinic**	**Median Days**
1. Endocrinology	73.3	1. Endocrinology	94.4
2. Neurology	71.3	2. Sleep Medicine	56.4
3. Sleep Medicine	54.4	3. Neurology	51.9
4. Spine and Rehab Medicine	46.9	4. Pulmonology	40.6
5. Sports Medicine	42.1	5. Spine and Rehab Medicine	40.4
6. Gastroenterology	41.6	6. Gastroenterology	34.5
7. Pulmonology	35.8	7. Cardiology	28.6
8. Ophthalmology	28.5	8. Pain Medicine	24.4
9. Pain Medicine	28.4	9. Dermatology	22.7
10. Urology	28.3	10. Ophthalmology	20.3

Ranked in Descending Order – Significant Disparity Average Wait Medicaid vs Non-Medicaid Insured Aurorans	
Specialty Clinic	**Effect Size (Vargha & Delaney's A)**
1. Pain Medicine	0.74
2. Sports Medicine	0.72
3. Spine & Rehab Medicine	0.67
4. Maternal & Fetal Medicine	0.67
5. Urology	0.56
6. Hematology & Oncology	0.55
7. Cardiology	0.54

**Rheumatology was evaluated as had just under 100 referrals and if had been included, would have ranked 9th in median wait time and had no significant difference in wait time compared to those who were commercially insured*

HCPF RAE Specialty Care Survey Report – 2019

Note: Region 3 corresponds to Aurora and were considered in combined findings

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Region 3 Findings (highlighted from below full region report)

- **Limited to no providers taking Medicaid members** – Urology, Dermatology, Endocrine, Gastroenterology
- **Limited availability and/or long wait times** – Rheumatology

Specialty areas with limited to no providers taking Medicaid members /new Medicaid patients

- Cardiology (6,7)
- **Urology*** (1,2,3,4,5,6,7)
- **Neurology*** (4,6,7)
- Pain Management (2,4)
- Psychology/Developmental (4)
- Dermatology (1,2,3,4,5,6,7)
- Endocrine (2,3,6,5,7)
- **Orthopedics*** – adults (1,2,6,7)
- **Gastroenterology*** (3,4,5) / GI (6,7)

*the same four specialties identified by Safety Net Providers Alliance

Specialty areas with limited availability and/or long wait times

- Rheumatology (1,2,3,4,5,6,7)
- Hepatology (2)
- ENT (2,6,7)
- Sleep Study (2)
- Podiatrists (2,6,7)
- Pain Management (4)

Specialty areas most likely to take Medicaid members/new patients

- Oncology (6,7)
- Cardiology (2,4)
- Pain Management (6,7)
- Radiology (6,7)
- Physical Therapy (2,4)
- Optometry/Ophthalmology (6,7)

Colorado Safety Net Collaborative Survey 2019

Top Referral Needs

- **Top 4 were mentioned 80% of the time. Others are at 40% or lower.**

Aurora Health Alliance Specialty Care Needs Assessment

Top Specialties (Mentioned 80% of the time):

Neurology
Orthopedics
Gastroenterology
Urology

Other Specialties (Mentioned 40% of the time or less):

Pain Management
Psychiatry
Ophthalmology
Endocrinology
TBI
Surgery
Ear/Nose/Throat
Breast Health
Cardiology
Rheumatology
Nephrology
Radiology
Dermatology

Volume of Referrals:

- Volume varied greatly, depending on size of practice and location, but most of our respondents have about 20-100 per month.
- Good news! Members report that referrals for children through Children's Hospital are well in hand. There does not appear to be a dependency on the patient's insurance type, or lack of insurance to have a successful referral.
- Bad news! Adult referrals are VERY hard. Even if a member of CSNC can get a referral, patients must often wait 6-9 months to get the care. Our members indicate that post in-hospital specialty follow up is not an issue and that ER specialty care is not an issue. It is the hand-off from a community provider to a specialist that is an issue.
- Specialty providers often cite that Medicaid-insured patients are unreliable which, we understand, can create a disincentive for taking Medicaid patients. Sticking with appointments is not easy for many of these patients. Life gets in the way. For example, if someone is in between housing situations or problems with kids, these are going to take precedence. The primary care practices we heard from realize this reality (and perception) about their clients and work with them to assure "compliance," – assisting with transportation, reminder calls, etc.

Ideas for Next Steps:

In general, more transparency in the referral process and decision-making is needed. We fully understand that not every referral is being done effectively, but it will take all members of the community – specialists, primary care providers and members how to create a successful referral. Information about how referrals should be made should be readily available. And results tracked.

There is agreement that there are challenges to specialty care referral for some specialties for all patients, regardless of insurance status. In these cases, the solutions to explore might center around capacity, workflow, and workforce. Our members indicate that post in-hospital specialty follow up is not an issue and that ER specialty care is not an issue. It is the hand-off from a community provider to a specialist that is an issue.

Here are some recommendations for how to address and alleviate this problem in Colorado that wee are happy to partner with you to solve:

Recommendation #1:

- Recommend practices, especially large ones like the University of Colorado or Optum, take 10 more adult Medicaid referrals a month for the top 4 and 5 (as identified by the community, not internally determined) above their current Medicaid caseload or commit to a 10% low income referral caseload. This should be over an established baseline from this year's data. If HCPF chose a flat number, that's 105 a month increase over current. If system or practice did that, they would reach 12,000 new patients and reduce the problems across Colorado.
- Increased referrals have to come from external sources like community clinics.

Recommendation #2:

- Specialists, Primary Care and Member experts define appropriate referral standards.
  - Starting with top 8 specialties
  - Following year, next 8 specialties

Recommendation #3:

Establish specialty care referral reporting requirements:

- how many referrals are requested from external and internal sources,
- what type are requested by specialty,
- how many are accepted by specialty,
- the patient's insurance status, and
- completion of the referral (did the patient show up, etc.)

Recommendation #4:

Continue the important work of defining both the scope and the breadth of Telehealth and eConsults. HCPF continues to work diligently on this issue for Medicaid.

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Appendix 1 – Raw Qualitative Data (Additional Direct Quotes)

Barriers to Specialty Care – Medicaid

20 - All clinics are full for Medicaid patients for the year. No new patients accepted.

14 - Answering based on my previous work in FQHC with adult patients-->clinics had a cap on Medicaid patients that they would see, so the patient would be put on a waiting list, there would only be 1 or 2 in the whole state who took Medicaid, transportation/time off work barriers for the patient

49 - availability, language barriers.

60 – Cost, location
47 - Developmental evaluations and specialty treatments (speech, physical and occupational therapies)

38 - Having them follow-up with appointments that are scheduled months in advance

19 - Limited number of specialists willing to take medicaid pts.

42 - Long wait times at offices who accept Medicaid.

12- Lower reimbursement for Medicaid

27 - Many clinic do not accept Medicaid, or at any given time they have stopped taking medication for some reason.

45 - many specialties are not willing to take uninsured or Medicaid patients

56 - Many specialties within my system (***) does not accept Medicaid

48 - Most of my patients are pregnant, and can MFM providers here take medicaid. I do have difficulty referring to other providers, ortho, physical therapy, endocrine in the referral processes, but generally we can get pts treated while they are pregnant. We do have long wait times for Ultrasound for all of our patients.

5 - Not accepting Medicaid patients

7 - Specialists willing to open their practice to accepting Medicaid patients. Our only choice is ***. Then when *** stopped accepting Medicaid patients we had absolutely NO WHERE to send our patients. Then *** takes no responsibility on the matter either.

36 - Specialty care access is pretty bad for several specialties regardless of insurance status. Neurology, Rheum, GI are a few examples. Medicaid adds more barriers. It was worse a couple years ago for medicaid but more providers in our system are seeing these patients IF they can get scheduled in one of our primary care clinics in the first place. A lot of primary care is capped to Medicaid

28 - The *** sets caps on how many Medicaid patients they can see for each specialty and it isn't very transparent. It is very difficult for us to know if someone is accepting Medicaid or not as it often changes and it is difficult to find out. Also, some greatly limit access.

8 - They do not want to take the bus, which is least expensive because they don't want to have to walk a little in between bus stop intersections.

62 - very long waitlists at clinics/institutions that accept medicaid and/or being closed to medicaid patients, having the time to individually advocate for patients to get urgent care when they need it (no time for this type of care coordination), helping patients address their barriers to getting the appointment scheduled and physically going to the appointment (they don't know how to navigate the complex system to get an appointment and often have transportation issues getting there). specifically with psychiatry, it is really tough to coordinate them getting prompt access…when they are near crisis but not in crisis yet (long waits, process to get to a prescriber, etc.)

52 - Waitlist duration Delays in care due to sending referral to *** that claims to take MCD but then denies referral due to being at capacity

24 - We don't have many options for Medicaid patients being referred out to Hand surgery/orthopedics specialist, sometimes we have to tell our patients to please follow up with Medicaid and see if they are able to assist them with a locations.

Barriers to Specialty Care – Uninsured

20 - Too expensive. No type of payment plans at times.

14 - Cost of care, specialty clinics that don't accept CICP, patient-level barriers around transportation, time off work, etc.

49 - they don't take new patients or uninsured patients.

60 - cost, location

19 - Colon cancer screening, beyond a fobt test is a joke for uninsured pts. We have little to no options to for dx colonoscopy for this population. Joint replacements (knees, hips) are also a huge challenge.

42 - Finding access to care, wait times.

27 - Affordability and locations that are easy to access
48 - Diagnostic procedure outside of *** are very difficult or impossible for most of my uninsured patients. We can get OB and limited GYN care, but if patients need non-gyn surgery or any other specialty referral, it is almost impossible. The top barrier is always cost.

5 - as previously noted (*had put not accepting patients*)

7 - Getting the patient to pay for services that they can't afford nor want to afford. I have found that specialists always accept cash, check, or charge. Once again it falls on patients willingness to pay.

28 - The largest barrier is cost and lack of cost transparency. My patients can't afford to go to *** if they are uninsured

8 - They are simply non-compliant and often no show to appts.

62 - Any expensive diagnostic tests and procedures are a huge issue and make it virtually impossible. Knowing the actual cost of the procedures they need, if a discounted price is available to be able to offer that to the patient. If we could have that, that would be helpful and allow the patient to make a decision but that is not available. Even having the basic tests or access for cheaper, common things would be helpful. EGDs/colonoscopies, hernia repairs, hysterectomy access, cardiac testing - nuclear medicine testing, ureteroscopy and cystoscopy would be very helpful and take care of a lot of unmet procedural/testing access for uninsured patients

52 - Lack of self pay discount rate or unaffordable self pay rate   Lack of culturally specific or non-english appropriate care

24 - patients refuse to continue with specialist appointments do to cost, patients being referred out for General Surgery don't have much assistance/Discount and they refuse to go through with the procedures. patients being referred out for MRI/CT scan and have no insurance end up canceling procedure due to cost of test. *** conducts a 90day follow up where we follow up on all referrals after 90days and we make sure patient was seen and treated, unfortunately our uninsured patients don't scheduled or cancel procedures.

1 - 1. Funding for tests and procedures 2.FInding lower cost options 3 No access to "elective" procedures at all

3 - Cost is the major barrier

13 - No access to procedures of any kind unless they are emergent.

37 - The symptoms have to be so bad before you can get them in, which causes worse outcomes - ability for MRIs - scheduling with procedural specialties and getting more than just a clinic visit

Solutions to Specialty Care - Medicaid

20 - Allotting a couple of providers to take on Medicaid patients only.

14 - Taking the specialty care to the patient populations who need it in the form of a mobile unit, using telehealth, partnering with their PCMH to get the labs/testing ordered done at that facility so that they don't have to go to an offsite facility (when possible), having the ability to "phone a friend" and have e-consults/phone consults available for primary care providers to manage the patient with the help of the specialist, offering specific specialty clinics at FQHCs (i.e. ***) and allowing patients enrolled at any FQHC to utilize the specialty clinic days/appointments (i.e. pt from *** could be scheduled at rheumatology specialty clinic being held at *** to better utilize the space/time/specialists' travel time, etc.). Finally, specialty care clinics should be using a PA-physician or NP-physician model more effectively, so that the APP can increase access to specialty care

60 - reduced cost services offered in-house

47 - expansion of services based on need and age. ASD care for children with CHP+ medicaid which limits care to under 4 yr. then does not cover additional services.

19 - Sliding fee scale/payment plans. Contracted # of probono cases per month

12 - E-consults should be expanded and work really well and should be paid for by Medicaid

27 - patients need a location that is accessible by bus and have affordable prices. Also, trying very hard not to cancel the appointments after they have taken a day off of work.

56 - Have specialists accept medicaid?

5 - Contracting rates improving.

7 - *** should NEVER stop taking Medicaid patients. They are funded by the STATE. I think *** needs to get involved and educate their participants and explain to them what is expected as a patient.

36 - A lot of clinics have metrics on how quickly a patient can be seen. Making sure that is also reflected in medicaid patients as well so it doesn't lead to more disparities.

28 - *** increasing number of Medicaid patients or restricting access for Medicaid patients
*** being transparent about Medicaid access and developing a central tool for care managers and providers to reference to see if someone is accepting Medicaid at this time

62 - Dedicated specialty care coordinator who has relationships, knows what is going on with all the clinics (waitlist situation/capacity, which clinics are willing to to take medicaid, their experiences with taking medicaid patients - challenges/frustrations/positives) - and actively manages the network to leverage opportunities, spread the appointments over the network, and works with providers and patients to overcome challenges to make it a positive solution. Providers may decrease numbers/not see patients due to the challenges and we need to mitigate those. The specialty care coordinator(s) should likely be paired with someone specifically who is a patient navigator and helps with transportation resources, language barriers, etc. to optimize attendance at appointments and challenges there. Having a provider with dedicated time to help patients who have more urgent needs have a doc-to-doc to help the patient access care. Having protocols/preferred referral guidelines from specialists about what workup they want before patients come to clinic has been helpful and should exist for all

the specialty care clinics to optimize the patient and specialists time once they are in the consult visit.

52 - Patients often want a second option or second opinion - I wish we had more diverse referral networks but I am not sure how to develop this network

Solutions to Specialty Care – Uninsured

20 - More options for payment plans.

14 - See suggestions for MCD patients, as I think that many of these could work for the uninsured patients, especially if the patients were able to be seen in their home clinic and could then pay their slide fee rate or the CICP fee to see the specialist. Expanding charity programs/prevention programs that patients can apply for (like the Komen's Women's Wellness program to men, if something like that doesn't already exist--it has been a while since I have worked in FQHC, so not sure if new programs have been created) – comment mentioned a lot of integrated/expanded care options (mobile, telehealth, e-consults, etc.)

49 - allowing a limited number of patients to be seen

19 - Have colonoscopy screening months with discounted colonoscopies available for uninsured pts.

48 - We have a great relationship with *** and *** to see our OB and some of our GYN patients using FQHC discount. I would LOVE if this were available for other specialties as well.

5 - as previously noted

28 - *** should develop a uninsured sliding scale discount program for patients who are uninsured They also should offer more cost transparency - specifically for providers so up front they can tell their patients what the cost will be. For pregnant women specifically if it very confusing to know what emergency Medicaid covers. Transparency around whether visits to OB triage or the ED will be covered by the insurance would be very helpful. I have had some uninsured patients get a bill after going to OB triage while pregnant with emergency Medicaid while some have not

8 - Getting their family or other support system on board with getting them to appts and taking Rx meds as prescribed.

62 - Same as medicaid but more solutions. Having transparent cost data for any options that exist particularly for low-risk procedures, a network of options that are out there/working to provide any sort of network for uninsured specialty care, maybe building more of volunteer provider network like what is at *** (providing financial support so it can expand - *** is starting to get long waitlists for its limited specialty clinics from *** showing the need for more services). Then having dedicated specialty care coordinator(s) who have relationships with providers/clinics, who know what is going on with all the clinics (waitlist situation/capacity, which clinics are willing to to take uninsured, their experiences with taking uninsured patients - challenges/frustrations/positives) - and actively manages the network to leverage opportunities, spread the appointments over the network, and works with providers and patients to overcome challenges to make it a positive solution. Providers may decrease numbers/not see patients due to the challenges and we need to mitigate those. The specialty care coordinator(s) should likely be paired with someone specifically who is a patient navigator and helps with transportation resources, language barriers, etc. to optimize attendance at appointments and challenges there. Having a provider with dedicated time to help patients who have more urgent needs have a doc-to-doc to help the patient access care is very important and it won't work well without provider involvement to handle more medical questions that come up with managing the network. Having protocols/preferred referral guidelines from specialists about what workup they want before patients come to clinic has been helpful and should exist for all the specialty care clinics to optimize the patient and specialists time once they are in the consult visit (and lowers patient cost with getting the workup since any labs become more expensive once in a specialist's office, etc.).

52 - Facilitated discussions to arrange self pay rates - would need to coordinate with all area FQs?

3 - 1. Legislative action to repeat statutory limitations on undocumented immigrants seeking procedural care at *** and ***.   2. Engagement with *** to provide charity care. This *** institution has little to no interest in providing care for uninsured patients.

13 - Nonprofit hospital systems could dedicate some amount of access to uninsured.

37 - I believe we need more government money allocated for this. *** helps out with some of this. Over the years the attitude is that if everyone does their part in providing care for free, it will work out. This is not true. Private docs can barely make it.

39 - getting free/reduced cost surgeries/ colonoscopies, etc.

Additional Comments within Uninsured Procedures Question

GYN surgery is a common unmet need. We do have some facilities that offer care for uninsured populations, but wait times are long. Colonoscopy not available at all for uninsured. Chronic pelvic pain is often difficult to get adequate treatment for in uninsured patients.

Anything that the patient has to pay for. This includes any specialist office visits or procedures.

Oncology services. Imaging is a huge barrier to care, and often is refused because patient cannot afford the services- most specifically are CT scans.