# GI ACCESSIBILITY FOR COLORADO MEDICAID ENROLLEES

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## RATIONALE

The impetus for this project came from the implementation of Medicaid expansion associated with the Affordable Care Act (ACA). Across the state, there were contradictory perceptions of the impact of Medicaid expansion on access to specialty care services. The prevailing perception was that because Medicaid expansion did not overwhelm the system as many had feared, there must be sufficient access to specialty care for Medicaid beneficiaries. However, another common perception was that Medicaid beneficiaries were experiencing difficulty accessing screening colonoscopies. By better understanding the scope of challenges in access to screening colonoscopies, we hoped to identify potential policy solutions to increase access to care.

An important caveat to these results has to do with the mandate that critical access hospitals (CAHs) and rural health clinics are required by law to provide services to anyone who seeks care from them, regardless of insurance status. Prior to the ACA, these hospitals were providing substantially more uncompensated care that post-ACA because of the increase in Medicaid enrollment. With the expansion of Medicaid, there is the potential that more people would seek routine care, but the average reimbursement would be lower because of the greater percentage of Medicaid beneficiaries. This context is important when interpreting the results because respondents from these hospitals mention they accept all referred Medicaid beneficiaries, but they not breaking even on the cost to provide these colonoscopies.

## GOALS OF THE PROJECT

1. Test perception that screening colonoscopy is not widely accessible to Medicaid beneficiaries
2. Provide stakeholders interested in the summary of this assessment a basic understanding of barriers to endoscopic screening for Colorado's medically underserved
    a. System-Level (policy issues)
    b. Patient-Level (social issues)
3. Summarize solutions to better ensure the medically underserved receive access to quality care

## METHODS

### PHASE 1: APRIL – JUNE 2016

Survey administered via key informant interview to GI practices and hospitals across Colorado to gather input regarding barriers and facilitators for accepting a variety of insurance and payment methods for endoscopic screening.

### PHASE 2A: OCTOBER – DECEMBER 2017

Survey administered via online survey collection software to GI practices and hospitals across Colorado to better understand capacity, appointment wait times for colonoscopy, use of patient navigation, and reimbursement challenges.

### PHASE 2B: NOVEMBER 2017 – APRIL 2018

Survey administered via email to select primary care practices using patient navigation for cancer screening in Colorado to understand real-time appointment wait times and delays or challenges in patients scheduling colonoscopies.

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## RESULTS

### REACH

22 total GI practices participated*

Three primary care clinic systems participated, including two individual urban clinic locations and two individual rural clinic locations

*6 GI practices completed both Phase 1 and Phase 2A

### MAJOR BARRIERS

1. Patients no-show or late
2. Reimbursement rates
3. Non-compliance with bowel prep and follow-up

### CONSENSUS SOLUTIONS

1. Support for case management and patient navigation services
2. Increasing reimbursement rates

### ACCESS AND MEDICAID ACCEPTANCE

All participating GI facilities report accepting at least *some* Medicaid beneficiaries. While most facilities report wait times for all patients of less than 4 months, the experience, as defined by wait time, for these Medicaid beneficiaries varies by geography. This data is broadly representative of Medicaid access to GI specialty care in Colorado but may not represent the experience of Medicaid enrollees in specific geographic areas.

- Population Distribution
  - A greater proportion of rural Coloradans are enrolled in Medicaid and they comprise a greater proportion of GI facilities' patient population in rural areas
- Wait Times
  - Medicaid wait times (as reported by GI facilities) are generally longer in urban areas than in rural communities
    - Half of urban facilities report wait times *over* 1 month
    - 80% of rural facilities report wait times *less than* one month
  - Waits longer than 6 months are uncommon and appear to be restricted to self-pay and *specific* GI facilities, suggesting 6-month waits are more common with free-standing endoscopy centers.

### BREAK-EVEN POINT FOR REIMBURSEMENT

The survey asked about the *break-even* point for reimbursement in an attempt to understand the cost to provide screening colonoscopies. The intent was not to understand *profitability*, rather to identify the point at which a provider was not losing money on the procedure.

Many participating GI groups indicated that it is difficult for them to accurately assess their true break-even point for screening Medicaid enrollees. However, some trends were identified:

- Rural practices suggest a reimbursement rate *at least* as high as Medicare
    - 60% rural respondents say the break even higher than Medicare
- Urban practices suggest a reimbursement rate between that of current Medicaid and Medicare
    - 50% urban respondents agree

The break-even point could be related to *volume* in rural areas: 60% rural facilities say they are at less than 50% capacity while there are no urban facilities under 50% capacity and 33% of urban facilities are at over 90% capacity.

## PATIENT NAVIGATION

GI facilities, regardless of location or facility type, may not know if their referring primary care practices use PN. Improved coordination and communication between primary care practices and GI facilities could improve patient experience and provide workflow efficiencies. 45% of GI facilities identified that they use some PN within their specialty care setting, and most of these facilities are part of a system that also provides primary care services.

## PRIMARY CARE PERSPECTIVE

Overall, wait times are greater in rural areas than in urban areas. The average wait time in rural areas is 60 days, while it is 40 days in urban areas, or 150% greater.

Across participating clinics, the Medicaid payer mix is roughly the same.

Anecdotal & Process Data

- Some rural primary care practices (PCPs) experience difficulty scheduling patients because the referral must be sent to the GI group for scheduling and coordination, adding an additional step to the referral process. PCPs also cite delays in receiving timely replies and follow-up from GI facilities.
    - This additional step could be part of the reason actual delay between primary care referral created and appointment scheduled is greater, in practice, in rural areas than it seems it should be based upon GI facility capacity and volume.
- Some PCPs refer to specific GI facilities based upon the patient's payer source. Additional follow-up is needed to understand the rationale and impact of this approach.
- Some GI facilities require a consult prior to the colonoscopy procedure. PNs cite this step as a structural and logistical barrier they are unable to adequately remedy for patients. One PCP participating in this project described greater difficulty in getting Medicaid beneficiaries to complete colonoscopy when their GI partner stopped allowing direct referral for the procedure.

## RECOMMENDATIONS

The results of this survey and interview project suggest three recommendations. These recommendations can be acted upon by non-profits, medical providers and clinical staff, health departments, and public insurance systems.

1. Consider opportunities to increase reimbursement
2. Training and technical assistance on role, scope, and benefit of Patient Navigation for GI facilities and their referring primary care practices

3. Training and technical assistance on referral work flows between primary care and specialty care with the inclusion of a patient navigator

Increasing Medicaid reimbursement for colonoscopies is likely to increase the total number of appointments available to Colorado's Medicaid enrollees in both urban and rural areas. However, increasing reimbursement rates alone will not increase all providers' acceptance of Medicaid. Providing training and technical assistance for both GI facilities and their referring primary care practices on successful implementation of patient navigation as well as efficient work flows and patient follow-up can increase patient compliance and reduce no-shows.

## LIMITATIONS

The small sample size was a limitation in this assessment. There was a concerted effort to obtain geographic and practice type representation, but with a small sample size, the specific practices interviewed may not be fully representative of all GI specialty providers or primary care practices serving the Medicaid population. Additionally, 12/22 of the GI respondents (65%) were current or former CCSP GI screening providers. It would have ultimately been beneficial to interview more non-CCSP partners. Additionally, it is difficult to know if respondents felt completely comfortable disclosing information about barriers for fear of linkage to specific responses as the interviews were carried out through a telephone approach.

Finally, none of the participating primary care practices refer to the GI facility respondents at a significant volume. One goal of this project was to understand the difference in wait times from the GI facility's perspective as compared to the patient's perspective (as reported by the PCP), but we did not receive responses from the PCP-GI facility dyads we had hoped in order to conduct this assessment.

## CONCLUSIONS

Medicaid expansion halved the uninsured rate in Colorado, providing access to preventive health services for over 300,000 Coloradans, but these individuals experience challenges in accessing preventive services such as screening colonoscopies. Potential solutions to increase access to timely screening are perceived differently in rural as compared to urban areas. Increased reimbursement rates, from current Medicaid to Medicare levels, may increase the number of Medicaid enrollees GI facilities accept, particularly in rural areas. PN services are viewed as helpful in assuring Medicaid beneficiaries show up for appointments and are well-prepared, addressing the major barriers of both rural and urban communities. Additional efforts are necessary to understand the challenges and opportunities for increased coordination of referrals in rural Colorado.

PN and care coordination services are a viable solution for increasing preventive service accessibility for Medicaid enrollees. Wide-scale adoption and reimbursement for these services could increase patient adherence and increase preventive service utilization among the medically underserved. Coupling increased reimbursement with PN would address most challenges in Medicaid enrollee access to screening colonoscopy.