Advisory Board | Medical Group Strategy Council

Safeguarding Ambulatory Access for Medicaid Patients

The Medical Group's Role in Strengthening the Community Safety Net

IMPLEMENTATION RESOURCE

The Medicaid population presents a challenge for many health care providers. Frustrated by low reimbursement rates and high patient complexity, some independent physician practices have closed their doors to Medicaid. But realistically, this strategy is a non-starter for most employed medical groups, whose parent health systems maintain a cultural commitment to serve the entire community. More practically, turning Medicaid patients away from ambulatory care increases the risk that they will use the emergency department (ED) instead, driving up health system costs and jeopardizing efforts to improve Medicaid sustainability through better population health management.

As a result, employed medical groups must strengthen Medicaid patient access to physician services, with three options for doing so—though not mutually exclusive and often used in combination—at their disposal:

OPTION 1 Partner with Existing Community Clinics

OPTION 2 Establish Own Medicaid-Focused Primary Care Clinic

OPTION 3 Bolster Medicaid Access Across Existing Practices

OPTION 1 Partner with Existing Community Clinics

Access improvement has been high on medical group priority lists for years. But for Medicaid patients, groups face a different dilemma than they do with commercial patients. On one hand, medical groups must ensure that Medicaid patients have access to physician services. On the other hand, medical groups do not want to take on so many Medicaid patients that they crowd out more lucrative commercial volumes or overwhelm the existing care management infrastructure.

As a result, medical groups should consider whether the most effective means to provide ambulatory access to Medicaid patients is to partner with a community provider, such as a federally qualified health center (FQHC).

Community Clinic Advantages

- Often receive higher Medicaid rates
- Located within communities they serve, ameliorating transportation challenges
- Due to high Medicaid and uninsured volumes, can provide wraparound support services on site and at scale

Partnering with a community clinic does not simply mean diverting patients its way. Rather, the medical group must be actively engaged in ensuring the partnership's longevity. Two steps are particularly important.

STEP 1

Provide Direct Support to Increase Capacity

If community partners cannot care for enough of the market's safety-net patients, consider whether the medical group or its parent health system can support this population in expanding primary care capacity.

Phoenix-based Dignity Health Arizona, for example, established a partnership with local free clinic Mission of Mercy to provide a medical home for roughly 1,200 uninsured patients who otherwise were using Dignity EDs for low-acuity needs. Through this partnership, Dignity agreed to provide $250,000 in first-year start-up costs, which roughly covered the per-patient encounter costs for each of those referrals. Dignity also provides $125,000 annually in ongoing financial support. While these funds primarily are targeted at uninsured rather than Medicaid patients, they strengthen Mission of Mercy's ability to serve the entire safety-net population.

Other Ways to Support Community Clinics

- Space (e.g., allowing clinic to co-locate near hospital ED)
- Leadership training
- Access to technology
- Coordinated marketing and advocacy
- Clinician recruitment

STEP 2

Aid Expansion of Specialty Care Capabilities

Many community clinics focus on primary care, while specialty access remains a challenge for Medicaid patients. Medical groups can strengthen partnerships by helping clinics provide specialty care through one of the strategies listed below.

Arm PCPs with information

Children's Healthcare of Atlanta (CHOA) has few employed general pediatricians, so most primary care for children is provided within the community. However, the hospital fields a significant number of Medicaid referrals for specialty care. To keep these volumes manageable, CHOA physicians work to educate community pediatricians on conditions that often result in specialty referrals but could be handled at primary care. Education occurs both informally (e.g., "lunch and learn" meetings) and formally (e.g., creation of clinical pathways shared with community pediatricians through CHOA's clinical integration network).

Provide on-site specialty care

Aqua Healthcare (pseudonym) rotates its employed specialists through local FQHCs on a "leasing" model—the FQHC pays Aqua for the specialists' time, then bills Medicaid for the service. Aqua compensates participating physicians either through a shift rate (per hour or per half day) or through a portion of its compensation model that supports involvement in leadership activities. This model does not necessarily add Medicaid patients to Aqua providers' workload—many would have been referred to them regardless—but seeing patients at the FQHC rather than in Aqua's offices facilitates data continuity and allows both patients and physicians better access to the wraparound social services that the FQHC provides on site.

Offer real-time consultations

CHOA runs a telephone hotline for community pediatricians to call with questions on common conditions such as diabetes and concussions, and it is piloting a similar service for behavioral health.

Some providers are branching into consults via telehealth. A pilot program run through Community Health Center, a network of 200 FQHCs across Connecticut, showed that 70 percent of the time, PCPs who were able to consult virtually with specialists could resolve the patient's issue without the need for a referral. On the strength of these results, Connecticut last year became the first state to secure Medicaid reimbursement for this type of e-consult program.

Community Health Center E-Consult Pilot

- Using custom-built online platform, PCP submits request to cardiologist, endocrinologist, or nephrologist (services with high Medicaid demand)
- Specialist accesses PCP notes, patient records
- Clinician confirms care plan or advises follow-up

OPTION 2 Establish Own Medicaid-Focused Primary Care Clinic

Diverting patients to a community-based provider may not be feasible if there isn't a good partner in the market. In that case, some health systems have chosen to create their own Medicaid-focused primary care clinics.

Because regulatory restrictions generally prevent hospitals from operating FQHCs, such clinics do not qualify for enhanced Medicaid reimbursement. So, before taking this step, health systems and medical groups should think through the economic realities of this investment.

Questions to Consider Before Launching a Stand-Alone Medicaid Clinic

- What volume of Medicaid patients do we expect this clinic to serve?
- What services will the clinic provide?
- What staffing and other resources will those services require?
- How will this clinic generate return on the investment? Will fee-for-service Medicaid reimbursement (or related payments) cover costs? Can we get grant money? If we are at risk for Medicaid patients, will the clinic help us to keep spending below target and generate savings? Or is our primary goal simply reduced ED utilization?

With fee-for-service Medicaid reimbursement low, grant money not always reliable, and few health systems yet at risk for Medicaid patients, that last driver—reducing ED utilization—tends to be the most common reason for non-safety net health systems to establish their own Medicaid-focused clinics. The goal for these clinics is to head off non-emergency Medicaid volumes by making lower-acuity primary or urgent care services as convenient as possible.

For example, Catholic Health System in Buffalo, NY, is constructing a walk-in primary care clinic next to one of its hospitals that sees frequent ED utilization by low-acuity Medicaid patients. The clinic, which will be staffed by nurse practitioners, will not try to divert patients already in the ED. Rather, an ED-based nurse navigator will educate patients about the clinic afterwards in hopes of diverting subsequent visits. Clinic staff will provide walk-in care for immediate needs and work to connect patients to another source for ongoing primary care. However, recognizing that the clinic's location near the ED may be convenient for transportation-constrained Medicaid patients, the system is open to the idea that it could evolve to provide some long-term primary care services.

OPTION 3 Bolster Medicaid Access Across Existing Practices

Finally, medical groups will likely find that even if they use the above options, geographic realities, patient preferences, or other market-specific factors mean they are still treating at least some Medicaid patients within their existing physician practices. Three strategies can help ease common access difficulties in doing so.

STRATEGY 1

Consider Mandatory Minimum Medicaid Panel Size

If volumes are high enough, some medical groups mandate that physicians maintain a minimum Medicaid panel size to ensure equitable distribution across the group. St. Vincent Health in Indiana used this strategy to accommodate an influx of patients after the state expanded Medicaid under a waiver that reimburses providers for Medicaid patients at Medicare rates, among other changes. Required minimums are set at the provider level, with ratios varied based on Medicaid population density.

St. Vincent Medicaid Panel Requirements

200
Minimum for practices with low Medicaid volumes

450
Minimum for practices with high Medicaid volumes

STRATEGY 2

Address Compensation Concerns

St. Vincent's strategy works in part because Indiana's Medicaid waiver means practices have access to higher Medicaid rates, reducing the financial burden of caring for this population (although other challenges still exist). In other states, where Medicaid revenues are usually quite low, medical groups should ensure that physician compensation models are not a barrier to Medicaid access.

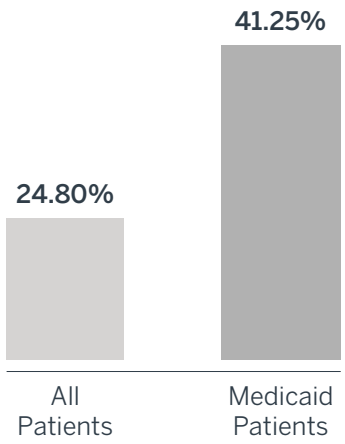
More specifically, groups that use a compensation model based on net income or collections will likely find it more difficult to mandate Medicaid access than those using a model based on wRVUs or salary. While medical groups may have other principled reasons to use compensation models based on net income, they should recognize the potential impact such models may have on access to care for safety-net patients.

STRATEGY 3

Adjust Scheduling to Reduce No-Show Rates

Various studies have found that Medicaid patients tend to have higher no-show rates than other populations. This problem often stems primarily from social factors such as transportation difficulties, lack of childcare, or jobs with no paid time off—challenges that common no-show reduction strategies, such as appointment reminders, cannot remedy.

Example: No-Show Rates in Illinois College of Optometry Clinics



Changes in scheduling practices may help reduce no-show rates for the Medicaid population. An analysis of data from the University of Missouri found that schedulers who asked patients when they wanted to come in—rather than offering the first available appointment slot—had a lower no-show rate. Offering appointment slots at times that are most convenient to Medicaid patients, such as when public transportation is available, can also help.

Some groups also routinely double-book appointment slots scheduled for Medicaid patients, but this strategy can cause problems if both patients show up. One way to refine this practice is to track no-show rates and double-book only those patients who habitually miss appointments. A study at a large Veterans Affairs endoscopy clinic, which used a "predictive overbooking" algorithm to gauge how several factors influenced the risk of patient no-shows, found that the proportion of previous cancellations or no-shows was the strongest predictor of another missed appointment.

For More on Medicaid Sustainability

Strengthening ambulatory access is just one facet of a successful Medicaid strategy. True Medicaid sustainability requires a system-wide approach to stabilize economics under fee-for-service today while considering a longer-term shift toward Medicaid risk and population management.

Want to learn more? Read our recent publication *Preserving the Community Safety Net: 12 Imperatives for Designing a Sustainable Medicaid Strategy*. This briefing, by our sister research program, the Health Care Advisory Board, is available to Medical Group Strategy Council members through special arrangement at **advisory.com**.

Advisory Board

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