

REPORT ON SPECIALTY ACCESS

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for
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for
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SPECIALTY ACCESS

Background

For the past several years, there has been a community-wide effort to take a systemic view of health services to persons without health insurance in Santa Cruz County. The Santa Cruz County Community Foundation provided leadership to bring the community together to discuss the issue of the uninsured. As a result of those initial meetings and a community-wide forum on the uninsured, a group was formed to begin planning to develop a program to insure our county's children. The work of that group resulted in the formation and implementation of the Healthy Kids program, and at present, all children in Santa Cruz County have access to comprehensive health insurance. As a result of the CAP grant and the institution of the Health Improvement Partnership (HIP), there has been an effort to take a systemic view of health care services for adult indigent patients.

The Indigent Care Committee (ICC) was formed, and that group has been discussing services available for indigents, with a special focus on the MediCruz program. The ICC has been discussing all aspects of medical services for indigents: funding, eligibility, benefits, expenditures, access, etc. Within that broad context, they have noted that access to primary care in our county appears not to be a major problem. We are fortunate to have a very good system of safety net clinics for primary medical and dental care. Access to specialty services, however, is an important and problematic issue in indigent care. The remainder of this report and recommendations will focus on that one issue.

As a part of the indigent care challenge, we have struggled with the issue of adequate access to physician and dental specialty services for indigent patients. In some cases, specialty services are limited for non-MediCal patients (MediCruz and sponsored), and in some cases for MediCal patients as well. The situation varies from specialty to specialty and changes over time, generally as a reflection of capacity within the specialty practices. When new specialists come to the community, the increased capacity within that medical specialty increases access for all patients, including indigents, and the access problem is alleviated until that new practice nears capacity. Payers of services for indigent patients typically reimburse specialists for services at a rate lower than other payers e.g. private insurance, and as a

practice fills, the indigent patients are generally the first one group to be denied access.

To begin to address the specialty access issue in a systematic way, we have reviewed information available about the issue on a statewide level and looked to other communities that have proposed or instituted programs to better provide specialty services for indigents. In order to propose possible solutions for our own community, I conducted interviews with the medical or executive directors of the Central Coast Alliance for Health, Santa Cruz Health Center, Watsonville Health Center, Planned Parenthood, Women's Health Center, Salud Para La Gente, and Dientes to gain an accurate picture of access issues experienced by the safety net clinics. I also interviewed the medical director of Physicians Medical Group and the CEO of Santa Cruz Medical Foundation in order to better understand problems experienced by private specialists in providing services to persons referred by the safety net clinics. I also drew on my own experience dealing with specialists and the medical society on this issue over many years as the Medical Director for the county. The following represents my findings and recommendations.

I. SPECIALTY ACCESS PROBLEMS AND SOLUTIONS ELSEWHERE

A. The California HealthCare Foundation recently (June 2004) published Examining Access to Specialty Care for California's Uninsured (executive summary attached). In that report, they surveyed medical directors in federally qualified health centers (FQHC) throughout the state. The medical directors were asked about specialty care access issues for uninsured patients. A second survey was conducted of medical directors of hospital outpatient departments that serve the uninsured. That group was asked about the factors that affect the hospitals' willingness and capacity to serve the uninsured. The FQHC medical directors characterized access as "often" or "almost always" problematic for 16 of the 24 specialties listed on the survey for adults. One-half of the medical directors believe that access is worse today than it was two years ago. In the study areas, hospitals were the major source of specialty care for the uninsured who use FQHC's, accounting for 73% of the organizations listed by the FQHC medical directors as referral destinations. Only 16% of the medical directors listed a physician in private practice as one of the three referral destinations for specialty care. This is very different from the situation in Santa Cruz, where most referrals are to private offices.

B. Recommendations for developing and executing a plan to improve specialty access made in the report include the following:

1. Implement or expand local initiatives to provide insurance to low income residents
2. Strengthen primary care/hospital (specialty) relationships.
3. Provide advanced training to primary care providers to reduce need (for referrals)
4. Consider bringing specialists to primary care settings.
5. Build on existing efforts and experience (encourage volunteerism)

In Santa Cruz, many of these recommendations are being considered or are underway (see recommendations to follow).

C. We have spent a fair amount of time in doing environmental scans – looking to other communities for successful models or ideas in addressing indigent care. We have learned much of value – funding, different partnerships, risk sharing, increasing volunteerism, etc.

What we have learned specifically related to increasing access to specialty services is that most successful programs rely on volunteerism, and that they have some sort of glue to hold them together – generally a nurse or other case management function.

- D. Volunteerism is already afoot in Santa Cruz County. Many physicians regularly provide services to patients for no reimbursement at all. Unfortunately, there has never been an effort to track the amount of free care is given by our community's physicians, and therefore no way to report on the volunteer efforts. Also, although MediCruz pays for services, given the historically low level of reimbursement, many physicians regard services to MediCruz to be volunteering. All physicians with whom I have discussed indigent care believe they are contributing much of their time to the community, and most feel they receive no recognition for those services. I believe that any effort to increase physician volunteerism must include or be preceded by an effort to recognize what volunteer services they are already providing.

- E. Case management seems to be an important part of successful programs. We know that case management works from our own experience with the ED Frequent Users Grant and from prior experience with the HSA prenatal clinic. Case management is discussed at greater length in a following section.

II. SPECIALTY ACCESS ISSUES FROM THE PERSPECTIVE OF THE SAFETY NET CLINICS

- A. As mentioned above, access to specialty services varies by specialty, by pay source for the patient, sometimes by geography, and changes over time as a function of capacity. Some specialties lack access simply because there are not enough specialists. These specialists lack access for patients regardless of pay source (sometimes including private insurance). Some specialists have capacity, but deny access to patients according to pay source. Some will accept MediCal, but not MediCruz. Some will accept neither.
- B. In general, most safety net patients have access to most specialties. Most safety net clinic medical directors believe access to specialty services is greater than it has been in the recent past. Many problems remain, however. In some specialties, consultations and/or procedures are available only in Salinas or at Santa Clara Valley Medical Center. In some, care is available, but only following a very long waiting time.
- C. When asked to list the specialties with the least access locally, there was agreement among most medical directors that rheumatology and otorhinolaryngology (ENT) are the most problematic. Other specialties were mentioned as problematic by some and not by others. These include pulmonology, plastic surgery (especially hand surgery), neurology (South County), vascular surgery, and cardiology. Very recently, oncology has become a problem specialty. Until recently, oncology services in South County were provided by an oncology group under contract to the hospital. That contract is no longer in effect, and oncology services have become a problem. Oncology is also a problem area due to the very high cost of the medicines involved in cancer treatment and the recent death of a north county physician.

Access to specialty services is not limited to medical services. Dental specialty care is an issue. Primary dental services are available through Dientes and Salud Para La Gente. Oral surgery and sedation dental services for adults, especially developmentally disabled adults, present serious access issues.

D. Orthopedic surgery remains in a unique situation. The county operates an orthopedic clinic in Santa Cruz, staffed by one orthopedic surgeon from Santa Clara Valley Medical Center, and one local orthopedic surgeon who volunteers his time. The North County Health Clinic provides outpatient orthopedic services. Surgical procedures that are necessary are provided at Santa Clara Valley Medical Center (SCVMC) and some patients are seen at Natividad Hospital in Salinas. There is currently a one-month wait list for the clinic, and the waiting period for elective services at SCVMC is many months. Some local orthopedists have agreed to accept referrals on a case-by-case basis.

E. All of the safety net clinic medical directors are concerned about access to specialty care for the patients receiving care in their clinics. They have been very creative in finding sources of care for their patients, and spend a fair amount of time trying to secure care for their patients. They are willing to try to continue to develop relationships with providers of specialty services and to address the concerns and needs of the specialists. They are also willing to review cases to ensure referrals and preliminary work-ups are appropriate.

III. SPECIALIST CONCERNS

In addition to poor or no reimbursement, some specialists have voiced the following concerns or stated reasons why they do not like to accept referrals from safety net providers:

- A. Referrals often come to the specialist with little information about why the patient is being referred, or without an adequate pre-referral work-up.
- B. Some patients are referred inappropriately for specific diagnostic tests or studies. Screening is needed.
- C. Often, the patient has not seen a physician prior to referral (the referral comes directly from a mid-level practitioner). Some specialists wish the referral to come only from a physician, and some require direct communication from the referring physician.
- D. When the specialist calls to discuss the case, the physician who referred the case is not in, or cannot be identified by the clinic. Messages left for referring physicians often receive no response.
- E. Some specialists are concerned that further diagnosis or care plans suggested by the specialist will not be followed and that patients will receive poor follow-up care following the referral. They want to be certain that there is good follow-up care.
- F. Some specialists feel that the referring clinic will not accept the patient back, and that the specialist will be obligated to see the patient on an ongoing basis.
- G. Some specialists claim that the no-show rate for safety net clinic patients is very high.
- H. Some specialists do not have interpreter services available on staff, and are not comfortable seeing patients who do not speak English.

The above concerns are not expressed by all specialists, and no specialists voice all of the concerns. Many of the concerns can be addressed through effective communications between the referring physician(s) and the specialist(s). Recent communications between safety net representatives and local cardiologists provide an example of how concerns can be addressed. The attached meeting minutes regarding the cardiology referral process list the concerns about referrals from the HSA clinic in Santa Cruz, and the response to those concerns. As noted in those minutes “Though the above recommended changes are particular to the Emeline clinic, similar processes could be implemented in the other Santa Cruz County Safety Net Clinics.”

IV. REIMBURSEMENT AND FINANCING ISSUES

- A. Though not often discussed, the low reimbursement for specialty services provided to safety net clinic patients is a deterrent to access. The Central Coast Alliance for Health (the Alliance) and the County (HSA) have both taken positive steps in order to address this issue. In the past, the Alliance has paid for specialist services on a fee-for-service basis, and offered participating specialists the opportunity to participate in year-end risk pool settlements. Recently, they have budgeted for those settlements and incorporated anticipated settlement payments into the fee-for-service payments at the time of service. This has resulted in a higher rate of reimbursement at the time of service. The Alliance rate currently averages approximately 80% of Medicare payments. (This is a composite number – some specialties will be higher, some lower.) The MediCruz rate is 90% of Medicare. To the extent that the Alliance and HSA can continue to try to offer attractive rates of reimbursement for services to their respective patient populations, physicians serving those patients will feel adequately compensated, be more willing to see those patients, and probably be willing to do more to provide voluntary services to those patients who have no source of payment at all.
- B. MediCruz has paid very high rates for outpatient services at our local hospitals for many years. This includes Emergency Departments, hospital outpatient testing and procedures, etc. The county pays the Dominican and Watsonville Community hospitals 70% of their charges. Sutter provides MediCruz \$100,000 in free services to MediCruz patients, plus access to care services for non-qualifying, uninsured individuals. This portion of the MediCruz budget is the one with the greatest growth over the past several years. Services provided at these rates include outpatient diagnostic studies such as various scans, outpatient surgeries, and outpatient oncology services. An evaluation of the county's MediCruz program by the Pacific Health Consulting Group has identified this area as one that should receive attention. If the agreements with the hospitals could be renegotiated to allow the county to pay MediCal, or other similar rates, those dollars saved could be budgeted for specialist reimbursement or other indigent care needs.

- C. The county has recently negotiated a rate for specified diagnostic studies with the Santa Cruz Medical Foundation. That agreement will allow the county to pay a rate approximating 165% of Medicare for diagnostic studies like MRI's, CT scans, etc. Although higher than MediCal rates, the reimbursement under this agreement is significantly less than 70% of charges.

- D. The County and Sutter have another agreement known as “Access to Care”. Under that agreement, persons not eligible for MediCal or MediCruz can be referred to Sutter for services provided by the facility and an SCMF physician. This is part of their community benefit activities.

V. THE NEXT STEPS GRANT – WONDERFUL NEWS!!!

- A. The Health Improvement Partnership of Santa Cruz County (HIP) has been notified that our grant request to the Health Resources and Services Administration (HRSA) has been awarded. This two-year grant will provide funding to improve access to health services, including specialty services, for medically indigent adults in our county. It will focus on three areas:
1. Improving eligibility screening and enrollment for those who are eligible for existing coverage but not enrolled. The grant will provide staff to ensure that those who are eligible for MediCal, Medicare, or other programs are identified and that services provided to them are reimbursed by those programs.
 2. Improving access to health care itself by resolving barriers to provider participation (especially among specialists) and using human capital of intensive case management and incentives to keep people in the most appropriate care – i.e. out of the emergency departments.
 3. Improving the overall system of care by using technology to coordinate the smooth flow of information, move to electronic billing and accounts receivables, and have improved management information.
- B. The grant will allow the community to improve access to specialty services. In addition to providing staff to increase eligibility, it provides for staff for case management. A good model of case management is the old prenatal clinic at the county. That clinic had a nurse dedicated to case management of the patients. If a patient missed an appointment, she would call. If an outside service were recommended by the obstetrician, she would arrange it and make sure it got done. She did not spend a lot of time on those functions, but most importantly, was there and available to meet the needs of the patients and clinicians when necessary.
- C. One of the concerns of the specialists currently providing services to indigent patients is a feeling that recommendations made by the specialist will not be carried out. Another is a frustration with not being able to contact the referring physician. A single point-of-contact nurse case manager/coordinator at each safety net clinic would

help alleviate both those concerns. Automated information systems, such as Axolotl, that allow information exchange between the referring provider and the specialist will be of great help, but a dedicated person is very beneficial.

- D. In addition to all of the above, the grant allows some of the funds (15%) to be paid directly to providers. This will enable the HIP and the community to consider and fund various models to improve access to specialty services, at least on a pilot basis.

VI. RECOMMENDATIONS:

- A. Consider various models of improving specialty services. Use grant funds and current community interest to encourage development of new models for providing specialist services to safety net clinic patients. Identify specialties for pilot programs based on current access problems – that is, begin with rheumatology, ENT or other problem specialties. Possible pilots would include the following:
1. Ask the specialists if they are willing to schedule periodic sessions at the safety net clinic on a routine and regular basis to provide services to referred patients. The specialist could be reimbursed on an hourly basis and the clinic could draw down FQHC funds for the MediCal patients to offset the cost. This option would require the specialist to close down his/her office for those hours, and lose the revenue for those hours while continuing overhead costs. Additionally, this option is more effective for specialties that do not have medical equipment needs: it works better for the cognitive specialties than the procedural ones. A benefit of this option is that by being on site at the safety net clinic, the specialist can teach the primary care staff regarding the specialty, and interpersonal relationships among the specialist(s) and primary care providers will develop.
 2. Ask the specialists to set aside a block of time in their offices to see referrals, reimbursed on either a fee-for-service or an hourly basis. The fee-for-service option is the current model and would be improved by an increase in reimbursement. The hourly basis would have to be negotiated, and may restrict access for those patients who could not meet the schedule of available services. The benefit of this option is that the specialist would not have to close the office, and could see safety net patients in an office with necessary and familiar equipment and supplies.
 3. Provide stipends to specialists willing to join a specialist providers network to provide services to safety net clinic patients. The stipend would be in addition to the fee-for service payments. This option was not recommended by the private sector medical directors because it lacks accountability and there is no way it ensures greater access.

4. Establish some specialty offices as satellite FQHC clinics. This would allow enhanced revenue for services provided in those satellite clinics.
5. Consider the establishment of an oncology clinic at the HSA clinic in Santa Cruz. The cost of drugs used by oncologists to treat cancer is very high. The county has the ability to purchase medicines at a very favorable public health-priced rate. The county cannot purchase the drugs and give them to the patients for use at an off site clinic, but could purchase the drugs at greatly reduced costs if they were able to be administered in a county clinic or possibly if the drugs were for a county patient.

Following resolution of the reimbursement recommendations presented below, specialists should be approached as individuals and groups to discuss possible models.

B. Renegotiate reimbursement agreements and policies. This, in terms of timing, is the first priority. Addressing issues regarding access to services with most physician practices begins with reimbursement. I strongly encourage the community to address the many complexities of reimbursement prior to approaching the specialty community regarding any recommendations.

1. The county should provide a fiscal and policy analysis of the following:
 - a. What would be the cost of reimbursing specialists at 110% of Medicare rates. This represents the rate that would be realized if we are successful in our application to the Medicare program for relief from Locality 99. I believe it is a fair and adequate rate to offer the specialists.
 - b. What would be the savings if the hospitals were able to accept MediCal rates for outpatient services? Medicare rates? Could those savings be used to enhance payments to specialists for services to safety net clinic patients or to provide other enhancements to the “system”?
 - c. If the grant funds from the new grant are used to enhance specialty services, how can those enhancements be sustained following the cessation of the grant?

- d. Continue to explore options available under the FQHC program for funding of on-site and satellite specialist clinic services.
2. The Alliance should continue to evaluate how they might be able to continue to try to encourage specialist participation the MediCal.
3. The County should assertively try to renegotiate agreements with local hospitals for outpatient services. Paying 70% of charges for those services is a much higher rate than most public programs, and removes many dollars from the pool that could provide other necessary services. There may be some ability to reexamine inpatient rates in order to provide an incentive for the hospitals to renegotiate the outpatient rates.

C. Encourage better communications and relationships between safety net clinics and specialists

1. The safety net medical directors should be willing to provide specialist physicians with necessary information to make the referral successful. This might include better information regarding the reason for the referral, the prior work-up, the way a specialist can most effectively respond to the referring physician, and other information. I believe that the model represented in the attached notes regarding cardiology services to the north county patients from HSA present a good model. The model might not be necessary for all specialists, but could be offered to all if they wish. That model requires that all referrals to specialists be screened by the medical director of the referring clinic prior to referral. This addresses concerns about appropriateness and adequacy of pre-referral work-up. Listing the medical director on the referral form as the contact for the specialist decreases the possibility that the specialist will not be able to contact the referring physician after the visit. Phone consultation to review history and medical data on referrals is another option before a visit is scheduled.
2. There is a need to create a method for safety net providers to have meaningful discussions with specialists on an ongoing basis. These discussions could focus on referral issues as well as the need to recruit needed specialists into the county. The safety net clinic medical directors are well organized. The Safety Net Coalition (SNC) of Santa Cruz County meets for two hours on a monthly

schedule. These meetings include the executive and medical directors of the safety net clinics, the Alliance medical directors, management staff from the county, and others. The clinics are also on Axolotl/Elysium, which will make communications easier with many specialists using the system.

3. It is recommended that that once a quarter the SNC meeting be devoted to specialty access. Those meetings would replace the regular meetings of the SNC, and would be attended only by the medical directors of the SNC, the Alliance, the medical directors of the Santa Cruz Medical Foundation and Physicians Medical Group. Meetings would be chaired by the Health Officer. Discussions at these quarterly meetings would focus on specialty access and specialist recruitment issues. This group would be responsible for reporting to the HIP on issues pertaining to specialty access and recruitment needs in the community. Medical leaders from the hospitals and others from the medical community could be invited on an as-needed basis.
4. The safety net medical directors also meet for a pot luck dinner quarterly to discuss issues of mutual concern. In the recent past, some of these gatherings have focused on specialty care issues. These meetings represent a great opportunity for relationship building between the safety net medical directors and specialists. Regularly inviting a group of specialists to these gatherings to discuss referral criteria, pre-referral work-ups, systems for contacting primary care providers, specialty and primary care concerns, data on types and timeliness of referrals, or whatever, provides a natural and powerful way to build relationships between referring physicians and specialists. Those relationships are perhaps equal in importance to reimbursement in terms of timely access to necessary services.

Attachments:

- 1) Executive Summary – CHCF report on Access to Specialty Care for California's Uninsured
- 2) Meeting Minutes re. Cardiology Referral Process
- 3) MediCruz Referral Data FY 04/05