

Medicaid Patients' Access to Subspecialty Ambulatory Care in Connecticut

The overall quality of American health care and medical education is negatively affected by disparities in patients' access to care.¹ Many internal medicine residency programs provide primary care to patients with Medicaid. We hypothesized that Medicaid patients lack full access to ambulatory subspecialty care (SC), which necessarily affects the educational experiences of residents who provide their primary care.

Clinic attending physicians (chiefs) at all 17 residency teaching clinics in Connecticut responded to an e-mail questionnaire asking about the frequency of Medicaid patients' timely access to ambulatory and (when needed) procedural SC (TABLE).

Zero to 18 subspecialties were "never, rarely or sometimes" available for patients in Connecticut's 17 teaching clinics. Care was more available when centers had training programs in SCs (odds ratio, 3.5; 95% confidence interval, 2.2–5.8). Seventy-seven percent answered that SC was less accessible than for their privately insured patients.

Connecticut is an affluent state, yet access to SC was described as "never, rare, or sometimes" in 36% of SC centers. The American Medical Association's code of ethics states that "each physician has an obligation to share in providing care to the indigent."² The government requires hospitals "to ensure that Medicaid beneficiaries have full access to all of its available services."³ If many Medicaid patients cannot access essential services, then it may explain mediocre outcomes in underserved groups.¹

While this study should be expanded and verified, our findings should concern physicians and health care policy-makers. This survey was conducted at teaching clinics where trainees might assimilate practice disparities. They observe firsthand the inconsistent application of ethical concepts we expect them to master (ie, "society has an obligation to make access to an adequate level of healthcare available to all its members regardless of ability to pay."⁴) and realities "on the ground." They might conclude either that there are not enough subspecialists (possible, but unlikely for most disciplines in Connecticut) or that ethical obligations are insufficient for some physicians in our state to care for this segment of the population. With health care reform, Medicaid beneficiaries are projected to increase by 15 million,⁵ only exacerbating this problem.

There are potential solutions. We propose that hospitals and their physicians should proactively create equally shared coverage for essential services, as the public health code proposes.³ Additionally, hospitals and state licensure boards could require participation as a condition of privileges. Lastly, regulatory bodies (eg, departments of public health, Joint Commission, and Center for Medicaid Services) could audit the community service assurance of hospitals.³ To the extent that we physicians are advocates for patients and the health of our society, we might object collectively to this status quo and participate locally, to contribute our time, and politically, to create a more just system.^{2,4}

Perhaps most importantly, we owe it to our trainees to "not look the other way." At a minimum, we can "name" injustices that they observe and explore reasons for and solutions to such problems. As teachers, we can demonstrate through modeling of persistent patient advocacy that more often than not, vital services can be obtained if we persevere. And we can work with our hospital leaders to politely confront injustices, appealing to the humanity and beneficence of our colleagues, to install local solutions.

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- 2 American Medical Association. AMA code of medical ethics: opinion 9.065—caring for the poor. <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9065.page>. Accessed October 28, 2010.
- 3 GPO Access. Public Health Code, pt 124: Medical Facility Construction Modernization. 42 CFR §124.603 Provision of Services (d). <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=d488872ca072512228d9a1497bc80c03&rqn=div8&view=text&node=42:1.0.1.11.78.4.39.3&idno=42>. Accessed October 28, 2010.
- 4 American Medical Association. AMA code of medical ethics: opinion 2.095—the provision of adequate health care. <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2095.shtml>. Accessed October 28, 2010.
- 5 Lowes R. Will healthcare reform increase Medicaid pay as well as enrollment? Medscape MD website. <http://www.medscape.com/viewarticle/718673>. Accessed October 28, 2010.

TABLE **RESPONSES OF CONNECTICUT TEACHING CLINIC CHIEFS TO THEIR EXPERIENCE IN OBTAINING SUBSPECIALTY CARE FOR MEDICAID PATIENTS**

Subspecialty	Never, No. (%)	Rarely, No. (%)	Sometimes, No. (%)	Usually, No. (%)	Always, No. (%)
OB-GYN	...	1	...	6	10
Psychiatry	...	4	4	7	2
General surgery	...	...	1	10	6
Orthopedics	2	3	5	4	3
Ear, nose, and throat	1	4	3	6	3
CT surgery	...	2	5	7	2
Vascular surgery	...	...	8	7	2
Urology	1	1	4	7	3
Neurosurgery	3	6	5	2	1
Ophthalmology	...	...	6	5	6
Cardiology	...	...	2	6	9
Gastroenterology	...	...	4	7	6
Pulmonary	...	...	3	4	10
Rheumatology	...	2	4	4	7
Nephrology	...	1	4	5	7
Geriatrics	...	2	3	5	3
Infectious disease	1	...	1	4	11
Endocrinology	1	2	4	3	7
Dermatology	3	4	2	4	3
Hematology-oncology	...	...	3	3	8
Total	12 (4)	32 (10.3)	71 (21.5)	106 (32)	109 (33)

Abbreviation: OB-GYN, obstetrics-gynecology; CT = cardiothoracic; no entry means none.