

## PERSPECTIVES

# On Medicaid and the Affordable Care Act in Connecticut

## The Problem with Subspecialty Services

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**Background:** Medicaid is the federal program, administered by states, for health care for the poor. The Affordable Care Act (ACA†) has added a large number of new recipients to this program.

**Hypothesis:** Medicaid programs in some, if not many, states do not provide patients uniform access to subspecialty care guaranteed by the federal statutes. Insofar as the ACA does not address this pre-existing “sub-specialty gap” and more patients are now covered by Medicaid under the ACA, the gap is likely to increase and may contribute to disparities of health care access and outcomes.

**Methods:** A brief description of previous studies demonstrating or suggesting a subspecialty gap in Medicaid services is accompanied by perspectives of the authors, using published literature — most notably the Denver, Colorado health care system — to propose various solutions that may be deployed to address gaps in subspecialty coverage.

**Results:** All published studies describing the Medicaid subspecialty gap are qualitative, survey designs. There are no authoritative objective data regarding the exact prevalence of gaps for each subspecialty in each state. However, surveys of caregivers suggest that gaps were prevalent in the United States prior to initiation of the ACA. Even fewer papers have addressed solutions (in light of the paucity of data describing the magnitude of the problem), and proposed solutions remain speculative and not grounded in objective data.

**Conclusions:** There is reason to believe that a substantial proportion of U.S. citizens — those who are guaranteed a full complement of health services through Medicaid — have difficult or no access to some subspecialty services, many of which other citizens take for granted. This problem deserves greater attention to verify its existence, quantify its magnitude, and develop solutions.

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†Abbreviations: ACA, Affordable Care Act; APA, Administrative Procedures Act.

Keywords: Medicaid, health care, insurance, subspecialty care, justice

Over the past decade, Americans have become increasingly aware that the health care system overall provides poor “return on investment.” Despite expending nearly \$9,000 per capita among the top-spending nations, the United States ranks 35th, just behind Costa Rica, for life expectancy and 34th, just behind Cuba, for infant mortality [1]. While many factors contribute to the high price paid and relatively poor outcomes, policy-makers and politicians have focused efforts to extend health care coverage to a large group of roughly 40 million previously uninsured patients and to address supplanting the current fee-for-service model with a more quality- and outcomes-based approach to remuneration. However, another plausible contributor to poor outcomes is disparate access of minority groups and poor citizens, many of whom have government-provided health care (i.e., Medicaid), to high quality care provided to non-minority, privately insured citizens. A 2012 report by the Department of Health and Human Services [2] details poorer outcomes of minority groups and does not illuminate logistic barriers to care based on insurance status. In this essay, we review data to suggest that one factor contributing to health care disparities in the United States, and perhaps to overall poor health care outcomes, relates to insufficient access of this country’s 66 million Medicaid patients to subspecialty medical and surgical services.

### **THE PROBLEM: INSUFFICIENT ACCESS OF THE POOR TO MEDICAID SERVICES IN SOME SUBSPECIALTIES**

In 2010, we sampled Connecticut’s teaching clinics to gauge whether Medicaid patients, whose care is often provided by trainees, had access to a similar complement of medical services afforded to privately insured patients [3]. A lion’s share of care to the poor is provided in hospitals that receive reimbursement for teaching and specifically to provide medical care to the under-served as well as in federally subsidized clinics. Overall, directors of these clinics in Connecticut reported substantial difficulty in

making appointments for patients requiring both medical and surgical subspecialty care. For instance, 41 percent of directors indicated that their patients could never, rarely, or only sometimes see an endocrinologist [3]. For dermatology, the rate was 53 percent; for orthopedics, 59 percent; and for neurosurgery, 82 percent. Beyond this “Medicaid gap,” we posited that trainees were also ill-served. Insofar as they could not sometimes ascertain vital services for their clinic patients, they are also exposed to sub-optimal behavior by consulting physicians and are generally accepting of this status quo.

We discovered that this problem is not isolated to Connecticut. In 2010, the Commonwealth Fund reported that nationwide, 91 percent of 795 responding federally funded community clinics reported difficulty obtaining subspecialty care for uninsured patients [4]. Access for patients with Medicaid fee-for-service was not much better, with 71 percent reporting difficulty getting specialty access, whereas 49 percent of Medicare patients reported difficulty. While centers that formed relationships with nearby hospitals fared, on average, 12 percent better, access remained less than 50 percent overall, even for centers with hospital affiliations. While this is the only national survey of access to subspecialty care, it demonstrates that federally subsidized clinics that share care of Medicaid and uninsured patients with teaching and safety-net hospitals experience at least as much difficulty in obtaining subspecialty services for Medicaid patients as Connecticut’s teaching clinics.

A similar pattern of poor, unequal access has been noted in pediatric populations. Bisgaier and Rhodes made telephone calls to 273 specialty practices in Illinois, asking for appointments for a child with private insurance and a second call for a child with Medicaid. Sixty-six percent refused Medicaid, whereas only 11 percent refused appointments for children with private insurance. Among practices accepting Medicaid, wait times were 22 days longer [5]. A review of studies that have examined impact

of insurance status on children's access to specialty services has demonstrated mixed results. In some states, access for children with Medicaid was very good, especially compared to children with no insurance, whose access was uniformly poor [6].

Our study demonstrated a very similar pattern to Bisgaier and Rhodes' of subspecialty gaps in coverage of adults covered by Medicaid. It is also notable that the gap appears to be more common in both pediatric and adult Medicaid populations for surgical services. Connecticut may be similar to others, insofar as the "gap" in coverage has been documented more in surgical than medical subspecialties such as orthopedics, neurosurgery, urology, and others [7,8].

While it is possible that physicians object to providing care to Medicaid populations for reasons other than remuneration, many physicians freely share their displeasure off the record at the low rates of payment for Medicaid patient care. Federal law requires states to provide Medicaid reimbursement rates that will entice participation of a sufficient number of subspecialists to fill the demand for services [9]. Unfortunately, there is insufficient transparency in physician and facility reimbursement rates for various common services. Facilities and individuals we contacted refused to provide the absolute, or even differential, reimbursement rates for various services that may vary from physician to physician and hospital to hospital. Some reimbursement rates (e.g., for Medicare) are determined by arcane formulas used by the government, whereas others are negotiated with insurers. As a result, large differences in reimbursement rates are not uncommon even within small states like Connecticut, so providers are wary about sharing the rate they've negotiated and, in

some cases, may be prohibited from sharing such rates<sup>1</sup>.

One colleague was willing to share his/her reimbursement to permit readers a sense of the gradient between Medicaid and private insurance. For tonsillectomy/adenoidectomy, Blue Cross paid the provider \$508, Medicaid paid \$151, and Medicare paid \$294. The exact amounts for each provider for each service can vary considerably based on the size of the provider group and success negotiating with private payers. Additionally, Medicaid rates are set by states and may also vary. Nonetheless, this single example provides the reader with a sense of the gradient between Medicaid and private insurance and why some providers may be indignant at the nonsense of it that may — in some cases — make providing the service a financially losing proposition. (The byzantine system of reimbursement itself is noteworthy: The system is not only not transparent, but during our research, we found it militantly secretive). It is also noteworthy that the federal government deems tonsillectomy worth \$294, i.e., what Medicare pays, while the state, which administers Medicaid, has chosen a rate that is nearly half. In light of the mandate in federal law that requires states to offer reimbursement sufficient to entice physicians to participate [9], this single example — if representative of the system — challenges the degree to which it is a hollow and unenforced mandate. Patients who do not have ready access to these services also have no recourse since they have no legal standing to challenge Medicaid plans (see below).

### *The Affordable Care Act and the Subspecialty Gap*

How will the Affordable Care Act (ACA) address the gap for subspecialty cov-

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<sup>1</sup>In the absence of comprehensive, representative data, we gleaned from the published literature the magnitude of differences in physician reimbursement rates. For example, for a total hip replacement, the average surgeon reimbursement by Medicaid in Hawaii in 2012 was \$1,385.91 (<http://www.medquest.us/PDFs/Provider%20Memos/Medicaid%20Fee%20Schedule.pdf>.) The Healthcare Bluebook, which compiles data regarding costs and average reimbursements, lists \$2,764 as a fair fee ([https://www.healthcarebluebook.com/page\\_Results.aspx?id=28&dataset=md&g=Total%20Hip%20Replacement](https://www.healthcarebluebook.com/page_Results.aspx?id=28&dataset=md&g=Total%20Hip%20Replacement)). To determine definitively how systematically (and severely) Medicaid underpays for services would require a comprehensive list of procedures and services, with fees paid by Medicaid and private insurance. No such list is available to the public, and since rates are set by the states, rates can differ substantially from state to state and provider to provider.

erage of Medicaid patients? On January 1, 2013, both primary care physicians and subspecialists in family medicine, pediatrics, and internal medicine became eligible for higher reimbursement rates [10]. There are, as yet, no data to support that this initiative has impacted access to medical subspecialty services. No similar increase in payment rates occurred for surgical subspecialty care. For states that have chosen to reject expansion of Medicaid, the subspecialty gap is unlikely to be impacted, for better or worse.

In preparation for full implementation of the ACA, Connecticut's health care leaders and policymakers crafted the SustiNet Health Partnership to more carefully define and provide care needs of under-served populations [11]. SustiNet is a "publicly-administered health plan" that began providing care in January 2014 for "existing state-sponsored populations, state employees and retirees as well as Medicaid and HUSKY beneficiaries. SustiNet will then become a new health coverage option for municipalities, private employers and families" [11]. The ACA requires participating states to provide medical care to all prior Medicaid patients and a large group of the working poor who now qualify for Medicaid. How will absorbing this estimated 300,000 to 500,000 additional patients [12] — as high as a 50 percent increase in Medicaid beneficiaries — impact the subspecialty gap [13]? While it is plausible that additional ACA funds will be sufficient to underwrite primary care and subspecialty medical care for both new and previous beneficiaries, the ACA does not specifically address the gap in subspecialty care for Medicaid beneficiaries because fees have not and are not scheduled to increase to entice more subspecialists into the system. In the absence of substantial increments in subspecialist remuneration or another solution, the subspecialty gap among Connecticut's Medicaid patients could increase substantially. To the extent that many of these patients were formerly uninsured and so had access to no primary or specialty care, the number of patients without specialty care won't change. But the number who are supposed to have such federally mandated access is certain to

increase, and without measures to encourage more subspecialists to provide such care, more patients entitled to specialty care may not receive it.

Aside from moral and legal arguments for providing this care, unmet needs among the newly minted Medicaid working poor could have unintended consequences that ripple through the Connecticut economy. Even for those who don't agree that health care should be a right, the economic implications of not providing a substantial group of the population with a complement of health care services could bind many potentially happy and productive fellow citizens to infirmity and dependence upon the state for support through preventable/treatable medical disability. These "ripple effects" are explicated elsewhere [14], and we (physician-authors) lack the macroeconomic training to hazard estimates of cost/savings associated with filling the surgical gap. However, the abstraction is as follows: Providing sufficient health care improves worker productivity [14]. There are also data to suggest a roughly 10 percent increment in earnings for healthier workers [14], which they in turn use to pay higher income taxes and spend on products and services that "ripple" through the economy. In the extreme situation, where absence of medical services leads not only to lower productivity but to unemployment/disability, the potentially productive citizen instead adds cost to the system in the form of disability benefits and no offsetting positive ripple effect. Using a concrete example, if you've been working and your hip has degenerated to the point where pain is disabling and there is no access to hip repair/replacement, there is no choice but to convert from a citizen who contributes to the economy (productivity, taxes, and consumer spending) to one who only receives benefits (\$12,000/year just in Social Security [14]) at the expense of those remaining in the workforce. We cannot assert with certainty that there are sufficient numbers of citizens whose productivity would increase or who would be converted from beneficiaries-only to economically productive citizens by solving the subspe-

cialty gap. But if the costs of the now-missing subspecialty services are spread among stakeholders, including physicians who might contribute reduced-rate services, cost is likely to be low, and thus, net impact is very likely to be economically positive.

## POTENTIAL SOLUTIONS

Neuhausen and colleagues have proposed potential solutions to this problem that affects all states [15]. In an effort to identify home-grown solutions, they queried medical directors at 20 community health centers in 16 states to identify how they had attempted to fill their Medicaid subspecialty gaps. They identified six “models” employed by clinics:

- Tin cup. Uses personal relationships with sub-specialists to “beg” (hence the tin cup metaphor) for services through informal arrangements.

- Hospital partnership. Contracting with nearby community hospitals to provide subspecialty services.

- Buy your own sub-specialists. Employing sub-specialists in the community clinics to fill the gap.

- Telehealth. Paying sub-specialists to provide telemedical assessments, with an agreement to provide procedures when needed.

- Teaching community. Including sub-specialists as instructors in educational programs that serve the poor, entraining their participation to provide procedures when needed for “teaching patients.”

- Integrated system. Explicitly combining the resources of the community clinics, local health departments, and public hospitals to address full services for all patients (insured, uninsured, and Medicaid) in a geographic locale.

While unscientific, they concluded that the integrated system appeared “to provide the most comprehensive and cohesive access to subspecialty care” [15].

David and colleagues [16] reported that “vertically integrated hospitals are able to shift expensive patient recovery tasks downstream to lower-cost delivery systems by discharging patients earlier and in poorer

health.” They go further to say that patients in vertically integrated hospitals do not receive substandard care. On the contrary, says David, “health outcomes are no worse when patients receive care from an integrated provider, and in some cases, integration leads to better outcomes. The evidence suggests that by improving the efficiency of the timing of patient transitions, integration solves coordination problems that would otherwise arise under pure market exchange.”

### *Denver Health — An Integrated System Approach*

The Denver Health Medical Center is cited by Neuhausen as an exemplary solution that provides high quality care to underserved populations [15]. Dr. Patricia Gabow pioneered this system, which provides both inpatient and outpatient care for a population that includes 70 percent either uninsured or Medicaid-insured. The system evolved over more than a century with Denver Health, an organization that was founded in 1860. A seminal step was consolidation of the city’s health commission and the hospital in 1916, which was fortified by a merger of visiting nurses, the public health department, and hospital forming the “Department of Health and Hospitals.” A neighborhood health and primary care network followed that included an ever-growing number of community health centers that also integrated with the hospital in the 1990s. The system gradually evolved when attending physicians from the community were integrated into inpatient care, and both undergraduate and graduate medical education were woven into the community health centers.

“Denver Health is now fully integrated organizationally and functionally, horizontally and vertically. The horizontal integration is achieved through an administrative team and shared processes and care protocols across all community health center (CHC) sites. Vertical integration is achieved since the system links the emergency system (911) pre-hospitalization service, a 349-bed hospital, 10 community health centers, 13 school-based clinics, public health depart-



ment, substance abuse and mental health treatment, a poison control center, an advice line and a managed care insurance product. Physicians are at the center of this continuum of care. All full-time physicians at Denver Health are salaried employees ... ” [17]

While exact figures are not available for access and wait times for subspecialty services in the system, “Patients benefit by easy access to specialty care. All adult and pediatric medical and surgical subspecialty services are available at the hospital campus” [17]. Despite the “unfavorable” payer mix, Denver Health has managed remarkably sound financial statistics [18]. Accordingly, assuming that the subspecialty gap at Denver Health is small, it appears to offer a model for comprehensive care for Medicaid and uninsured patients that is financially viable. At the core of this success story is a shared vision — of policy makers, civic and hospital leaders, and clinicians — that the city has an obligation to care for its poor, and serving that end is a civic duty. The degree to which this successful model that evolved over a century of careful planning among all stakeholders can be reproduced elsewhere, quickly, is uncertain.

### *Connecticut's Home-Grown Solutions*

In our research [3], we found two solutions that may help fill the Medicaid services gap in Connecticut without adding substantial costs. First, there are three hospitals in Connecticut that have full-time subspecialists who provide services to all patients. Historically, university teaching hospitals have served this purpose, as trainees in subspecialties learn in clinics that serve the poor, but one community teaching hospital invested in employing a full complement of subspecialists who served all patients, irrespective of insurance status. This model has costs, borne by the hospital, that may exceed income generated by the practitioners, but such teaching hospitals often obtain extra federal monies for graduate medical education that offset the costs.

Another hospital confronted its subspecialty gap in a creative manner that deserves mention, as it may serve as a financially sus-

tainable model for others. The teaching attending chief quantified and presented features of the gap in subspecialty services to senior hospital leadership. They worked together to craft a solution in which hospital administrative and physician-leaders had “crucial conversations” [19] with subspecialty division chiefs, many in private practice, to appeal to their sense of philanthropy and civic duty. Most were reluctant and unsure for several reasons. First, subspecialists were already experiencing substantial cuts in reimbursement. Asking them to add more patients with poor reimbursement rates from Medicaid would only further reduce their salaries. Why should they shoulder the cost of government’s failure to provide reasonable fee-for-service? Second, some feared that installation of subspecialty services might lead to flocking of poor people from around the state to their hospital clinic that had full services, which would overwhelm the local system. Third, they doubted the professionalism of colleagues to share the responsibility equally. Distributed equally among all subspecialists, the burden was not excessive, but everyone had to participate. In the end, using a model of shared sacrifice for the public good and sequential “crucial conversations” [19], it took less than 12 months for every subspecialty to be covered every day of the year, a system that has so far survived 24 months. Aside from a meager salary line for one high-traffic subspecialty that required a dedicated clinic day, this solution was realized with the principal cost being the time and effort to convince physicians to share the uncovered cases.

While the philanthropy of these community physicians is laudable, financial incentives (such as tax credits and permitting some portion of the work, e.g., the difference between Medicare and Medicaid reimbursement, to be considered a charitable donation) might encourage ongoing participation and installation of similar programs elsewhere. But this would simply shift costs; that is, if the government uses tax incentives to entice participation, why not simply apply those funds to align remuneration with Medicare rates that most subspecialists accept?

The Sustinet Health Partnership Board of Directors is comprised of state political leaders, policy makers, and stakeholders who have taken extraordinary steps to integrate the ACA and the health care needs of Medicaid and soon-to-be-insured patients. We suspect that both Sustinet leaders and other key stakeholders may not be fully aware of the subspecialty gap and the degree to which ACA implementation will likely widen it. Indeed, if Sustinet is to become a viable alternative health care insurer for “municipalities, private employers and families [11],” it will need to solve the subspecialty gap, since these groups are unlikely to tolerate forgoing critical subspecialty services. Hospitals also have an important stake in how the burgeoning Medicaid and insurance exchange patients will receive services and so are natural allies with Sustinet policymakers to advocate for sustainable, integrated care models.

Another unpalatable solution is one that has only been intimated nationally: Medicaid patients could legally demand subspecialty care. In 2011, amid cuts to Medicaid services in California, litigants (both patients and providers) in *Douglas v. Independent Living Center*, *Douglas v. California Pharmacists Association*, and *Douglas v. Santa Rosa Memorial Hospital* challenged whether cuts to vital, previously provided services were legal. The Ninth Circuit Court reviewed the case and issued injunctions to block California’s reductions in Medicaid services. But in 2012, the Supreme Court found that the rate reductions complied with federal law, suggesting that the plaintiffs pursue their arguments under the Administrative Procedures Act (APA) [20].

The case has not yet been reargued but could have important implications in defining Medicaid patients’ legal recourse when states modify services.

## OUTCOMES AND CONCLUSIONS

The intended outcome of the ACA is to increase access of previously uninsured groups to affordable health care, in order to improve the public’s health. That goal will be threatened if gaps, like the subspecialty gap in

Medicaid, are not confronted and repaired. We acknowledge that the current level of evidence that a subspecialty gap even exists is based on survey data. There are neither federal nor state-sponsored studies to objectively and rigorously quantify the problem. However, the available (albeit survey) studies of professionals who serve this population report that a problem exists, which places patients at risk of not receiving some vital services. Such data might be embarrassing to some, but it is the first critical step to verifying and, if confirmed, quantifying this problem.

The Charter of Medical Professionalism, approved by major medical groups, is arguably among the most authoritative documents delineating physicians’ professional ethics in the 21st century. It includes:

“Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care. Within each system, the physician should work to eliminate barriers to access based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession” [21].

If we accept its validity, the Charter suggests physicians have a responsibility to define and then help policymakers craft solutions to the subspecialty gap. Some of the solutions outlined by Neuhausen (for example, “begging” subspecialists) are not solutions at all. Sustinet and other state programs like it may be the beginning of a more comprehensive, integrated system without the large gaps noted in previous studies [3,4]. It is important to note that some specialties and services are well covered, while others (e.g., rheumatology, endocrinology, dermatology, neurosurgery, and orthopedics) have substantial gaps in coverage [3]. Building a system like Denver Health would be the ideal but would take time and require sustained collaboration of health officials, hospitals, teaching and fed-

erally funded clinics, physicians, nurses, and trainees whose efforts have not been well integrated or coordinated in Connecticut. However, publicly transparent and regular reappraisals of the gap might be necessary to keep this issue on policymakers' radar.

Could physician and hospital activism contribute to a timely solution? Solutions will not materialize unless there is acknowledgment that the subspecialty gap exists and that it is worth fixing. Then stakeholders must partner to confront it with concrete solutions. Subspecialists are very unlikely to step forward spontaneously to volunteer to fix it, given the lack of economic incentives to do so. It is worth noting here that while Medicaid reimbursement rates may be substantially below those paid by private insurance, they still represent a substantial hourly rate. For context, assuming a total payment of \$1,400 for operative and post-operative care following hip replacement, surgeons still accrue \$140/hour. Even though well below the average market value for their time, the Medicaid rate is still well above that for other medical specialists (e.g., hospitalists whose hourly wage is roughly \$100/hour in Connecticut). Surgeons may not flourish financially from Medicaid cases, but neither are they likely to experience financial hardship if each capable surgeon contributes equally to provide services to Medicaid patients (i.e., we estimate <10 cases/year/surgeon in most hospitals) [22].

The conversation must begin at the public health (e.g., SustiNet) and community hospital levels. Stakeholders, including physicians, might petition the governor to apply ACA monies to ensure fair, market-appropriate fees for subspecialists and hospitals that provide the beds and operating rooms for these vital services. Using Connecticut as an example, a united front of SustiNet, the Connecticut Hospital Association, and the Connecticut State Medical Society is the best chance of ensuring that our poorest neighbors receive a reasonable standard of care in this affluent state. This paper highlights a number of potential solutions. Every community has its own unique patient population, physician resources, and infrastructure. So perhaps ultimately each com-

munity will customize solutions that complement resources and needs, otherwise the great promise of the ACA could be undermined or unnecessarily diminished by an oversight such as the subspecialty gap.

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