"Patients Who Can't Get an Appointment Go to the ER": Access to Specialty Care for Publicly Insured Children

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Study objective: Emergency departments (EDs) frequently refer patients for needed outpatient specialty care, but little is known about the dynamics of these referrals when patients are publicly insured. Hence, we explored factors, including the role of ED referrals, associated with specialists' willingness to accept patients covered by Medicaid and the Children's Health Insurance Program (CHIP).

Methods: We conducted semistructured qualitative interviews with a purposive sample of 26 specialists and 14 primary care physicians in Cook County, Illinois, from April to September 2009, until theme saturation was reached. Transcripts and notes were entered into ATLAS.ti and analyzed using an iterative coding process to identify patterns of responses, ensure reliability, examine discrepancies, and achieve consensus through content analysis.

Results: Themes that emerged indicate that primary care physicians face considerable barriers getting publicly insured patients into outpatient specialty care and use the ED to facilitate this process. Specialty physicians reported that decisions to refuse or limit the number of patients with Medicaid/CHIP are due to economic strain or direct pressure from their institutions. Factors associated with specialist acceptance of patients with Medicaid/CHIP included high acuity or complexity, personal request from or an informal economic relationship with the primary care physician, geography, and patient hardship. Referral through the ED was a common and expected mechanism for publicly insured patients to access specialty care.

Conclusion: These exploratory findings suggest that specialists are willing to see children with Medicaid/CHIP if they are referred from an ED. As health systems restructure, EDs have the potential to play a role in improving care coordination and access to outpatient specialty care. [Ann Emerg Med. 2013;61:394-403.]

Please see page 395 for the Editor's Capsule Summary of this article.

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INTRODUCTION

As full implementation of the Affordable Care Act transpires between now and 2014, public programs and regulations of commercial insurers will be leveraged in an effort to attain near-universal coverage for Americans that is equitable, affordable, and improves system efficiency.[1-3] Medicaid and the Children's Health Insurance Program (CHIP) have greatly expanded access to preventive care.[4] However, there is evidence that the 25 million children[5] currently relying on Medicaid coverage face impeded access to outpatient appointments with specialist physicians who can provide cognitive or procedural expertise for rare or complex health conditions.[6-10] These trends elicit concerns about reimbursement rates for public coverage relative to commercial insurance and a shortage of providers serving publicly insured patients.[11-13] The emergency department (ED) has long been considered a primary care access point for uninsured and underinsured patients, but less is known about the role EDs play in providing access to specialty care.

Providers' willingness (or unwillingness) to accept Medicaid coverage is one factor that can directly obstruct the delivery of needed medical care for persons covered by Medicaid.[14] Although little is known about the factors that influence providers' willingness to provide outpatient care to publicly insured children, even less is known about how ED referrals factor into specialist decisionmaking. This study broadly explores primary care physician and specialist perceptions of the barriers and strategies currently being used to get patients insured by Medicaid/CHIP into outpatient specialty care. Specifically, we examine provider comments on the role of the ED in facilitating this process.

Editor's Capsule Summary

What is already known on this topic

Patients without private insurance are frequently referred to outpatient specialists.

What question this study addressed

What are the specialist follow-up referral barriers for children without private health insurance?

What this study adds to our knowledge

This qualitative analysis of 26 specialty and 14 primary care physicians confirmed substantial financially oriented barriers to outpatient referral, and the frequent use of the emergency department to facilitate such referrals.

How this is relevant to clinical practice

Even in nonemergency situations, the emergency department is used to facilitate specialty referrals for children without private health insurance.

METHODS

Study Design

Between April and September 2009, the University of Chicago Survey Lab carried out a series of open-ended interviews with specialty physicians who treat children and primary care physicians who refer to such specialists.

The original purpose of these qualitative interviews was 3-fold:

1. Inform a planned simulated patient research study design by better understanding the process through which parents normally obtain outpatient appointments for their children to be seen by specialty physicians in Cook County.[15]
2. Uncover potential barriers to pediatric specialty care access and identify potential policy solutions by asking practitioners about their experiences and ideas concerning access to pediatric specialty care.
3. Refine and elaborate our overall understanding of current pediatric outpatient specialty care provision in Cook County by augmenting statistical, administrative, and published research data with the perspectives of individual physicians serving local patients.

Using a protocol approved by the Institutional Review Boards at the University of Chicago and the University of Pennsylvania, trained interviewers conducted in-depth semistructured interviews about child access to specialty care.

Participants and Study Setting

The 40 physicians (26 specialists and 14 primary care physicians), who varied in specialty type, health system affiliation, and payer mix (ie, percentage of patient population Medicaid-enrolled versus privately insured), were identified using information extracted from physician licensure data provided by the state of Illinois. This was not a random sample of physicians. Physicians were recruited from across specialty areas that the principal investigator's research suggested were in high demand, short supply, or both.

Study Protocol

Specialists and primary care physicians who see children were identified through a combination of medical provider referrals (using a snowball technique) and the state licensure database. A snowball sampling technique is the process of accumulating referrals by using identified respondents to locate additional respondents.

Introductory letters were mailed to identified physicians and followed up with a telephone call. A verbal consent script explained the study's purpose and requested voluntary participation without compensation. Interested participants were given the option of completing their interview in-person or via telephone. In-person interviews (n=3) took place in private locations that were convenient for the participants. Participants were also given the option to decline being audiotaped. Notes from taped (n=38) and nontaped (n=2) interviews were written up within 48 hours of the interview.

Purpose of Qualitative Interviews

Qualitative methods are inherently different from quantitative methods that use probability sampling. Probability sampling is a tool for measuring phenomena across large numbers of individuals and providing frequency distributions or correlational patterns that are generalizable in a proportional way to the underlying population as a whole. Purposive, in-depth, personal interviews of the sort conducted here are tools for uncovering the range of major issues, explanations, and experiences that frame an issue for real actors in the real world. The different purposes of each approach lead to different criteria for adequate sampling, questionnaire or guide construction, interview administration, data analysis, and conclusions.

Probability sampling is appropriate when the range of questions and response choices have already been identified so that standardized questions can be posed to a large and representative sample of the population of interest. Purposive sampling is appropriate when more discursive, in-depth, and respondent-driven conversations are needed to identify the key questions and response categories that exist in real-world contexts, as opposed to in the mind of the researcher alone. The logic of a probability sample is driven by statistical requirements for reliable generalization of sample distributions to the real distributions of characteristics in the population from which the sample was drawn. In contrast, the logic of a purposive sample is to select representatives from various cross-cutting status positions that are relevant to individual experiences and beliefs with respect to the topic at hand.

Thus, this was not a random sample of physicians. We spoke with doctors practicing at university and nonuniversity hospital

clinics, at private and public clinics, and those practicing in multiple settings. We spoke with doctors who serve many Medicaid patients and with doctors who serve few to no Medicaid patients. We made sure we heard from different kinds of medical specialists serving different geographical areas of the Cook County region. The purpose of our qualitative work was to learn about the *range* of viewpoints and experiences relevant to the research question. Rather than strive for a *high response rate* from respondents, as is necessary when using quantitative methods, qualitative interviewing methods strive for *theme saturation*. Theme saturation is reached when interviews no longer yield new information but just different versions of the same information. Although no 2 respondents will have exactly the same experiences or opinions to report, when additional interviews fail to expand the total range of experiences and opinions reported across cases, researchers are more confident they have heard the main outlines of the key experiences, rationales, and understandings current in the population of interest. To achieve theme saturation, researchers must collect data from a sample of respondents whose situations reflect variable circumstances in the population of interest with respect to the research question.

Because of these different approaches to the collection of data during an interview, different kinds of data result from each approach and different methods of analysis are used in each case. Counting responses is seldom a useful exercise with data from qualitative interviews because questions are not asked in a uniform manner, in a uniform order, or with a uniform set of response categories from which to choose. The number of times some topic is mentioned may be an artifact of the number of times the interviewer asked questions relevant to this topic rather than of the topic's importance overall. Instead, analysis of responses to qualitative interview questions involves listing the range of responses and looking for broad themes and patterns.

Because we did not know in advance what the range of difficulties might be in children's access to outpatient specialty care, it was appropriate to use interview guides rather than close-coded questionnaires. All questions on our guides were open-ended. Interview guides are also more flexible than questionnaires in allowing interviewers to cover targeted areas in the order that best fits with a respondent's narrative. The content and probes for the primary care physician and specialist interview guides were vetted by a panel of primary care and specialist physicians and health services researchers. Both interview guides included questions about the percentage of Medicaid-enrolled patients in their practice and the process of scheduling specialty appointments. Specific questions from the primary care physician and specialist interview guides are delineated in Figure 1.

Subspecialists

How do patients make new patient appointments with you?

Is there a difference between the way patients with public insurance (Medicaid or All Kids) typically go through the scheduling process compared to privately insured children?

What percentage of the time do you get contacted personally by a primary care doctor to get a kid in to see you? Under what conditions does this happen? Do you find personal contacts disruptive or helpful? How so?

Do all new patients need to have referrals from their primary care doctor in order to get an appointment with you? Does this policy vary by insurance type? If so, how?

Primary Care Physicians

How do you decide which specialist to refer a patient to?

Do you know which specialists will accept patients with Medicaid?

Have you ever not referred a patient who could have benefited from a specialist because you could not find a specialist who took their insurance?

Have you ever referred a patient to go to the emergency department for acute specialty care or as a way to access nonemergent specialty care?

Figure 1. Semistructured questions used on interview guides

Data Analysis

Interview transcripts and field notes were entered into ATLAS.ti qualitative data management and analysis software. Using analysis methods grounded in the principles of qualitative research,[16] senior staff at the Survey Laboratory used an iterative coding process to identify patterns of responses in the data. One of the themes readily identified by interviewees and coders alike was institutional rationing of appointment availability based on insurance status. Any provider disclosure of restricting access for children with Medicaid as distinct from children with commercial health insurance coverage was considered "rationing by insurance status." For the purposes of this paper, 3 of the authors (KVR, JB, and CCL) independently reviewed all written and coded transcripts and conducted additional content analysis within this theme to identify the factors associated with appointment success among publicly insured children. The rationale for this investigation is that identifying the factors that overcome accepted mechanisms to restrict access to specialty care may be used to help develop strategies to expand access instead.

RESULTS

Characteristics of Study Participants

The characteristics of participants and their medical practices are outlined in Table 1. All participants served at least some pediatric patients, with children constituting 10% to 100% of specialists' patient populations and 20% to 100% of primary care physicians' patient populations. Additionally, all

Table 1. Characteristics of participants in the sample (n=40).

Characteristic	Subspecialists (n=26)	Primary Care Physicians (n=14)
Subspecialty type, n (%)		
Subspecialists		
Allergy/immunology	2 (8)	
Cardiology	1 (4)	
Developmental pediatrics*	4 (15)	
Emergency medicine	1 (4)	
Neurology	3 (11)	
Ophthalmology	2 (8)	
Orthopedic surgery	3 (11)	
Otolaryngology	3 (11)	
Pediatric intensive care	1 (4)	
Physical medicine/rehabilitation	1 (4)	
Psychiatry	3 (11)	
Pulmonary diseases	1 (4)	
Radiology	1 (4)	
Primary care physicians		
Adolescent medicine		1 (7)
Family medicine		1 (7)
General pediatrics		12 (86)
Practice type, n (%)		
Academic hospital	10 (39)	3 (21)
Community health center†	1 (4)	2 (14)
Nonacademic hospital	5 (19)	0
Private—Group practice	5 (19)	5 (36)
Private—Solo practice	5 (19)	4 (29)
Clinical patient population		
Percentage outpatient (vs. inpatient)		
Mean (SE)	68 (7)	96 (2)
Range	0–100	70–100
Percentage pediatric (vs. adult)		
Mean (SE)	73 (7)	92 (6)
Range	10–100	20–100
Percentage Medicaid (vs. commercial)‡		
Mean (SE)	40 (6)	52 (11)
Range	1–99	1–95

*Includes developmental pediatricians and neurodevelopmental disabilities specialists.
†Includes federally qualified health centers (FQHCs) and FQHC look-alikes.
‡Refers to percent of child patients covered by Medicaid.

participants saw at least some pediatric patients covered by Medicaid, ranging from 1% to 99% of specialists' patient populations and from 1% to 95% of primary care physicians' patient populations. Of the 26 specialists, only 8 (31%) spent greater than half of their clinical time in the inpatient setting. In contrast, all 14 primary care physicians predominantly practiced in the outpatient setting.

Rationing by Insurance Status

Among the 18 specialists who predominantly practiced in the outpatient setting, 13 (72%) reported rationing appointments by insurance status. The remaining 5 (28%) outpatient specialists indicated a reluctance (either personally or on the part of their organization) to limit appointment slots for Medicaid enrollees. For instance, an orthopedic surgeon with a group practice who did not report rationing and did not know what percentage of his patient population was Medicaid enrolled said,

> I do feel that children need to be cared for . . . . And I didn't like the idea that a child might not be cared for because of money.

Among primary care physician respondents, 11 (79%) reported encountering limitations in specialty appointment access for their Medicaid-enrolled patients that are distinct from those encountered with their commercially insured patients. Of the 3 (21%) primary care physicians who said they have not encountered rationing by insurance type when making specialty referrals, 2 practice in community health centers that have institutional relationships with larger health systems for specialty service provision. For example, 1 of these community health center primary care physicians explained,

> We admit to [a local hospital]. And we've had a long relationship with them . . . . And so it's easy communication to get them in there . . . we are linked with their medical record system, so I can view their notes and their labs from the office.

Strategies for Allocating New-Patient Appointments to Children on Medicaid

Among providers who reported experiences with rationing by insurance status, 8 institutional strategies for systematically restricting access to new-patient appointments for children covered by Medicaid were identified. The following list presents each strategy with provider quotations that illustrate the explicit nature of these appointment assignment decisions. Additional provider quotations within each strategy are listed in Table 2.

1. Accept Medicaid enrollees on a first-come, first-serve basis for limited appointment slots:
   [Developmental pediatrician, academic hospital, 40% Medicaid] *Yeah, we are cutting down. In the last budget revision, we were called, you know, "You are losing money, so you need to improve your patient mix." . . . So what we're doing is just trying to restrict the number of Medicaid patients . . . . We have a number of slots for Medicaid, a limited number of slots actually.*
2. Accept Medicaid enrollees meeting a certain threshold of disease acuity:
   [Orthopedic surgeon, group practice, 45% Medicaid] *There's a few buzzwords that will get a* [Medicaid-enrolled] *patient in sooner rather than later . . . . And there's a few conditions that will get them—get them in. That we know about, get them in sooner rather than later as well . . . it depends on their acuity.*
3. Accept Medicaid enrollees lacking any alternatives who are in "a desperate situation":
   [Psychiatrist, solo practice, 1% Medicaid] *Once in a great while, I will take someone with Medicaid. But usually what happens is someone will call me, it will be like this tremendous*

Table 2. Strategies for rationing specialty appointments for Medicaid-enrolled children.

Categories	Illustrative Quotations
Limited appointment slots (Accept Medicaid-enrolled children first come, first serve for a limited number of slots)	**[Developmental pediatrician, academic hospital, 40% Medicaid]** Yeah, we are cutting down, yeah. We're trying to do that. Because we were, in the last budget revision, we were called and said, you know, "You are losing money, so you need to improve your patient mix." And we are busy now. So what we're doing is just trying to restrict the number of Medicaid patients . . . . The organization is not saying you make a different pay mix. The organization is saying you need to generate more revenue . . . . We have a number of slots for Medicaid, a limited number of slots actually. But they go—you know, we are scheduling much farther away from Medicaid and for typical—for no Medicaid patients.
	[Otolaryngologist, academic hospital, 33% Medicaid] Yes, I've had to try to limit the Medicaid that I accept, because I would be overwhelmed with nothing but Medicaid . . . . Well, I have so many Medicaid in my practice now that about a third of my practice is Medicaid. And we try to restrict it to the next avail—to new patients, new Medicaid patients, I still see them, but if you call for an appointment, you'll be told it's over a year or a year. And the only reason it's just a year is our system doesn't go out any further . . . . We try to do 1 new Medicaid per session, per clinic session.
	[Neurologist, academic hospital, 40% Medicaid] [Hospital] has a very small degree of pressure that they put on limiting Medicaid. For instance, I think that appointments probably take a little bit longer.
	[Ophthalmologist, solo practice, 65% Medicaid] Yeah the—generally I have set times of the month where I'll see new public aid patients . . . . It might be 3 or 4 days a month that are designated as new public aid patient days. And those slots, they may have to wait up to about 6 to 8 weeks to get those slots.
	[Pediatrician, group practice, 10% Medicaid] And so they limit the number of new patients per week, per month, per—you know . . . . And that's—you know, and it's even worse in the public aid side. On Medicaid or All Kids getting our children who have All Kids or Medicaid is impossible because there's a limited number of spots. You know they'll say okay well now I'm going to limit my clinic to—and we're talking academic institutions. We're not even talking [private practices]—so that's a bigger, even bigger challenge.
	[Adolescent medicine (primary care), academic hospital, 95% Medicaid] Our private specialists on the outside that will take insurance are reluctant to take patients on Medicaid, they'll take a very limited number, because they're not being paid and, you know, what their payment is, at least according to what they say, it's not very reasonable and they haven't been paid for more than 6 months to 9 months, is what they've told me recently.
	[Pediatrician, solo practice, 20% Medicaid] There are—I believe there are specific services at ____ who have managed—tried to manage the numbers of public aid referrals by limiting the number of physicians in their department who would see public aid or limiting the days of the week that they would be prepared to see public aid so that insurance would to some extent dictate. This is probably a—this could be something for all I know that's unwritten, unstated, or even illegal. But that's what's happening.
Disease acuity (Accept Medicaid-enrolled children for a given threshold of urgency)	**[Allergist-immunologist, solo practice, 1% Medicaid]** And at first, I took all kids with Public Aid. I don't see adults on Medicaid in general, it's just not part of our demographic here in the suburb I think. But the kids with Public Aid, I would see all of them originally when I started practicing many years ago. And then I noticed that as I learned more about the business of medicine that I was not getting reimbursed well. And so then I quit taking all Public Aid, I only took Public Aid asthma and food allergies, so the more serious allergy issues. So I would still see the more serious asthma and food allergy kids, but I would not see plain old dermatitis or allergic rhinitis or hayfever. I left that, you know, to the primary cares . . . . But yes, sometimes the pediatrician will call if they have an emergency and see if someone can come right over.
	[Otolaryngologist, academic hospital, 50% Medicaid] They've [the hospital] made an effort for us to limit the more Medicaid, so that there can be a 50-50 balance. So basically, you know, to see—if you're somebody with a hearing loss, you can see me next week, right? But if you're somebody who's got big tonsils . . . that they view as something that can be done by the general otolaryngologist as opposed to the subspecialized otolaryngologist, they say, "Well, either you can see me in 2 months or you can see Dr. _____ next week."
	[Orthopedic surgeon, group practice, 45% Medicaid] Yeah pretty much. And also conditions. There's a few buzzwords that will get a patient in sooner rather than later . . . . And there's a few conditions that will get them—get them in. That we know about, get them in sooner rather than later as well . . . it depends on their acuity.
Geographic proximity (Accept Medicaid-enrolled children residing near specialty clinic)	**[Developmental pediatrician, group practice, unknown percent Medicaid]** And we prioritize kids based on geography; that is, if they live across the street from our outpatient activities at [a street], they come to [a street]. If they live across from our outpatient activities in [neighborhood], they come to [a neighborhood]. If they live across from our outpatient activities in the [area of city], that's where they go.
Informal economic exchange with primary care physicians (Accept Medicaid-enrolled children from primary care physicians known to refer privately insured)	**[Orthopedic surgeon, group practice, 33% Medicaid]** Obviously with certain primary doctors that we have a good relationship you know they send us a lot of patients in general then we usually take it upon ourselves to also see their Medicaid patients as well . . . . We don't take anybody who just calls in . . . . It just can't be anybody's doctor's office . . . . I mean the insurance issue is a deal. It's just one of those things where if it's a person that we don't get typically a lot of referrals from we don't also want to just take—only get the patients that don't pay very well. I mean it's just one of those things, I think it is a problem for them trying to find somebody but it's also their making. If they refer all their patients to us then we're happy to take their lesser-payer patients or even their no-pay patients or self-pay patients.

Table 2. Continued.

Categories	Illustrative Quotations
	[Neurologist, solo practice, 5% Medicaid] These are all on referral from physicians. And for example, there's another hospital where the kids I see are mostly Medicaid. I am willing to see them for 2 reasons. One is there aren't very many of them . . . . They're sprinkled with—sprinkled among them are adults who are better paid.
	[Pediatrician, academic hospital, 5% Medicaid] I know one of the groups I refer to doesn't take public aid but has taken my public aid patients as a courtesy to me . . . . Whatever it is, it's a give and take. They're going to—you know they appreciate the business and the reward is that I get a little bit of extra care for my patients.
Professional courtesies/ favors (Accept Medicaid-enrolled children if primary care physician personally calls)	**[Otolaryngologist, academic hospital, 50% Medicaid]** Unless—I mean, unless I find out about it and the pediatrician calls me directly or the parents find a way to get in touch with me, and then I'm like, "Oh, yeah, come next week." (*laughter*) But, as we know, that doesn't always—you know, you have to be sort of an empowered, knowledgeable, you know, parent who sort of knows who to work the system, which is not usually the case, so . . . . And then, of course, I respond to it because, you know, we're talking about a human being, so.
	[Ophthalmologist, solo practice, 65% Medicaid] Yeah I'm probably seeing 2 or 3 patients a day like that where I get a phone call from a pediatrician who wants me to see a patient and I just say send him over . . . . It works very well. The pediatrician uses discretion and I've never had it come an occasion where it hasn't been that way you know where pediatricians are just calling as a favor to see a routine patient. It doesn't happen.
	[Pediatrician, solo practice, 20% Medicaid] Well it depends on the issue like if there's something going on that I have a high priority for personally I'll call—the primary care doctor like me can call the specialist and ask for a favor . . . . I don't use my favors very willingly but other doctors do. And I'm sure those specialists have trouble saying no. We guard them carefully, our favors.
	[Pediatrician, group practice, 60% Medicaid] Yeah, I mean, I call or page the doctor on call for that specialty. And I usually start with the resident or a fellow on call and tell them the issue and see if they can see that patient. And sometimes they'll refer me to the attending. Or sometimes they'll tell me, "We can see him, this is how you do it," and they'll actually tell me how to make the appointment. And in those cases, often I'm making the appointment, rather than having the referral coordinator make the appointment, because I already did the work.
	[Adolescent medicine (primary care), academic hospital, 95% Medicaid] Well, initially I would have the family call. At this point, that isn't even an option for some of these specialists, I personally need to call. And it has to be me and not a nurse or a resident; it needs to be attending to attending, so it takes a huge amount of time to get some of these specialists to see the patients. And it's almost a favor to me that they're doing it, which that should not be the system. [Interviewer: So does that—I know you're mostly dealing with Medicaid kids, but do you have those same sort of problems when you have kids with private insurance?] No, with private, they just call themselves and make an appointment.
Affiliated primary care physician referrals (Accept Medicaid-enrolled patients from affiliated institution's primary care physician practices)	**[Neurologist, academic hospital, 40% Medicaid]** I think the hospital made a policy of providing slots for individuals that—for physicians that were on a preferred list if you will. I mean that were affiliated with the hospital.
	[Pediatrician, group practice, 60% Medicaid] In [a local university hospital], I don't know who created the new rules, but they are telling the patients, "If you don't belong to our group of doctors, we won't take you." Even if you are—or if you have private insurance, it doesn't matter where you come from. And I don't know; it's uncomfortable. This is happening this year.
	[Adolescent medicine (primary care), academic hospital, 95% Medicaid] So the subspecialists in the private sector are not really accessible to my Medicaid patients. I used to use [hospital] . . . but lately they haven't been willing to take patients that are assigned to our particular clinic . . . and that's become a huge issue for our program, as well as for private physicians in the community.
Affiliated ER referrals (Accept Medicaid-enrolled patients from affiliated institution's ER)	**[Otolaryngologist, academic hospital, 33% Medicaid]** They go to the ER and get in the [a local university hospital] system, they'll be seen. So some patients who can't get an appointment will go to the ER and get sent that way, get in the system that way. And then I am obligated to see them if they're in the [a local university hospital] system.
	[Orthopedic surgeon, group practice, 33% Medicaid] Well we don't accept new Medicaid patients in our practice unless they're from the ER or unless the doctor has called us and that's purely financial to be honest . . . . I can tell you there's a couple primaries that don't send us their other payers and you know all we do is basically accept their Medicaid patients only through the ER.
	[Pediatrician, solo practice, 70% Medicaid] The idea is that if I send them to the emergency room and they see them in the emergency room, they need to be referred to a specialist. They need a specialist, so I'm bypassing a number of problems. I'm fully aware that I'm crowding the emergency room.
	[Pediatrician, group practice, 60% Medicaid] It happened relatively recently, where someone actually was seen in an outside emergency room, had a clearly fractured bone. Was told by that emergency room that they needed to see their primary care physician to arrange outpatient follow-up. I think mainly because they didn't have a pediatric orthopedist. So they came to our clinic. And instead of trying to call orthopedics and saying this child has a definitely broken bone, when can you see them, we just sent them to the emergency room, because they'd already been without orthopedic care for 3 days basically. So yeah, sometimes we do that.
	[Pediatrician, solo practice, 65% Medicaid] [A local university hospital] sent me a letter saying, "Don't send us any more Public Aid patients. Sorry to tell you that." I used to send some of my neurology patients there, because I have a high Polish-speaking population. And [a doctor] speaks Polish over there. And she was taking Public Aid patients and I guess she still does for the ones that come into the system there, from the ER. But I can't send any new Public Aid patients to her. The old ones, she still takes.

hard-luck story. And I make exceptions for 1 tiny group. I make exceptions for very, very, very young children . . . if it's a really desperate situation and they can't find anybody else, I will make an exception and I'll take them, knowing that I'm not going to get paid, knowing that they're probably going to be fairly labor-intensive. And I do that because there's nobody else willing to touch these children.

4. Accept Medicaid enrollees residing within a certain threshold of geographic proximity to the specialty clinic or target geographic areas with more privately insured people:
   [Developmental pediatrician, group practice, unknown percent Medicaid] *And we prioritize kids based on geography. That is, if they live across the street from our outpatient activities at* [street]*, they come to* [street].
5. Accept Medicaid enrollees from referring primary care physicians with an informal economic exchange relationship with the specialty clinic:
   [Orthopedic surgeon, group practice, 33% Medicaid] *Obviously with certain primary doctors that we have a good relationship you know they send us a lot of patients in general then we usually take it upon ourselves to also see their Medicaid patients as well . . . . We don't take anybody who just calls in . . . . I mean the insurance issue is a deal. If they refer all their patients to us then we're happy to take their lesser-payer patients.*
6. Accept Medicaid enrollees from referring primary care physicians who personally call specialist offices to request a professional courtesy/favor:
   [Pediatrician, solo practice, 20% Medicaid] *Well it depends on the issue like if there's something going on that I have a high priority for personally I'll call—the primary care doctor can call the specialist and ask for a favor . . . we guard them carefully, our favors.*
7. Accept Medicaid enrollees from referring primary care physicians with an institutional affiliation:
   [Neurologist, academic hospital, 40% Medicaid] *I think the hospital made a policy of providing slots—for physicians* [primary care physicians] *that were on a preferred list if you will. I mean that were affiliated with the hospital.*
8. Accept Medicaid enrollees from referring emergency departments with an institutional affiliation:
   [Otolaryngologist, academic hospital, 33% Medicaid] *So some patients who can't get an appointment will go to the ER and get sent that way, get in the system that way. And then I am obligated to see them if they're in the system.*

Emergency Departments as Access Providers: Reasons for Appointment Success

Of particular relevance for emergency physicians, our results indicated that for many children on public insurance, the ED serves as a critical access point to specialty care. Although some primary care physicians felt negatively about using the ED as a "middle-man," many acknowledged this as a successful approach.

[Pediatrician, academic hospital, 5% Medicaid] *Let's say you have a dermatologic condition that is you know pretty difficult for the patient to endure . . . and you don't know what to tell them clinically. And the dermatology team can't see you literally for 2 or 3 months. So you always can go to the ER and if they think you need to be seen by a dermatologist they'll call one . . . . Well, I don't think that's a very efficient way of doing it.*

[Pediatrician, community health center, 85% Medicaid] *Sometimes I will call the subspecialist and say, "This child needs to be seen. What is the best way you think to get them seen?" And sometimes they'll actually say, "Well, we don't have a clinic right now. And if you really think he needs care right this minute, you need to send him to the emergency room."*

[Pediatrician, group practice, 70% Medicaid] *If an ER patient shows up as you know from the EMTALA requirements, the Emergency Medical Treatment Labor Act . . . you can't turn them away. You have to see them and stabilize them.*

Specialists described an "obligation" to see patients referred from the ED, even if their practice did not otherwise accept public insurance and even if they considered the complaint nonurgent.

[Psychiatrist, academic hospital, 30% Medicaid] *Occasionally parents resort to bringing the kid into the emergency department because they can't manage to get an outpatient appointment. It's a way of jumping the waiting list . . . . People show up in the emergency department and say my kid is out of Ritalin . . . . Which is inappropriate. It's an emergency room. But people do it.*

To accommodate this obligation, specialists spoke of specific mechanisms for distributing these publicly insured patients equitably across practices, mechanisms that they often did not have in place to accommodate referrals from primary care physicians.

[Orthopedic surgeon, group practice, 33% Medicaid] *We don't accept new Medicaid patients in our practice unless they're from the ER . . . . It's just because if we did that we'd be the only one in the area doing that and we'd be just inundated with a bunch of people with a lesser—a smaller payer. So I don't think it would be appropriate because I don't think the other groups would concede that type of thing. So we've all sort of in this area practiced the idea that if it comes through the ER then it's yours.*

Conversely, when specialists were asked whether a centralized resource list of pediatric specialists who accept Medicaid would help resolve the problem of access for publicly insured children, the idea was resisted because of concerns about equitability.

[Allergist-immunologist, unknown percent Medicaid] *I mean, you can do that. But also what it's going to do is it's going to increase patient dumping.*

[Orthopedic surgeon, unknown percent Medicaid, with a strong rule of serving all comers regardless of insurance type

or ability to pay]: *"I probably would refuse . . .* [to be on a list of Medicaid providers]. *I've always been able to afford it* [taking patients regardless of their ability to pay] *happily, but it is a luxury. And I would have to be a little bit careful not to get slammed.*

Examples such as these suggest that there are aspects of the ED referral process, perhaps the EMTALA requirements in particular,[17] which increase the likelihood of successfully obtaining an appointment with specialty physicians. It also seems to be the case that accepting patients through the ED helps with the more equitable distribution of Medicaid patients among specialists who are willing to accept publicly insured patients.

LIMITATIONS

Like all qualitative studies, results are exploratory. Although we explored primary care physician and specialist perceptions of the barriers and strategies currently being used to get patients insured by Medicaid/CHIP into outpatient specialty care, we did not explore the dynamics of access for privately insured children. We interviewed a purposeful sample of physicians from primary care and 13 specialties, so not all specialties were included. Moreover, we confined our interviews to 1 urban area with a high concentration of medical specialists.[18] Results cannot be generalized to rural areas, other urban areas, or even other specialties in the same area. There is likely geographic variation in institutional strategies because of differences in Medicaid policies by state and a broader range of provider opinions than was identified in this study. Participation in this study was voluntary and confidential and no incentives were offered to respondents. Consequently, persons who consented to be interviewed were self-selected to care about the issue of access or motivated by anger/frustration with the current system. There is also the possibility of a social desirability response bias, as providers may have presented themselves in an overly positive light. Nonetheless, in our pool of physician interviewees, we heard a diverse range of opinions: from doctors who volunteer their time to provide care for low-income children to doctors who indicated they would rarely accept Medicaid-enrolled children in their practices.

DISCUSSION

Emergency department visits have long been considered markers of failed access to outpatient care, particularly failure to access primary care.[19-21] However, as our results show, inability to access specialty care can lead pediatric patients to the ED as well. Our qualitative study reveals that this phenomenon may be partially driven by providers and the systems in which they deliver care, as opposed to patients or their parents. In interviews, primary care providers and pediatric specialists alike acknowledged that using the ED as a "middle-man" represents a viable "work-around" in circumventing the access limitations faced by publicly insured children.

This finding begs 2 crucial questions: First, why does this strategy work? What is different about a referral that comes through the ED as compared to one from a primary care physician's office? And second, can we translate those functional aspects of the ED referral process to the primary care setting as we work to improve the access of publicly insured children to much-needed specialty care?

To understand what would make a provider more willing to see patients who come through the ED, it is helpful to review the factors that motivate nonacceptance of public insurance. Prior research has shown that provider nonacceptance of public insurance is motivated by differential reimbursement rates between Medicaid and commercial payers,[6,11] as well as providers' dissatisfaction with Medicaid payment procedures (timing and paperwork),[22] Medicaid recipients' tendency to miss scheduled appointments,[23,24] and other underlying negative attitudes/beliefs about Medicaid-enrolled patients.[25] Although the above concerns were reiterated by our respondents, we did not learn that any of these factors were improved by seeing patients referred through the ED as opposed to by their primary care physician.

Instead, when specialists discussed their reasons for seeing patients who come in through the ED, they spoke of an "obligation" to take the referral and described the mechanisms in place to distribute the ED patients across the hospital-affiliated practices within a given specialty. These institutionalized strategies, such as call systems, allow for a relatively equitable distribution of lower-paying patients across providers. In contrast, referrals from primary care physicians often do not have the benefit of established distribution mechanisms. For these patients, specialty practices have devised their own strategies, as outlined in our results, for deciding which publicly insured children to see.

Although qualitative evidence cannot quantify the overall prevalence of specialty appointment rationing for Medicaid-enrolled children, it does bring to light the rationing decisions that are part of physicians' daily practices. Regardless of the prevalence of experiences recounted to us by specialty physicians, primary care physicians, and their administrators, each was telling us about real cases that had happened in their practices and which provided salient examples to them about the state of pediatric specialty care, insurance to cover such care, and access to such care for children in Cook County.

As W.I. Thomas[26] said, if something is perceived as real, it is real in its consequences. Whether or not Medicaid fails to cover the true costs of care provided by specialty physicians, the physicians whom we interviewed clearly believe this to be the case and find ways to organize their practices to reduce this financial burden. Practices varied from locating in areas far away from most Medicaid patients, to restricting "slots" for Medicaid, to restricting days on which Medicaid patients can be seen, to reducing time spent with Medicaid patients, to not seeing Medicaid patients at all. More subtle patterns of taking patients only from referring primary care doctors who also routinely send them privately insured patients were also described by multiple specialists.

Because the overall theme of ways to avoid or reduce the number of Medicaid patients served because of low (or delayed) reimbursement was omnipresent throughout our interviews despite the wide range of strategies described for achieving this, and because we spoke with a broad range of physician types, we feel confident asserting that "patient mix"—a euphemism for proportion on Medicaid—is a core concern of specialty practices. It is also clear that although specialty physicians take different tacks with respect to limiting their acceptance of Medicaid, there are some who accept large numbers of Medicaid patients whereas others accept relatively few. Across all interviews, there was an unchallenged claim that Medicaid does not pay adequately to cover specialty care, and this assumption structures the worldviews and behaviors of specialty care providers serving children in Cook County.

Given the current economic and political climate, it seems unlikely that Medicaid reimbursement rates for specialty care will improve substantially in the near future. Productive debates moving forward must focus on *how* current institutional rationing mechanisms can inform initiatives to maximize efficiency and equity.[27-30] It is encouraging to note that when mechanisms for equitably distributing lower-paying patients are in place, such as through ED referrals, providers are able to accommodate them. These results do not imply that the ED is a solution to the access limitations faced by publicly insured patients. The current trends of ever-increasing ED volumes and longer wait times for emergency care make this an inefficient solution with the potential to compromise the care of high-acuity patients.[31] Rather, these results suggest that the translation of such mechanisms to the outpatient setting, perhaps through system redesign, such as Accountable Care Organizations and bundled payments, may improve access to specialty care for publicly insured children. However, if in a given health system, the ED is expected to play a major role in care coordination between primary care physicians and specialists, that role should be explicitly recognized and appropriate staff and institutional support should be available to help with the process.

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