I. Executive Summary

Medicaid is the number one health insurer in the United States, insuring more than 1 in 5 Americans (Henry J Kaiser Family Foundation, 2018), or 67,305,506 individuals (Medicaid.gov Keeping America Healthy, 2018). This also holds true for Colorado where Medicaid insures over 1.1 million Coloradans (Colorado Health Institute, 2017). With the expansion of Medicaid under the Affordable Care Act (ACA), enrollment in Medicaid and the Children's Health Insurance Program (CHIP) increased 29% (Henry J Kaiser Family Foundation, 2018). As of March 2018, Colorado has experienced the fourth largest jump in Medicaid enrollment, with a 71% increase since the beginning of the ACA (Henry J Kaiser Family Foundation, 2018).

A significant and recurring issue that Medicaid patients face is that, despite the program insuring an immense number of people, many medical practices do not accept Medicaid patients (Bisgaier J, 2011). This creates a gap in access to health care. In states such as Colorado that have expanded Medicaid, the gap in access to care has become even larger. Practices that do accept Medicaid have become saturated and unable to cope with the increased demand. One of the largest gaps in the Denver Metro area is access to specialty care, with only a limited number of specialty physicians accepting established adult Medicaid patients, and even fewer accepting new adult Medicaid patients according to a preliminary survey of physicians in the area by Mile High Health Alliance.

There are numerous reasons that specialty physicians cite for not wanting to accept more Medicaid patients into their practices. These include issues related to the billing process including: the low reimbursement rate, increased wait time for reimbursement, and added complexity of billing for Medicaid patients compared to other insurers. Specialty physicians also cite that Medicaid patients are socially complex, medically complex, and non-compliant with treatment plans (Niess MA, 2018). These attitudes show that not only are there systemic problems with how Medicaid is functioning, but there are stigmas that come with being a patient covered by Medicaid. These stigmas are not wholly based in fact, but are prevalent among healthcare professionals.

There are numerous facets to the problem of low specialty acceptance of Medicaid patients, none of which can be solved in one simple step. The proposed solutions outlined here are a threefold process. First is to increase care coordination and patient navigation services for Medicaid patients. This will assist the patients in accessing resources that will allow them to make the most of their specialty appointments. Over time, this may help alleviate some of the provider biases about the social complexity of Medicaid patients by helping the patients navigate some of their socioeconomic barriers and adhere to their appointments and treatments. The second step is to focus on policy change. Some practices feel that accepting Medicaid patients causes them to lose money and time. Therefore, the recommendations are: to increase reimbursement rates, speed up reimbursement times, and create a billing platform that is equivalent to that of Medicare. Additionally, new policy needs to address reimbursement for transportation to and *from* appointments, telemedicine, and e-consults. Policy and finance changes can be enacted more easily, whereas stigma can take generations to reverse. This is why the third recommendation is

to change the format of medical education to teach about Medicaid as an insurance and educate on social responsibility and how to manage one's own biases.

Currently healthcare reform is a huge point of contention in our state and country. We are at a pivotal point, and it is important as we reform our system to make sure that the changes made will increase access and decrease stigma associated with being a patient of a lower socioeconomic class. This three-pronged approach of how to proceed will not be an overnight solution to the issue of specialty acceptance for Medicaid patients, but will open a dialogue between patients and providers and will get us one step closer to health equity.

II. Introduction

As the largest health insurer in the United States, there are many issues facing Medicaid. One of the largest ongoing issues is that there is a huge gap in the access of specialty care for patients covered under Medicaid. This gap exists across the United States. As approximately 1 in 5 Coloradans are covered under Medicaid (Colorado Health Institute, 2017), this issue is a priority for many groups working in Colorado. The first step in bridging this gap is fully understanding the cause for it. Physicians often cite that Medicaid does not pay enough; however, there are other reasons also at play. One of the greatest barriers that Medicaid patients face in trying to find health care is the large social stigma that many physicians hold. Along with this stigma, there is also a complex billing process that prevents physicians from accepting Medicaid patients. The combination of the negative attitudes that physicians hold toward Medicaid patients along with the difficulties they face in trying to bill the patients causes many specialty physicians to deny Medicaid patients up front.

Here, three potential solutions to the issue of Medicaid acceptance in specialty care are proposed. The first is to increase the use of care coordinators in primary care practices in order to decrease social barriers patients face to accessing specialty care and maximize the benefit from each visit. The second is to standardize and simplify the billing process and increase the reimbursement rates. This will help by decreasing the administrative burden on specialty offices and providing greater incentives for accepting Medicaid patients. The final proposal is to implement a curriculum in medical schools focusing on Medicaid as a pivotal form of insurance in our country and disproving social stigmas that Medicaid patients often face when interacting with physicians. This three pronged approach provides a framework to improve how physicians interact both with Medicaid as an insurance provider and the patients who are on Medicaid. By focusing on the issue of Medicaid in specialty care, hopefully a dialogue can begin to promote health equity for all individuals regardless of what insurance they are covered under.

III. The Issue

Lack of specialty care access

With the ACA, Medicaid coverage increased across the country. In Colorado there was a 71% increase in patients covered under Medicaid (Henry J Kaiser Family Foundation, 2018). With the

influx of patients comes additional strain on the system and gaps in access to care have become more prominent. This is especially true in specialty care. Although the focus of this paper is adult Medicaid patients, the trend of limited access to specialty care has been found both in adult Medicaid and in CHIP (Bisgaier J, 2011). It has also been found that wait times are considerably longer for Medicaid patients than for privately insured patients (Bisgaier J, 2011). Over the years it has also been shown that patients with low socioeconomic status have worse disease severity (Prescott E V. J., 1999), more hospitalizations and exacerbations (Prescott E L. P., 1999), and differences in procedural recommendations from providers (Williams RL, 2015). Overall, specialty providers have negative attitudes toward Medicaid patients and patients with lower socioeconomic status. They also display strong explicit biases against them that may affect quality of care (Niess MA, 2018). This stigma against Medicaid patients can partially account for the differences in health outcomes and is also contributing to the difficulty Medicaid patients face in finding a specialty health care provider that will accept them.

The intersection of the following three issues is self-reinforcing:

- Specialty physicians having overt biases against Medicaid patients;
- Lack of access to specialty care for Medicaid patients; and
- Lower socioeconomic status patients having worse health outcomes.

Specialty care physicians having overt biases against Medicaid patients leads to a lack of access to specialty care for this patient population. This, in turn, contributes to lower socioeconomic status patients having worse health outcomes. A survey conducted by the Colorado Medical Society (CMS) in 2014, found that specialty providers who are members of CMS believe medical complications and mental health concerns to be moderate problems in accepting Medicaid patients. However, if specialists won't accept Medicaid patients, how are these patients expected to get the treatment for their "medical complications" and "mental illness" and how are these preconceptions to be broken?

There are multiple groups in Colorado working to address the gap in specialty care access. One of these groups is Mile High Health Alliance (MHHA), which is a nonprofit organization in Denver. They have created a specialty referral network, but have had great difficulty enrolling specialty physicians to participate. MHHA is part of a cohort working under a grant from the Kaiser Family Foundation (KFF). The other non-profits in the cohort include: Summit Community Care Clinic, Hopelight Clinic, and Boulder County Health Improvement Collaborative. In Colorado, the Regional Accountable Entities (RAEs) are part of the Accountable Care Collaborative (ACC) and are also working to address this issue through care coordination and referral networks (Table 1 and Figure 1). Organizations have recently been awarded RAE status and are currently working to implement these initiatives, some of which are included as part of the recommendations described here.

Responsibilities of the RAEs
Coordinating the physical and behavioral health for clients in their region
Overseeing behavioral and physical health regional networks
Onboarding and activating clients
Developing and supporting Health Teams
Making value-based payments to Health Teams
Convening Health Neighborhoods

Table 1. Summary of the responsibilities of the Regional Accountable Entities as laid out by the Colorado Health Care Policy and Financing Office (Colorado Department of Health Care Policy & Financing, 2016).

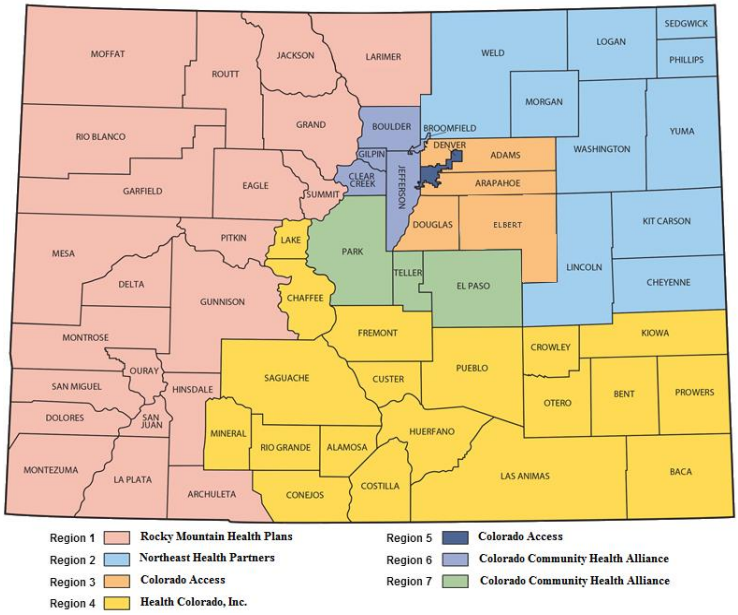

Figure 1. Map of the counties in Colorado that fall under each Regional Accountable Entity (Colorado Department of Health Care Policy & Financing, 2018).

Billing Complexity

Across the system most people agree that reimbursement rates need to be increased to make access to care in any specialty easier for patients, this includes physicians, patients, and Colorado's Department of Health Care Policy and Financing (HCPF; the governing body for Medicaid in Colorado). Low reimbursement rates cause a majority of specialty care physicians to choose not to accept Medicaid patients into their practices. Additionally, Medicaid's process to bill and receive reimbursement (including speed of payments) is perceived to be incredibly complex and often interrupts office workflows. These issues are difficult for small practices to navigate, leading some physicians to prefer offering charity care over accepting Medicaid patients if treating these patients at all.

Interestingly, even though there is agreement that rates are too low, a recent study by the University of Colorado found that states that had participated in the expansion saw that hospitals

were six times less likely to close their doors (Lindrooth, Perraillon, Hardy, & Tung, 2018). While reimbursement rates remain lower than any other insurance provider, the increase in those covered has helped the medical sector economy. The reasoning for this is likely two-fold. First, coverage by any insurance allows patients to be seen in primary care for preventative care services within the hospital system over emergency rooms. This reduces healthcare expenditures on the part of the hospital, as emergency room visits lead to inefficient use of funds. One study estimates that in 2010, $4.4 billion annually could be saved by managing non-emergent care in other clinics besides the ER (an estimated 13.7 to 27.1 percent of ED visits that year) (Weinick, Burns, & Mehrotra, 2010). The cost of uncompensated care from uninsured patients has declined within hospitals in states that have undergone Medicaid expansion, as shown in Figure 2 (Cunningham, Rudowitz, Young, Garfield, & Foutz, 2016). Uninsured rates in Colorado have fallen from 14.3 percent to 6.7 percent (Norris, 2018) since the expansion. Secondly, there are now more consumers in the hospital system, leading to increased revenue. These combined lead to hospitals not closing their doors.

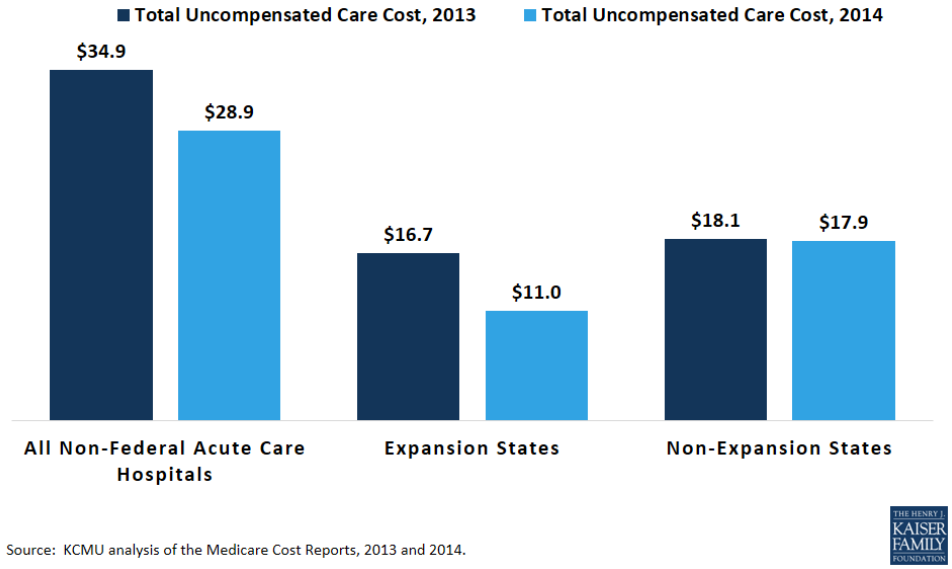

Figure 2. Costs of care in hospitals in expansion states broken down by compensated care costs and non-compensated care costs ($ in billions) (Cunningham, Rudowitz, Young, Garfield, & Foutz, 2016).

The ACA worked to expand Medicaid to cover more individuals. During this process, many people were concerned that this would increase the gap of access to care as reimbursement rates are too low to motivate physicians to take on new Medicaid patients. As a part of the ACA, in order to try to solve this concern, Medicaid rates were increased temporarily by the federal government up to the same level as Medicare rates for primary care, an average increase of 73% in 2013 (Crawford & McGinnis, 2014). A study by Zuckerman, et al found that increased payments at best only modestly increased physician willingness to take on new Medicaid patients (Zuckerman, Skopec, & Epstein, 2017). Another study showed no significant increase in physician acceptance of Medicaid patients following the ACA reimbursement rate bump. While not fully understood, part

of the reason for this decrease in buy in could have been due to the temporary nature of the increase (Decker, 2016). Overall, it is evident that Medicaid rate compensation is highly complex and not the sole issue.

Colorado has made Medicaid coverage a priority, as we were one of six states that decided to use state funds to keep the reimbursement rate increase after 2014. According to the KFF, in Colorado, physicians are estimated to be compensated for Medicaid $0.80 for every Medicare dollar. As every ICD10 code is billed and compensated differently by Medicaid, it is difficult to calculate the exact rate of compensation compared to Medicare. This leads to multiple different estimations (Table) which makes it difficult to determine how large the gap is and what the reimbursement increase needs to be. The Centers for Medicare and Medicaid Services have created a list of federally mandated Medicaid benefits as well as optional ones that each state can decide to offer or not. Tables 2 and Appendix 1 illustrate the federal requirements and Colorado State benefits.

Mandatory Benefits
Inpatient Hospital Services
Outpatient Hospital Services
Early and Periodic Screening, Diagnostic and Treatment Services
Nursing Facility Services
Home Health Services
Physician Services
Rural Health Clinic Services
Federally Qualified Health Center Services
Laboratory and X-ray Services
Family Planning Services
Nurse Midwife Services
Certified Pediatric and Family Nurse Practitioner Services
Freestanding Birth Center Services (licensed)
Transportation *to* Medical Care
Tobacco Cessation Counseling for Pregnant Women

Table 2. Federally Mandated Benefits for Medicaid Coverage, from Centers for Medicare and Medicaid Services (Centers for Medicare and Medicaid Services, n.d.).

With the expansion and the recent roll out of a new platform for billing, many providers have the belief that Medicaid billing is extremely complex and difficult to navigate. In conversations conducted by MHHA, some specialty physicians indicated that due to the complexity of billing, they would rather close clinic for a day and see patients free of charge than bill Medicaid. A recent survey, performed with the support of the Colorado Medical Society (CMS), demonstrated that specialty physicians list that low reimbursement, administrative burden, and reimbursement delays are major systemic problems with accepting Medicaid (Niess MA, 2018). In a follow up survey of physicians in the Denver Metro area, one physician stated:

> "I have not been paid for Medicaid patients that I have seen to remove a skin cancer for 1.5 years. My staff has spent countless hours to address issues in payment and revalidation. Just for these reasons I am considering discontinuing taking any

> Medicaid patients. There is a lack of access to surgical dermatologists to treat skin cancers for this population and Medicaid as an institution makes it very difficult to continue to function in this capacity. I have been quite frustrated with Medicaid and the cumbersome problems. It is NOT the patient population itself… in fact, these patients are a delight to work with in my practice. It is Medicaid that is a problem. Please address the problems with Medicaid itself."

While physicians are experiencing complexity and delays in being reimbursed, HCPF states that once they receive the claim, they pay providers within 7 days. These two views show a huge disconnect between providers and HCPF. In order for solutions to be accepted on both sides, there will need to be work done to clarify what is actually happening.

The Misunderstood Medicaid Patient

Physician attitudes and beliefs about patients covered under Medicaid tend to be more negative than positive. These attitudes include the perception that Medicaid patients range from being aggressive and non-compliant to having poor hygiene and being the wrong presence in a waiting room (the waiting room effect). In a recent study, physicians from non-primary care specialties were found to believe that Medicaid patients are both socially and medically complicated with poor adherence to physician recommendations. Physicians were also found to disagree with the idea that Medicaid patients have strong family support (Niess MA, 2018), as demonstrated in Figure 3.

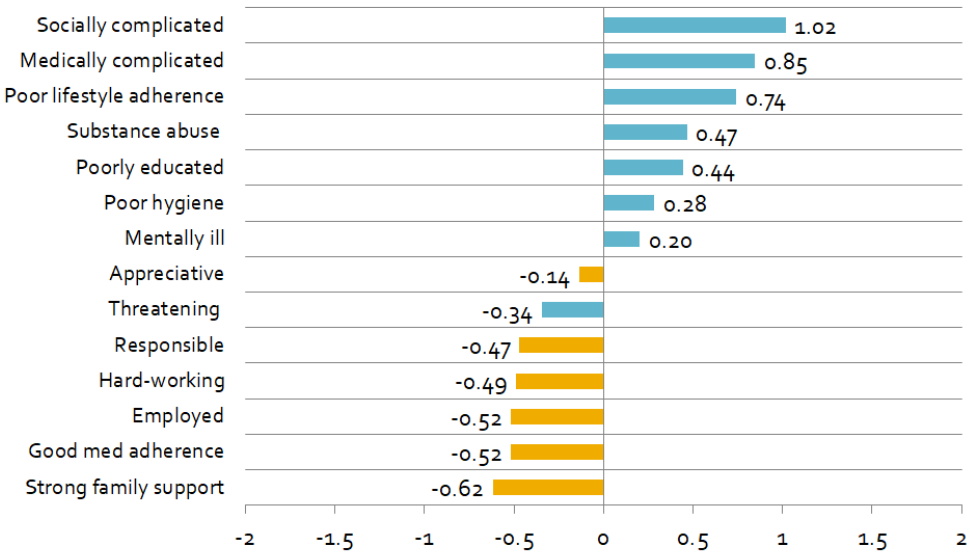

Figure 3. Data illustrating physician attitudes about patients covered under Medicaid. Zero illustrates indifferent attitudes while negative values indicate disagreement and positive values indicate agreement with the statement. Larger values indicate stronger beliefs.

While it is true that Medicaid patients tend to follow through less with specialty care referrals and miss or show up late to appointments (Forrest, Shadmi, Nutting, & Starfield, 2007) (Calfee, et al.,

2012) (Kaplan-Lewis & Percac-Lima, 2013), it is important to keep in mind that these patients face many socioeconomic barriers to their health. Rather than focusing on the fact that the patient did not show up to their appointment, focus instead on typical barriers. Likely the patient could not get transportation to and from the appointment, they were not able to get off work, or afford to take time off, or they had to stay home to be a caregiver to a parent or child.

Additionally, with Medicaid expansion in Colorado, the general group of people covered under Medicaid has changed. As shown in the Table 3, many individuals above the federal poverty level now qualify for Medicaid coverage. Many Medicaid patients in Colorado work at least one job. According to HCPF, after the expansion, three out of four adult patients (ages 16 to 64) worked at least one job (Colorado Department of Health Care Policy and Financing, 2016).

Income Limits	Who is covered
Up to 142% of FPL	Children 0-18
Up to 195% of FPL	Pregnant women
Up to 260% of FPL for family income	Pregnant women and children under CHIP
Up to 138% of FPL	Non-elderly adults*

Table 3. New income limits on qualifying for Medicaid since the expansion in Colorado broken down by population covered (Norris, 2018).

There is a shared stigma in health care that Medicaid patients do not work and that they utilize the system to get free health care.

> "They don't bring their copays! Most have more financial support than they admitted - smoke/nice jewelry and clothes, etc. Fed/state pays better than working - why should they work?" (Niess MA, 2018)

Another large stigma that many Medicaid patients have to overcome is the idea that they are entitled and more litigious than other patients.

> "The most difficult to take care of and the most unreliable and demanding. And litigious and unemployed." (Niess MA, 2018)

There is limited evidence to support that these patient populations are more likely to file legal claims against physicians (Allen Ref 15). Many other stigmas toward Medicaid patients exist including that they are: substance abusers, aggressive, unkempt, non-compliant, mentally ill, no-shows, and poorly educated individuals. There are also stigmas that these patients have no strong family support and are unappreciative of the care they are receiving.

It is difficult to say whether many of these stigmas were at one point based in fact or if they come from a subconscious bias that exists in today's society. It is also important to note that many patients have biases toward signing up for Medicaid and will often go without insurance for a while to avoid being on welfare. This can lead to worsened health by the time that they do finally go see a doctor, contributing to their medical and social complexity. A study by Allen, et. al explored

stigmatization in healthcare toward lower income populations. During an interview in the study they heard the following from a patient on Medicaid:

> "I think that the kind of insurance you have identifies you as what kind of group you fall in. [Having Medicaid puts me into the] broke, poor class, the class that is welfare class. The doctor who's sitting there, he's definitely upper class. Probably sees me coming in and says, man, I am paying for this." (Allen, Wright, Harding, & Broffman, 2014)

Stigmatization in health care has been linked to poorer health outcomes. Allen, et. al. examined the role of stigma in lower income populations and their access to healthcare. They found that stigma within the health care system towards these patients led to lower self-reported quality of care. Many patients felt singled out and shamed to be on Medicaid. This led them to select not to return to the clinic for follow-up care (Allen, Wright, Harding, & Broffman, 2014). In order to increase the quality of care and overall health outcomes for Medicaid patients, these stigmas need to be addressed.

IV. Our Solution

Care Coordination/Patient Navigation

Specialty care works as a triad: the patient, the primary care provider (PCP), and the specialty physician. These three parts must all work together for there to be effective medical care given to the patient. However, the healthcare system is extremely complex and many patients, especially those with limited knowledge about healthcare, have difficulty navigating their care. To this end, the first recommendation is to utilize a comprehensive care coordination team. Overall, care coordination is the organization of a patient's care and the sharing of information to achieve safe, effective care. In the broad sense this can include: teamwork, care management, medication management, using health information technology, and utilizing a patient-centered medical home approach to care (U.S. Department of Health & Human Services, 2018). On a more specific scale, coordination involves: assigning roles and responsibilities between members of the triad, having open communication, ensuring smooth handoffs of care, continuing assessment and reevaluation of patient needs and goals, creating a care plan, and linking the patient to community resources (U.S. Department of Health & Human Services, 2018).

Throughout the implementation of care coordination across clinics, there has been discrepancy in how the role is defined and some confusion about the differences between care coordination and patient navigation. These discrepancies have led to inconsistencies in measuring the impact that care coordination has on metrics such as health outcomes, patient satisfaction, and health service costs (Conway A, 2017). In much of the literature, care coordination roles have been taken by nurses who are able to help patients navigate the healthcare system and give healthcare advice. The care coordination roles that were able to have frequent, in-person interactions with ongoing follow-up and the ones that used a behavioral change model of care were the roles that were more likely to result in favorable outcomes (Conway A, 2017). Patient navigation on the other hand

fulfills many of the same responsibilities as a care coordinator but is often filled by a social worker or an employee trained to take on this role.

Though there is a lot of overlap between care coordination and patient navigation, this paper will use the term care coordinator and define it as a nurse who is employed to conduct pre-visit planning, follow-up contacts on overdue services and measures that are out of range, and transition of care contacts to reconcile medications and make sure that patients understand provider instructions (Mullins A, 2013). To make this definition more robust, care coordinators also help navigate the socioeconomic barriers their patients face including: transportation, housing access, food accessibility, translational services for their appointments, and mental health services.

Between 1999 and 2009, health care referrals doubled from 41 million to 105 million and the probability than an ambulatory visit resulted in a referral to another physician increased by 94% (Barnett M, 2012) and specialty care continues to be an integral part of outpatient medical care. The vast number of physician contacts that PCPs must make to have effective referrals can cause confusion in the healthcare system and lead to missed contacts that affect patient care. Missed contacts can include the specialist clinic failing to get in contact with the patient to schedule an appointment, lack of follow-up on the referral on the part of the patient, or missing medical notes from the specialist appointment.

In the survey completed by CMS in 2014 (Niess MA, 2018), it was found that the top three problems that specialists have with Medicaid patients are perceptions that these patients have high occurrence of late/missed appointments, are non-adherent to treatment plans, and are socially complicated (Figure 4). CMS also found that the top three system changes that specialty physicians would like to see are additional support services for Medicaid patients through a network outside of their practice, improved access to behavioral healthcare, and Medicaid supplying a case manager for each Medicaid patient (Figure 4). These data correlate well with Vimalananda et al which found that patients are better satisfied with their specialty care coordination when they are able to have a relationship with one specific person continuously, their care coordinator (Vimalananda VG, 2018). This person would be easy to reach, reside in the primary care office, and help coordinate the patient's specialty care. This study found that specialists would like more comprehensive referrals (background on the patient as well as prior treatments for the issue), and PCPs would like more information from the specialists on where the treatment should go following the visit (this might also overlap with the role of e-consults). The recommendation, therefore, is to have a designated care coordinator, using the previous definition, located in primary care offices who is able to assist patients in preparing for their specialty visit and ensure that the PCP and specialist communications are complete and timely.

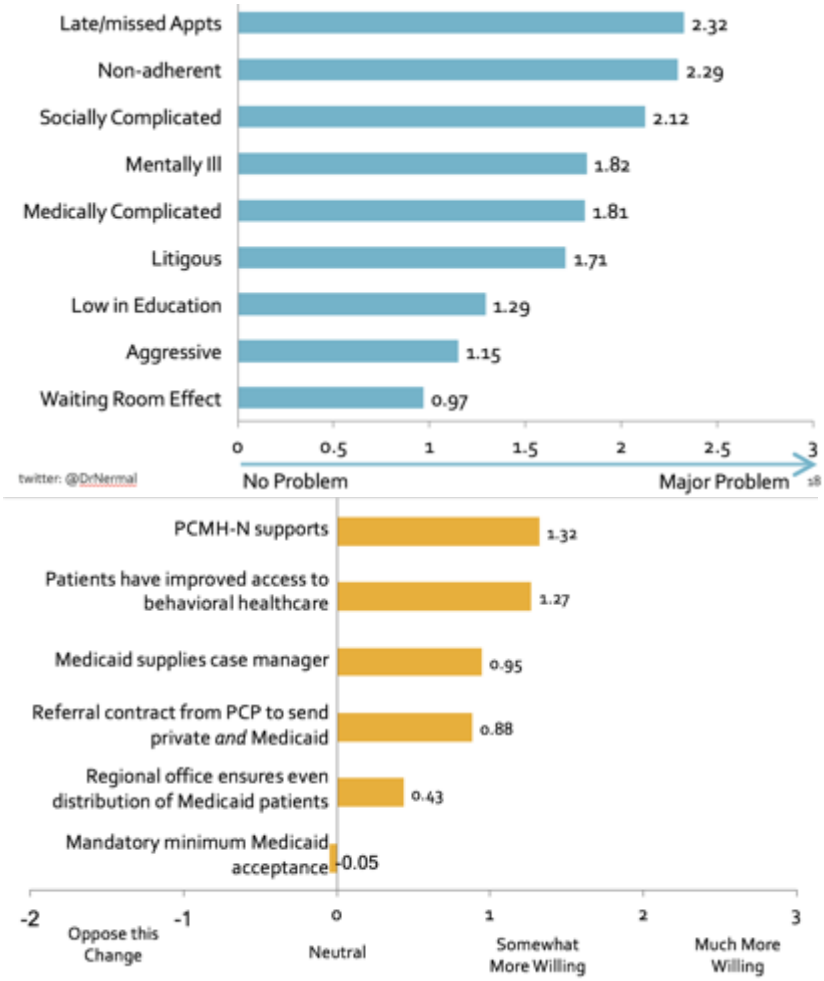

Figure 4. Data collected by CMS in 2014. A (above) – Specialty physician attitudes about how large a problem specific issues are for their practice. B (below) – Specialty physician willingness to accept additional Medicaid patients given systemic changes are made.

Care coordinators will act as patients' access point to their medical care. They work with the patient to obtain resources that affect their health such as housing, food, transportation, and behavioral health. These services could help specialty providers view Medicaid patients as less socially complicated. With regard to specialty visits care coordinators are able to act as the conduit between the patient, PCP, and specialist. Prior to the appointment, care coordinators can assist in scheduling, scheduling transportation, obtaining letters requesting time off work, connecting to translational services, and helping patients understand what to expect in their appointment. Following the specialist visit, the coordinator can follow-up and assist the patient in picking up prescriptions, scheduling follow-up visits, and understanding the instructions provided during the visit.

Creation of an online dashboard helping with referrals to specialty care would help care coordinators connect patients to the proper appointments. This dashboard would be a place where specialists that have openings can list appointment times. The care coordinator, when trying to connect the patient to an appointment, would be able to schedule the patient in the

dashboard based on what time they are available and whether they have access to transportation. This dashboard could also be used to schedule translational services for their appointments if needed. Another aspect of care that is often overlooked that this dashboard could assist with is ancillary services. Often, patients do not know where to go to obtain this care: physical therapy, occupational therapy, etc. Care coordinators can help connect patients to these services to make recovery and follow-up more effective and timely through the dashboard.

The healthcare system is extremely complicated and care coordinators can be used to pull all of the aspects of care together and close loops that may otherwise remain open between the three acting parties in specialty care. Care coordinators are able to work with all patients, but here the recommendation is specifically focusing on Medicaid patients as those patients are often the ones that require the most resources when coordinating their care. The healthcare system has biases against Medicaid patients. Working with care coordinators over time specialty physicians may experience a decrease in their stigma against Medicaid patients as the underlying issues behind the biases are addressed.

Policy Changes

There are three main issues that need to be addressed at a policy level to help increase health equity amongst Medicaid patients. These include: increasing reimbursement rates, increasing speed of reimbursement, and decreasing billing complexity. Additionally, policy changes need to be addressed surrounding compensation for telemedicine and e-consults. Finally, transportation needs to be further addressed during these proposals.

Reimbursement rates for Medicaid have historically been lower than any other form of insurance. Many efforts are already underway to reduce costs and increase compensation by Medicaid. In the United States in 2016, almost 18% of the gross domestic product (GDP) was spent on national health expenditure (NHE). Of this, approximately 17% is spent on Medicaid (approximately $565.5 billion in 2016). The amount of money the US spends on NHE is expected to rise by 2026 to almost 20% of the GDP (Centers for Medicare and Medicaid Services, 2018). A group called the Medicaid Provider Rate Review Advisory Committee (MPRRAC) was formed to look at each medical code every five years and determine if reimbursement levels are appropriate. Their results for 2018 are shown in the table below.

Service Description	Rate comparison (to other payers)
Evaluation and management and primary care	85.09%
Radiology services	81.86%
Physical and occupational therapy services	82.58%
Maternity services	69.49%
Surgeries	68.11%
Other physician services	66.96%
Dental services	98.07%-153.45%

Table 4. Reimbursement rates in Medicaid as compared to all other payers in 2018 (Medicaid Provider Rate Review Advisory Committee, 2018).

As demonstrated in table 3, specialty care is one of the lowest reimbursed fields in medicine. This strongly contributes to the lack of specialty care. We propose that increasing rates of specialty physician compensation to match the approximately 85% of average that primary care is receiving will help to increase access to specialists. According to the MPRRAC report released in 2018, HCPF believes that 80-100% of Medicare reimbursement is a reasonable rate for Medicaid (except in situations where Medicare is not indicative of quality of care in which case they compare to other states' Medicaid programs) (Medicaid Provider Rate Review Advisory Committee, 2018). By increasing reimbursement for specialists to this threshold, access to care, and ultimately health outcomes should increase for the state of Colorado.

Additionally, the billing complexity and speed of reimbursement need to be improved to help with specialty acceptance of Medicaid patients. The interruption to office work-flow is one reason that medical offices are less likely to accept Medicaid patients. HCPF has recently released a new billing system that is designed to decrease billing complexity. Anecdotally, many practices have found that this new system has actually increased the complexity. HCPF also states that they reimburse within 7 days of receiving a proper claim. With the delay that some specialty physicians experience, this indicates there is a major problem with how long it takes to file a proper claim that will be accepted. There is a very large disconnect between Medicaid administration and the physicians on the front line. These changes to billing complexity and speed of reimbursement would need to be made and monitored to ensure that Medicaid is matching what private insurance companies do.

E-consults, in which a PCP contacts a specialist about an established patient for advice and next steps in their care surrounding the specialty, are another area where policy changes need to be addressed. One way to help compensate for the lack of specialty care access is to allow Medicaid patient PCPs to be able to send an email to a specialist asking for advice on the patient's record. For this system to work, both the PCP and specialty physician need to be reimbursed for their time. As of right now, HCPF will reimburse for telemedicine, helping alleviate some of the system stress in rural environments. However, they do not currently reimburse for e-consults. This needs to change. This change will likely be especially beneficial to those specialties and subspecialties where there are very few physicians practicing at all.

Medical School Education

Another recommendation that we propose is to start at the bottom to address Medicaid access to care. At the University of Colorado, School of Medicine (CU SOM), there is relatively little taught about insurance in general and specifically Medicaid. Educating physicians while they are still in training and not burnt out from what they have experienced in clinic will help to mitigate some of the biases that physicians carry toward Medicaid patients. Additionally, understanding how billing and insurance coverage works on a basic level should help future physicians understand some of the complexity surrounding Medicaid billing.

At CU SOM currently there is an institutional initiative for curriculum reform. One aspect of this reform is creating courses for Health Systems Sciences to fill a need for further education surrounding insurances and physician biases. One class is currently being developed that will include a short lecture on Medicaid, followed by students taking on a patient navigation role for a few patients to see the challenges that Medicaid patients face on a daily basis. The school hopes that through this effort its students will leave as more socially aware, compassionate physicians.

V. Conclusion

As demonstrated, the issue of specialty care acceptance of Medicaid patients in Colorado is a complex and growing issue. As more patients are covered by Medicaid, the gap in access to care grows. Many Coloradans have medical problems that they cannot get help to treat. They are denied access to care not only because of the reimbursement issues surrounding Medicaid, but also because of the large stigma that surrounds these patients. A large number of specialty physicians in Colorado believe that patients covered under Medicaid are uneducated, unemployed, socially and medically complex patients. The deficit in specialty physicians accepting Medicaid has led to poorer health outcomes, increasing the medical complexity of this patient population.

There are a number of approaches that can be taken to help solve this problem and there is no *one* solution to fix everything. Rather a three pronged approach is the most appropriate direction of action. The first prong is finding the funding for an in depth and comprehensive care coordinator. This should help to alleviate the need for physician offices to navigate the social complexity of many patients under Medicaid. Our second prong is attempting to make legislative changes that will improve Medicaid as an insurance provider. By reducing the complexity of billing, increasing reimbursement rates themselves, and shortening the time it takes to get reimbursed, hopefully physicians will find accepting Medicaid easier. In addition, policy changes addressing transportation and e-consults should help to ensure that patients can actually be seen by physicians as there is a shortage of appointments in general for many specialties. Finally, the third prong is to start in medical school to educate future physicians about the health systems science surrounding Medicaid and to prevent the formation of stigma in regard to these patients.

While there is no easy answer to the lack of specialty care, these recommendations should be considered carefully as each one will be a large step in bridging the gap. It will be difficult to not only find the funding to make these changes but also to change years of stigma that Medicaid patients face. However, if physicians and legislators make this a priority, it is possible to make real change.

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VII. Appendix

Table 1: Health First Colorado Summary of Benefits, from Health First Colorado (Health First Colorado, 2018)

Health Care Provider Visits
Primary Care Medical Provider Visit
Specialist Visit
Home Health
Telemedicine
Vision Care
Dental Services
Dental Services
Hospitalization, Emergency Services, Transportation and Other Services
Emergency Room
Ambulance Services
Urgent Care Centers/Facilities
Outpatient Surgery at an Ambulatory Surgery Center
Outpatient Hospital Services
Inpatient Medical/Surgical Care
Organ and Transplants
Anesthesia
Breast Reconstruction
Hospice
Private Duty Nursing
Radiation Therapy and Chemotherapy Services
Maternity and New Born Care
Prenatal and Postpartum Care
Delivery and Inpatient Maternal Services
Newborn Child Coverage
Specialty Programs – Nurse Home Visitor Program (for first time mothers)
Specialty Programs – Prenatal Plus (for at risk mothers and babies)
Specialty Programs – Special Connections (for pregnant women with alcohol or drug misuse)
Mental Health, Substance Use Disorder, or Behavioral Health Services
Alcohol and/or Drug Assessment
Physical Assessment of Detoxification Progression Including Vital Signs Monitoring
Behavioral Health Counseling and Therapy, Individual

Alcohol and/or Drug Services, Group Counseling By a Clinician
Alcohol and/or Drug Services, Targeted Case Management
Safety Assessment Including Suicidal Ideation and Other Behavioral Issues
Level of Motivation Assessment for Treatment Evaluation
Drug Screening and Monitoring
Medication-Assisted Treatment
Inpatient Hospital
Outpatient Psychotherapy
Group Psychotherapy
Family Psychotherapy
Mental Health Assessment
Pharmacologic Management
Outpatient Day Treatment, Non-Residential
Emergency/Crisis Services
Clinic Services, Case Management
Biologically-Based Mental Illnesses and Disorders
Mental Health and Substance Use Disorder – Outpatient Hospital and Physician
Mental Health and Substance Use Disorder – Inpatient Hospital
School Based Mental Health Services

Pharmacy and Durable Medical Equipment Benefits

Prescription Drugs
Durable Medical Equipment

Physical, Occupational, or Speech Therapy

Home Health Therapies (Physical Therapy/Occupational Therapy/Speech Therapy) Acute
Home Health Therapies (Physical Therapy/Occupational Therapy/Speech Therapy) Long Term
Outpatient Speech Therapy
Inpatient Speech Therapy
Outpatient Physical Therapy/Occupational Therapy
Inpatient Physical Therapy/Occupational Therapy

Laboratory Services

Lab and Radiology

Preventative and Wellness Services

Preventative and Wellness Services and Chronic Disease Management
Immunizations
Colorectal Cancer Screening
Screening Mammography
Audiology
Allergy Testing and Injections
Screening Pap Tests
Gynecological Exam
Prostate Cancer Screening
Routine Foot Care

Family Planning Services

Office Visits and Counseling
Surgical Sterilization
Contraceptives and Emergency Contraceptives