

# Managing Access to Medical Specialists for the Uninsured: Specialty Access for the Uninsured Program

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## ABSTRACT

**Background:** Safety net clinics provide primary care to uninsured patients. However, receiving specialty care is more complex because most specialists are not employed by these clinics.

**Methods:** To improve specialty access, the Milwaukee Health Care Partnership created the Specialty Access for the Uninsured Program (SAUP). The program provides timely specialty care distributed equally across the 3 adult health systems in Milwaukee. This paper outlines the process and framework used to implement SAUP.

**Results:** Since SAUP implementation, 23 000 patients have been referred for specialty care, with a 91% appointment show rate.

**Discussion:** The current specialty access system is unsustainable. SAUP provides a framework to address inequalities in specialty care access.

**Conclusions:** The SAUP model demonstrates that a coordinated, equitable distribution of specialty referrals across health systems can improve access for uninsured populations. This collaborative framework offers a sustainable solution for other communities facing rising rates of uninsurance and the high costs of deferred care.

## BACKGROUND

Uninsured people comprise approximately 8% of the US population and 7.12% of the Milwaukee County, Wisconsin, population.<sup>1,2</sup> There are numerous health implications associated with being uninsured. Compared with an insured, age-matched population, adults aged 51 to 61 years who lost insurance were 82% more likely to report a decline in overall health and had a 35% to 43% increased risk of death over the next 13 to 17 years.<sup>3,4</sup>

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Among those with chronic conditions, such as cardiovascular disease and diabetes, uninsured adults had a 65% higher risk of stroke and a 22% higher risk of myocardial infarction.<sup>3</sup>

Federally Qualified Health Centers (FQHCs) provide vital primary care to uninsured patients. With the creation of these clinics, access to primary care for the uninsured improved drastically.<sup>5</sup> However, a survey of 814 FQHCs inquiring about specialty access revealed that 25% of visits result in a specialty referral.<sup>6</sup> A referral for specialty care is defined as care that cannot be provided by the patient's primary medical home. Receiving specialty care is more complex because most specialists are not employed by FQHCs. In a national

survey of FQHCs, 91% reported it is somewhat or very difficult to obtain off-site specialty care for their uninsured population.<sup>7</sup> Despite known health implications, high demand, and consistent difficulties obtaining specialty care, there is no federally funded safety net for specialty access for the uninsured.

The Milwaukee Health Care Partnership (MHCP), an unincorporated consortium, was launched in 2007.<sup>8</sup> The founders recognized that there was a high number of uninsured patients in Milwaukee and rising emergency department utilization at all major hospitals. MHCP members include the 3 adult health systems in Milwaukee County, 1 pediatric health system, safety net clinics, and city, county, and state governmental health agencies. To improve specialty access, the Specialty Access for the Uninsured Program (SAUP) was developed in 2012 by MHCP to provide timely, clinically appropriate specialty. Care is managed by primary care and is distributed equally across the 3 adult health systems in Milwaukee. This paper outlines the process and frame-

work used to implement SAUP and shares program results to date.

Within the adult Milwaukee County population, 7.12% (66,049 people) are uninsured.<sup>2</sup> The uninsured are largely concentrated in 4 urban Milwaukee ZIP codes (53215, 53204, 53205, and 53206) where the proportions of residents living below the poverty level are 23%, 31.36%, 44.44%, and 39.56%, respectively.<sup>9</sup>

## METHODS

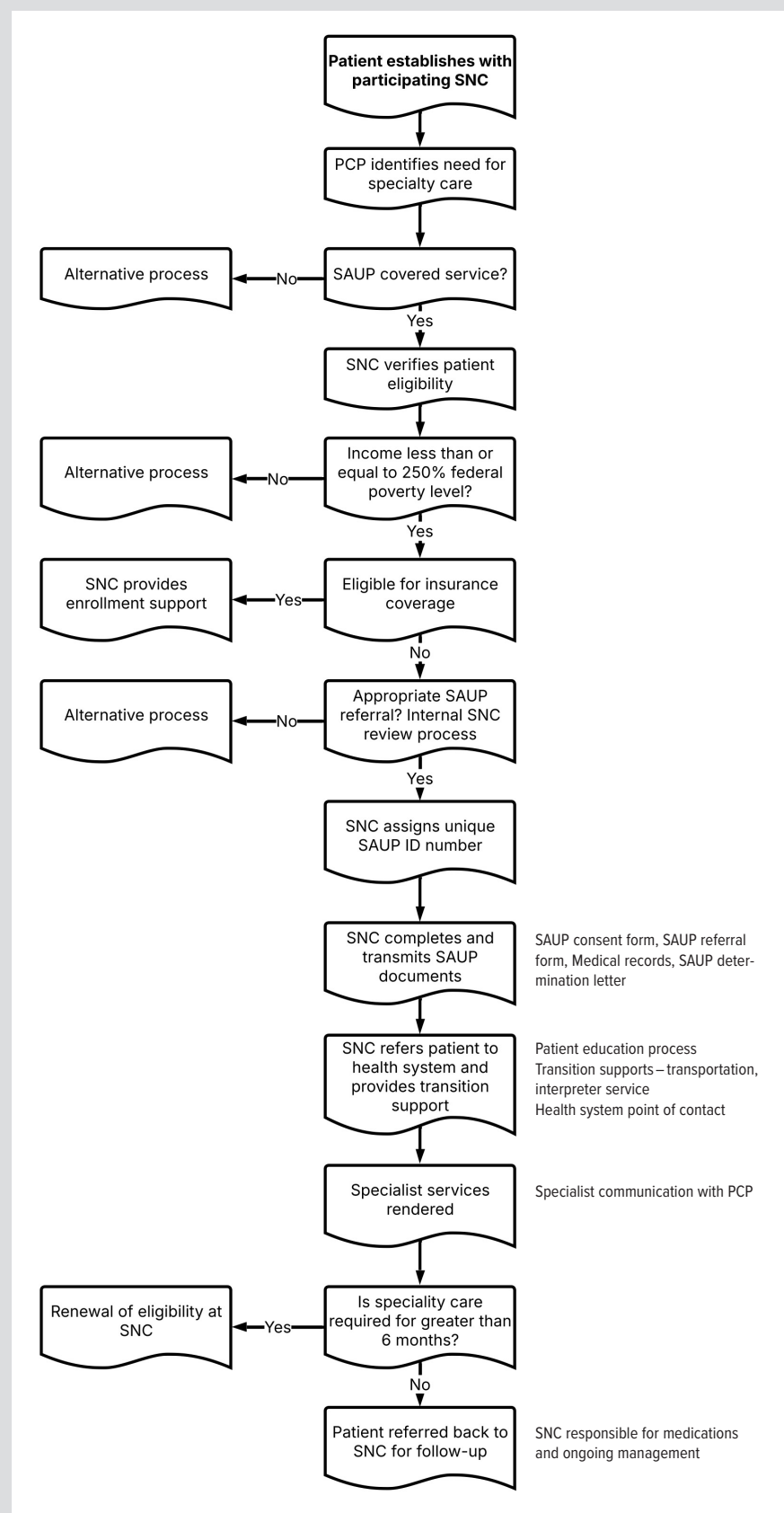
### Implementing SAUP and Program Utilization

Before SAUP implementation, specialty care was obtained through clinicians' interpersonal connections and peer-to-peer consultations or by sending patients to the emergency departments for acute issues in hopes of an inpatient specialty consultation, resulting in significant delays in patient care.<sup>10</sup>

MHCP leaders were asked to develop a program for the management of uninsured patients who require a medical specialist. This process was delegated to the MHCP Clinical Council, consisting of member organizations' chief medical officers. The group designed a program to equitably distribute specialist care among the health systems and ensure referrals are clinically appropriate and managed by primary care. Care through the SAUP program is categorized as "charity care" by the participating health systems, allowing it to be provided at no cost to the patient.

SAUP was created with the agreement that patients would be equitably distributed among the participating health systems in Milwaukee: Aurora Health Care (part of Advocate Health), Froedert & ThedaCare, Inc, and Ascension Wisconsin. This agreement ensures the financial and operational risk for specialty care needs is not unduly placed on any health care system. This is achieved by assigning 1 health system as a partner to a safety net clinic. The safety net clinic network consists of various free clinics and 5 FQHCs in Milwaukee County. The Figure depicts the typical workflow of SAUP eligibility determination.

**Figure.** Workflow of Specialty Access for the Uninsured Program Eligibility Determination



Abbreviations: SNC, safety net clinic; PCP, primary care provider; SAUP, Specialty Access for the Uninsured Program.

### SAUP Covered Services

Services covered by SAUP carry no out-of-pocket cost to the patient. These services mirror Wisconsin Medicaid guidelines, which include basic medical needs (laboratory work, diagnostic imaging, prescription drugs, and inpatient care). This comprises medically necessary outpatient and inpatient care, diagnostic tests and procedures ordered by specialists, specialty treatment, and certain preventive services. Restrictions of covered services are similar to Medicaid noncovered services, such as cosmetic procedures. SAUP differs from managed care organization initiatives in that case management is provided by safety net clinics rather than the payer directly.

### RESULTS

Since the implementation of SAUP in 2012, 23 000 patients have been referred to the program for specialty care, with an overall show rate of 91%. The top specialties referred are orthopedics, ophthalmology, and cardiology. The Table details the yearly breakdown of referrals provided by health systems and safety net clinics.

### DISCUSSION

As noted by Iuga and McGuire, medication nonadherence creates a vicious cycle of subsequent poor health outcomes, increased service utilization, and higher health care costs that are ultimately passed on to the patient.<sup>11</sup> Nationally, the annual cost of medical nonadherence is estimated between \$100 billion and \$300 billion.<sup>11</sup> Furthermore, patients who defer care report that their health and quality of life decline compared with those who seek timely medical attention.<sup>12</sup> This decline is exemplified by a cohort study finding that lack of insurance was associated with an increased relative hazard for stroke and all-cause death, as well as an increased risk of undiagnosed and uncontrolled hypertension and undiagnosed hyperlipidemia.<sup>13</sup> The urgency of addressing these barriers is heightened by the “Medicaid unwinding” – the process of redetermining eligibility for millions of enrollees following the end of the COVID-19 Public Health Emergency. As individuals lose coverage, the demand for safety net specialty services is expected to rise. Without SAUP, this vicious cycle of nonadherence and declining health would likely occur in the Milwaukee County population.

The program features that have made SAUP successful could make similar programs sustainable in other communities. SAUP ensures that a single health system does not bear the financial burden of all uninsured patients through referral monitoring. SAUP also encourages patients to establish a long-term primary care medical home, with ongoing management between primary care and specialists. Finally, the safety net clinics utilize systems to verify that patients meet SAUP eligibility criteria, ensuring that all referrals are both financially and clinically appropriate. SAUP’s commitment to these standards has contributed to SAUP’s 12-year

**Table.** Number of Health System-Based Versus Safety Net Clinic-Based Specialty Care Referrals per Year Since Start of SAUP

Year	Health System-Based Specialty Care	Safety Net Clinic-Based Specialty Care
2012	605	0
2013	967	790
2014	862	1604
2015	1034	1953
2016	1299	1773
2017	950	1169
2018	1409	1280
2019	1395	741
2020	1124	313
2021	1312	260
2022	1317	417
2023	1549	349

Abbreviation: SAUP, Specialty Access for the Uninsured Program.

longevity and future sustainability from both a business and clinical perspective.

As illustrated in the Table, the significant increase in health system referrals in 2018 occurred because participating health systems removed annual referral caps. The Table also illustrates the decrease in care at safety net clinics (which are largely staffed by volunteers) due to many factors and accelerated by challenges associated with COVID-19. Referral rates have been relatively stable for the past 5 years.

### SAUP Improvement Strategies

An area for SAUP improvement is interhealth system communication. Since many safety net clinics are funded through donations or, in the case of FQHCs, by meeting Health Resources and Services Administration benchmarks, many utilize paper charts or electronic health records outside of Epic (Epic Systems), while the health systems in Milwaukee all use Epic. This creates communication difficulties between the medical home and specialists. Improved health communication through the state-designated health information exchange system is one strategy deployed to exchange clinical information between the Epic and non-Epic organizations.

Another area of improvement for SAUP is embedding specialists at safety net clinics and encouraging them to hire their own specialists when feasible to maintain continuity at the medical home. However, there was a decline in safety net clinic specialists following the COVID-19 pandemic, and the number of specialists has not returned to prepandemic levels.

Telehealth is another opportunity for SAUP to extend specialist services. Some clinics have piloted programs where a primary care provider at a safety net clinic contacts a specialist via video in real time to determine if an in-person specialist visit is necessary. This has been particularly effective for some dermatological conditions.

## Limitations

A limitation of SAUP being managed by MHCP, a neutral third-party organization, is that data collection and access to individual health system data is limited. Access to more robust clinical and financial data would strengthen the program's effectiveness from a clinical and economic standpoint. We were not able to perform an in-depth cost analysis regarding the amount saved by health care systems due to SAUP; this is a necessary step toward expanding the program.

## CONCLUSIONS

With 8% of the US population remaining uninsured, the current system for accessing specialty care is unsustainable. The SAUP model provides a scalable framework for collaborative, equitable specialty care that mitigates the risks associated with deferred treatment. The authors hope these results will inspire other communities to implement similar managed specialty access programs for their uninsured and underinsured populations.

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