

**PROJECT REPORT**

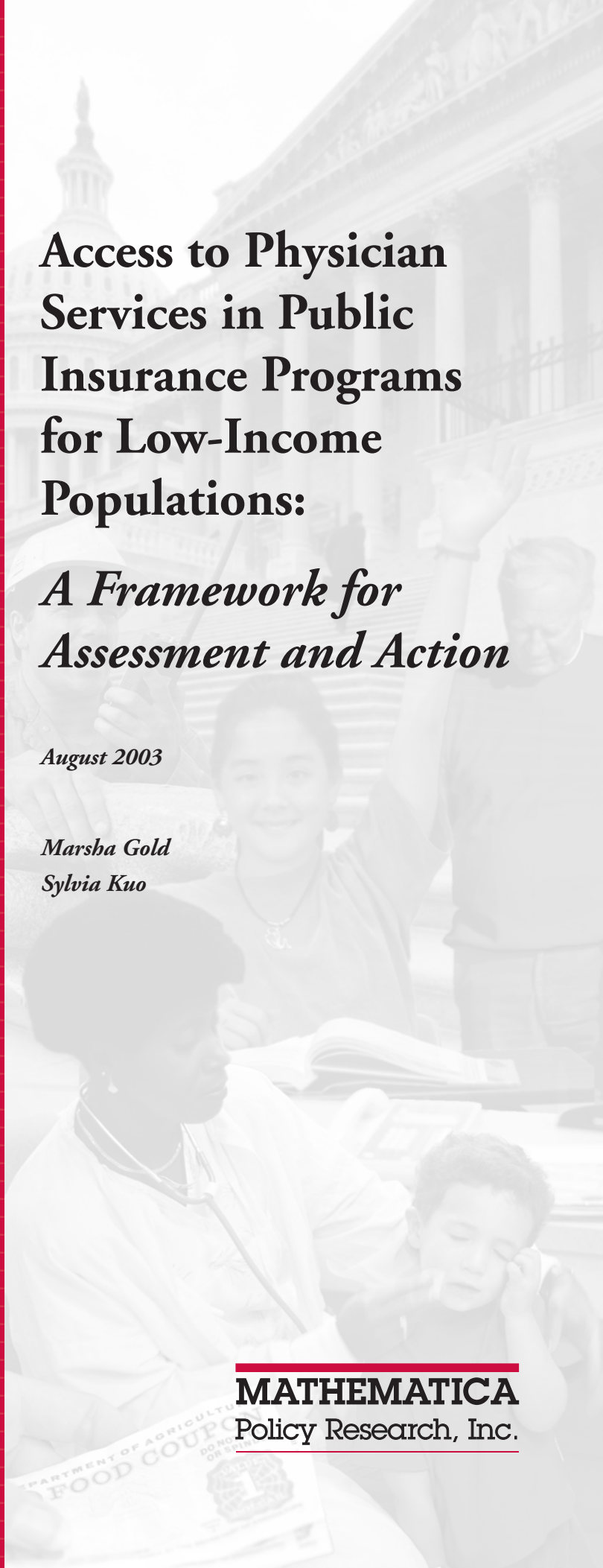
**Access to Physician  
Services in Public  
Insurance Programs  
for Low-Income  
Populations:**

*A Framework for  
Assessment and Action*

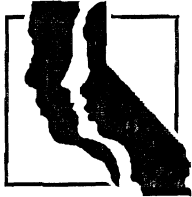
*August 2003*

*Marsha Gold  
Sylvia Kuo*

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CALIFORNIA  
HEALTH CARE  
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this paper.

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## ABOUT MATHEMATICA AND THE CALIFORNIA HEALTHCARE FOUNDATION

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**M**athematica, a nonpartisan research firm, conducts policy research and surveys for federal and state governments, foundations, and private-sector clients. The employee-owned company, with offices in Princeton, NJ, Washington, DC, and Cambridge, MA, has conducted the most important evaluations of nutrition, health care, education, welfare, employment, and early childhood policies and programs in the United States. Mathematica strive to improve public well-being by bringing the highest standards of quality, objectivity, and excellence to bear on the provision of information collection and analysis to its clients.

Marsha Gold, Sc.D., a senior fellow at Mathematica in Washington, DC, directed the study documented in this paper. Dr. Gold's work includes studies of Medicaid managed care, access to health care, and use of research information to support state policy. Sylvia Kuo, Ph.D., is a health researcher in MPR's office in Cambridge, Massachusetts.

The California HealthCare Foundation (CHCF), based in Oakland, California, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, the foundation's goal is to ensure that all Californians have access to affordable, quality health care. CHCF's work focuses on informing health policy decisions, advancing efficient business practices, improving the quality and efficiency of care delivery, and promoting informed health care and coverage decisions. CHCF commissions research and analysis, publishes and disseminates information, convenes stakeholders, and funds development of programs and models aimed at improving the health care delivery and financing systems.

CHCF's Medi-Cal Policy Institute seeks to facilitate and enhance the development of effective policy solutions for Medi-Cal and Healthy Families, with a particular interest in identifying and understanding options for improving enrollment and retention, access to care, and the quality of care provided to people served by these public programs.

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## O V E R V I E W

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States continue to struggle with ensuring adequate physician participation in public insurance programs such as Medicaid and SCHIP. There is no doubt that the extent and nature of the participation issues and the potential ways to address them are specific to each state's environment. However, conceptual work and national research on physician participation can provide a springboard for technical staff seeking to help state policymakers both assess the problems unique to their state and develop appropriate interventions.

This paper highlights what is known about the determinants of access to physician services and the potential ways in which these determinants can be influenced to improve access. It also organizes this information into a framework, shown below, that provides a structure for thinking through the issues and addressing them with the aid of currently available research findings. Specifically, the framework is intended to help states identify (1) the sources of problems with physician access, (2) the interventions that may be effective for different types of problems, and (3) the major parties to be involved in implementing these interventions.

### Framework for Assessment and Action

| <b>Assess Problems/Access Barriers</b>                                 | <b>Action via Potential Interventions</b>              |
|--|--|
| Provider supply: Adequate?   | Plan and provider contracting: Requirements            |
| Provider program participation: High?                                  | Payment: Adequate, predictable                         |
| Financial accessibility: Good coverage?                                | Delivery system: Features to ease access               |
| System accessibility: Easy to access?                                  | Monitoring: Identify emerging problems                 |
| Patient knowledge: Good? Problems for particular vulnerable subgroups? | Provider education: Patient needs and program policies |
| Patient preferences: Reflected in system?                              | Consumer education: How to seek care effectively       |

Chapter I reviews why physician access is an important issue in Medicaid and SCHIP. Chapter II details the framework, which incorporates six important factors that influence physician participation and, to the extent that these factors act as barriers to access, six types of interventions that have the potential to address them. The six factors include provider supply, provider participation, financial accessibility, system accessibility, patient knowledge and subgroup accessibility, and the degree of concurrence between system design and patient preferences. The interventions involve mechanisms related to contracting, payment, delivery systems, monitoring, provider education, and patient education.

Chapter III reviews the literature on the six factors that influence physician access, explaining why each is important, the empirical evidence on each, and the mechanisms used in attempts to address them.

Chapter IV concludes the paper with a discussion of the actions that have the potential to address access problems and the roles that each party—government, providers, health plans, and consumers—critical to the process might play in enhancing access to care. Specifically, states seeking to address these issues will need to:

- Identify concrete measures of key barriers to physician access
- Monitor performance against these measures on a regular basis
- When problems are identified, take action that is appropriate to the problem

The goal of equitable access to physician services in public insurance programs is more likely to be achieved if all critical parties share and commit themselves to this goal, each one doing its part to advance it. The analysis presented in this paper suggests that certain kinds of commitments from the following parties are most relevant to creating the collaborative environment that is needed to monitor and improve physician access:

- **Government.** Responsible for “equitable” payment and good business practices to encourage stable and broad-based provider participation organized in ways that create access for beneficiaries. This also means that government works to help all parties establish an open, effective dialogue.
- **Providers.** Responsible and willing to treat patients on a nondiscriminatory basis. This means that providers should be willing to (1) provide honest feedback to both plans and the state on what they need to make participation feasible, (2) take their fair share of publicly insured patients as long as reasonable conditions are met, and (3) educate themselves such that they fully understand the needs of their patients.
- **Health Plans.** As the agent of the state, responsible for structuring payment and practices in a way that encourages stable and broad-based provider participation in care systems that provide appropriate access. Health plans

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assume many of the same responsibilities of the state by either serving as a substitute for that state or complementing state action.

- **Consumers.** Responsible for being informed, assuming that there is an appropriate system and infrastructure to support education and access. This means that consumers need to be willing to learn how to use the health care system, particularly when it aims to accommodate their needs and preferences, and when they have been provided with appropriate education.

This paper was developed to support a unique effort in California, funded by the Medi-Cal Policy Institute, to learn more about the problems of physician access in Medi-Cal and Healthy Families within that state. While intended for use in California, the paper is written in general terms for application in any state. The boxes throughout the paper provide reference material on California and examples how the framework has been applied in a particular state. Those seeking to use the framework in other states will probably find it useful to develop information that is similar to these examples but specific to the state in question.

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# CHAPTER I

## WHY PHYSICIANS ACCESS IS AN IMPORTANT ISSUE IN PUBLIC INSURANCE PROGRAMS FOR LOW-INCOME POPULATIONS

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Since the late 1980s, the federal government and the states have directed considerable attention to expanding coverage for low-income children and families under Medicaid and, more recently, the State Children's Health Insurance Program (SCHIP) (Bilheimer and Colby 2001). Expansions in eligibility policies across the states have greatly increased the number of individuals (especially children) now eligible for coverage under Medicaid or SCHIP, reducing a critical financial barrier for millions of families seeking to enter health care delivery systems (Rosenbach et al. 2001). Coverage enables individuals to enter the system but does not guarantee that they will be able to obtain care from their physician of choice or will understand how to navigate the delivery system effectively.

While the development of public insurance programs such as Medicaid and SCHIP has improved access to physician care for Medicaid beneficiaries, problems continue to persist. Ensuring adequate provider participation and access to care have long been outstanding challenges in state Medicaid programs (Bindman et al. 2002; Perloff et al. 1997; Perloff, Kletke, and Fosset 1995; Gifford 1997; Coburn, Long, and Marquis 1999; Mitchell 1991). Compared with the uninsured, those with Medicaid coverage have substantially greater access to health care, but they have used the system differently from privately insured individuals [Kaiser Family Foundation (KFF) 1995]. Medicaid beneficiaries have been less likely to receive care in a physician's office than the privately insured and more likely to rely on publicly supported care providers (such as community health centers or clinics) and hospital-based providers (Rowland and Salganikoff 1994). Barriers to access include systemwide barriers (such as physician shortages, attitudes, and sensitivity), Medicaid-specific barriers (eligibility turnover, low physician payment rates, low levels of physician participation), and individual barriers that limit care seeking (KFF 1995).

In moving to mandatory Medicaid/SCHIP managed care, many states hoped to expand physician participation and generate better access to "mainstream care." Though some evidence indicates that mandatory Medicaid/SCHIP managed care may have improved access in some states, improvements are uneven, and Medicaid enrollees still rely disproportionately on traditional providers such as hospital-based facilities and community

health clinics [Gold et al 2002; U.S. General Accounting Office (GAO) 2000]. This means that, in today's health care environment, efforts to assess and/or improve access to physician services in Medicaid remain critical.

## CHAPTER II

### A FRAMEWORK FOR ASSESSING AND INFLUENCING ACCESS

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The framework we propose to use in assessing and influencing access to physician services for publicly insured populations is shown in Table 1. It has its roots in other frameworks that have been developed on the concept of access. From those frameworks, described below, we identify six factors that can be critical to access and then describe six mechanisms that can be used to address them and improve access. The form and content of these actions will depend on what the assessment shows about current barriers to access and what mechanisms to address them are already in place.

**Table 1: Framework for Assessment and Action**

| <b>ASSESS BARRIERS</b>          |   | <b>ACT: Potential Interventions</b> |                                    |
|---------------------------------|---|-------------------------------------|------------------------------------|
| Provider supply:                | Adequate?   | Plan and provider contracting:      | Requirements                       |
| Provider program participation: | High?   | Payment:                            | Adequate, predictable              |
| Financial accessibility:        | Good coverage?                                      | Delivery system:                    | Features to ease access            |
| System accessibility:           | Easy to access?                                     | Monitoring:                         | Identify emerging problems         |
| Patient knowledge:              | Good? Problems for particular vulnerable subgroups? | Provider education:                 | Patient needs and program policies |
| Patient preferences:            | Reflected in system?                                | Consumer education:                 | How to seek care effectively       |

#### A. OVERVIEW OF EXISTING ACCESS FRAMEWORKS

Researchers have a long and rich history in developing frameworks to study the concept of access to care (Gold 1998). Historically, the most widely used framework for measuring access to care is a behavioral framework developed to predict and explain utilization of health care services (Andersen 1968; Aday and Anderson 1981). The model characterizes

use of health care as a function of an individual's predisposition to use services, the factors enabling or impeding service utilization, and the individual's need for care. Predisposing factors include need, health beliefs and orientation to care, and socio-demographic variables. Enabling factors relate both to the care system itself (availability and organization of care) and its financial accessibility to individuals given their income, wealth, and insurance coverage. The model has been expanded to permit a fuller examination of how use affects outcomes and health status, taking into account mediating processes such as the appropriateness of care, efficacy of treatment, quality of providers, and patient adherence (Institute of Medicine (IOM) 1993). With the growth of managed care, the framework also has been elaborated to accommodate processes of plan (versus provider) selection and the influence of system features—such as provider panels, gate-keeping and referral rules, utilization management, and active outreach and education—on use and access (Gold 1998).

**Box 1: Physician Access is a Problem in Medi-Cal and Healthy Families:**

The Medi-Cal Policy Institute's 1999 statewide survey of Medi-Cal beneficiaries found that 56 percent reported difficulties in finding doctors who were willing to see Medi-Cal patients. Virtually all respondents (94 percent) said it is important for more doctors to participate in the program (Lake Snell Perry and Associates 2000). Qualitative studies based on interviews after the first year of operation of the Healthy Families Program suggest that access to particular specialists could be a problem (Fox et al 2001).

**B. SIX FACTORS THAT INFLUENCE PHYSICIAN ACCESS**

Existing work to conceptualize the determinants of access suggests that six key factors influence access to physician services in Medicaid. Each is reviewed below with a brief note on why it is relevant and may affect access, common indicators used in monitoring, and the types of interventions that in theory at least may be relevant in addressing problems.

*Provider supply.* The supply of providers is a necessary, though not sufficient, condition for physician access. The number, mix, and location of physicians determine the geographic accessibility of care. Such accessibility typically is measured in geographically based physician- to-population ratios developed from state licensure data. Because availability is a system variable, Medicaid and SCHIP programs can influence accessibility to only a limited extent. Potential options for enhancing supply include bonus payments or less geographically dependent ways of delivering care.

*Provider participation in public programs.* The extent to which available providers participate in public programs will determine the actual (versus theoretical) availability of care. Physicians may refuse to participate at all; those participating may limit their service (e.g., through capacity limits or lack of availability to new patients). Traditional Medicaid programs typically measure participation by the share of area physicians participating and the volume of service. Under managed care, today's geo-access software permits assessments of the adequacy of the physician network in terms of availability by distance and capacity. In theory, several types of policy levers are potentially available to states seeking to influence

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physician participation. These include payment policy (including promptness and ease of payment as well as level) and various other incentives or disincentives for participation (e.g., bonuses and clinical or data requirements).

*Financial accessibility.* The financial accessibility of care depends on the costs of care and the insurance coverage and/or income and other financial resources at an individual's disposal to pay those costs. Medicaid and SCHIP provide insurance coverage and thus make care more financially accessible, something that otherwise would be a major barrier, particularly for low- to moderate-income populations served by these programs. With its broad-based coverage and national limits on cost sharing, Medicaid traditionally has eliminated financial barriers to care for those who remain eligible. In Medicaid, eligibility turnover (and lack of coverage when ineligible) remains a major barrier to physician access, particularly if the safety net of providers available to the uninsured is limited. The growing flexibility provided to states in structuring benefits and cost sharing under SCHIP and for those Medicaid beneficiaries who are not categorically eligible could mean that financial accessibility may become a more important barrier now than in the past. In programs that include substantial cost sharing or very limited benefits, managers may want to consider how to develop, in their monitoring systems, a capacity to identify whether affordability is creating a barrier to care and what the implications may be for program design.

*System accessibility.* The way in which health care systems are designed and operated will influence the degree of accessibility of the available care. Important variables include: the design of office hours; the availability and ease of making appointments for urgent, routine, or preventive conditions; the availability of transportation; and the rules and processes that determine access to specialty services (such as gate-keeping and referral rules in managed care). States have used "secret shoppers," the extent of complaints, and beneficiary surveys to identify access problems related to system design. In the case of managed care, specific provisions may be included in the contracts to promote system accessibility.

*Patient knowledge, including subgroup accessibility.* Regardless of how system entry and flow work, accessibility depends on how well those covered by the program understand it. Patient knowledge is an issue, particularly when systems undergo change (for example, with the introduction of managed care). In some subgroups, knowledge also may be especially important when individuals have characteristics that may make access more difficult. For example, those who are sick and frail have more motivation to find out how to use the system because they are likely to use it more frequently and in many different ways. Racial or ethnic subgroups, particularly those influenced by the customs of other locales or countries, may have expectations about how to access care that differ from the systems in place in their communities. They may anticipate problems and be more sensitive to the hurdles in care seeking; in fact, they are likely to see delays as discrimination. Such barriers can be identified in beneficiary focus groups and surveys. If data are analyzed by subgroup, problems that are specific to the subgroups are more likely to be detected. State programs potentially can influence patient knowledge through the education and outreach they provide either directly or through contracted plans or educators.

*Concordance between system design and patient preferences.* Even with sound health care systems in place, access to physician services could be a problem if the available care does not match beneficiaries' preferences. For example, appointments may be timely, but individuals could want to be seen on an unscheduled basis and thus be willing to trade-off a wait in the office for the flexibility to seek care when it fits best with other demands on their time. Available providers may not match beneficiary preferences, such as for a female OB/GYN or a provider with certain racial or ethnic characteristics or a specific language ability. Such barriers come to light through consumer surveys and focus groups, though a review of delivery system characteristics against population characteristics of those served by the program may provide insight into a full range of barriers. In traditional Medicaid programs, policymakers largely are limited to improving participation rates. In managed care, barriers to access also can potentially be addressed by specific access standards, incentives, and requirements for cultural competency, though ultimately the effectiveness of these requirements depends on their acceptability and feasibility within the provider community.

### **C. MECHANISMS FOR INTERVENTION**

Effective access to physician services is unlikely to exist without the collaboration of government, providers, health plans (in the case of managed care), and individuals covered under the program. A variety of tools is potentially available to encourage effective collaboration among all parties in responding to diverse types of barriers to access. Six specific types of mechanisms could be relevant. Table 2 highlights examples relevant to each type.

*Contracting mechanisms.* Contract provisions can be used to introduce incentives or requirements for physicians and/or health plans (under managed care) to participate to an extent that encourages an adequate base of available providers.

*Payment mechanisms.* Payment rates for providers and plans can be set at a level and with a structure that promotes adequate and appropriate payment levels across regions and provider types and timely and predictable administration.

*Delivery system mechanisms.* Delivery systems can be structured in ways that make access easier upon entry and make it easy for beneficiaries to navigate the system.

*Monitoring mechanisms.* Monitoring data can provide states with early feedback on potential emerging problems, ongoing data on performance, and appropriate tools to enforce and promote behavior consistent with requirements.

*Provider education mechanisms.* Programs can be developed to educate and communicate better with the provider with respect to the characteristics, needs, constraints, and care-seeking behavior of those covered under the program; the rationale behind specific requirements, policies, and procedures; and where and how to resolve questions and complaints.

*Consumer education mechanisms.* Education can encourage high levels of knowledge by insured individuals on when and how to seek care, the importance and role of the primary care physician, the way in which specialists are accessed, and where and how to resolve questions and complaints.

**Table 2: Potential Mechanisms Available to Improve Physician Access in Public Insurance Programs for Low-Income Populations**

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Physician Contracting

Direct—Mandates or incentives to participate (e.g., link to licensure, state employees), conditions on participation

Indirect—Contractually required standards for network adequacy in managed care organizations' (MCOs) conditions of participation

Physician Payment

Payment rates (traditional program); any incentives that vary by setting, specialty, shortage areas

Actuarial soundness of capitation rates (MCOs)

Incentive payments: new physicians, willingness to meet minimum enrollment thresholds or increases

Variation by payment: geographic, by specialty as relates to incentives

Timeliness of payments

Predictability and stability of payments

Delivery System

Access standards

Care protocols (e.g., when specialists should be involved, how to access them)

Transportation

Access to translators

Staff training on cultural preferences, hiring staff people with appropriate skills

Monitoring

Networks or access standards

Consumer reports of access (surveys)

Complaints

Grievances

Provider Education

Characteristics of insured subgroup

Performance relative to concerns (e.g., compliance, broken appointments, litigation)

Adequacy and timeliness of payment

Why certain requirements are in place

How providers make their views known if there are problems

Consumer Education

When to seek care and why

Where to seek care (importance of a medical home, continuity)

The role of specialists

How to access the system

How consumers make their views known if access does not meet their expectations

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# CHAPTER III

## EMPIRICAL EVIDENCE ON FACTORS INFLUENCING PHYSICIAN ACCESS AND THE MECHANISMS AVAILABLE TO INFLUENCE THEM

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**D**espite critical gaps in the literature, a well-developed body of research has examined the barriers to care access and, to a much lesser extent, the practical strategies for responding to them in order to encourage better access. We briefly review what is known from the literature about each of the six barriers to access already highlighted, focusing on why the factor is relevant, what the literature says, and what mechanisms are available to address that kind of barrier.

### A. PROVIDER SUPPLY

#### 1. Why Provider Supply Is Relevant

Access to care requires care providers to be available, where availability is defined in terms of geographic access.<sup>1</sup> A fundamental structural barrier to access for low-income people stems from the fact that providers are unevenly distributed within and across areas. In many cases, the supply of physicians in low-income areas, where many publicly insured beneficiaries live, is less than optimal. When these shortages exist, states are likely to have a difficult time achieving satisfactory access to care in Medicaid and SCHIP programs. Because supply reflects physician preferences on locating their practice, states and, in particular, public insurance programs may have little ability to remedy the effects of limited provider supply on access to care in public programs.

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<sup>1</sup> Telemedicine may ultimately provide the option for long-distance treatment. However, most care now is received on a face-to-face visit with the provider.

**Box 2: Adequacy of California's Supply of Physicians:**

California's overall supply of active care patient physicians (195 per 100,000 population) is about equal to the nation's. However on a per capita basis, California's physician supply grew much less between 1989 and 1998 than did the nation's supply (4 versus 16 percent) [Health Resources and Services Administration (HRSA) 2000]. Though overall supply appears adequate, geographic location is an issue, and spot shortages may exist in some specialties (HRSA 2000). In 1998, 4 percent of active physicians were Hispanic/Latino and 3 percent were black/African Americans (HRSA 2002). In comparison, these groups represent 31 percent and 7 percent respectively of the overall population.

On average, physicians in California earn less than physicians nationwide. While incomes nationwide have increased at a moderate pace, they fell in California, from \$190,200 to \$172,400 in 1997 (KFF 2000). California physicians may therefore be feeling more fiscal pressure than physicians elsewhere in the nation and therefore be less willing to provide care to those whose insurance (or lack of insurance) leads to lower levels of payment.

## 2. Research on Physician Location Preferences and Decisions

Physicians tend to locate disproportionately in areas where the demand for services is high and likely to be well financed; typically, such areas are home to a privately insured patient base that is sufficiently large to support a physician's practice (Brasure et al. 1999; Fossett and Perloff 1999; IOM 1993). Often, these areas have a large population and high population density and are growing rapidly (Brasure et al. 1999). Residents also are likely to have high levels of health insurance coverage. In addition, physicians take into account cost-of-living and business expenses (Brasure et al. 1999). Although some physicians—such as those who are in racial or ethnic minority groups—may choose to practice in areas with large numbers of similar residents whose characteristics may be generally less attractive from an economic perspective (Komaromy et al. 1996), the general consequence of physician location decisions is that disproportionately fewer physicians practice in rural areas or residential pockets of urban areas where low-income individuals tend to concentrate.

Physician preferences vary somewhat for primary care and specialty practices, reflecting differences in demand and practice characteristics for these services. Given that primary care physicians draw their patients from the areas immediately surrounding their practices, they prefer to locate in higher-income areas with large numbers of privately insured patients (Fossett and Perloff 1999). Specialists are attracted to centralized locations, downtown or close to hospitals, that are accessible for large patient bases (Fossett and Perloff 1999).

Geographic maldistribution means that, in some areas, the number of physicians practicing is inadequate to meet patient care needs. The U.S. Department of Health and Human Services has developed an indicator of medically underserved areas (MUAs) to define areas most likely to be in this situation. MUAs are defined by a combination of the area's poverty rate, infant mortality rate, and physician-to-population ratio and are predominately located in inner cities, rural areas, and the South (Lillie-Blanton 1999). MUA designation has been used to award federal funds for the Community and Migrant Health Centers program; Medicaid-insured individuals and the uninsured are the predominant users of such care (GAO 2000). Though centers play an important role in care for the poor,

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sometimes Medicaid beneficiaries may prefer obtaining care in private physician offices (Lake Snell Perry and Associates 2000).

But while, in theory, private physicians located in cities could provide indigent care by cross-subsidizing the costs of such care from revenue generated by insured patients, the poor are often concentrated in inner cities in such a way as to make a cross-subsidization strategy economically infeasible (Fossett et al. 1989; Fossett and Perloff 1999). In any case, the current economic climate makes it less likely that private revenues can or will be stretched to meet the preferences of the inner-city poor (Reed, Cunningham, and Stoddard 2001). In rural areas, the physician scarcity problem is further compounded by issues of geographic dispersion (Lillie-Blanton 1999).

### **3. Mechanisms to Improve Provider Supply and Distribution**

Both the federal and state governments have launched initiatives to encourage providers to locate in underserved areas, by boosting the financial attractiveness of practicing in these areas and by subsidizing alternative care-delivery methods, such as telemedicine. Typically, these programs operate independently of Medicaid.

HRSA (2001) profiled the strategies of 10 states to recruit and retain physicians in underserved areas. Types of initiatives included the focused admissions/recruitment of students from rural or underserved areas; support for health professions education (stipends, preceptorships) in underserved areas; recruitment/placement programs for health professionals; practice development grants (i.e., start-up grants); malpractice premium subsidies; the provision of substitute physicians (*locum tenens* support); malpractice immunity for providing voluntary or free care; payment bonuses/other incentives offered by Medicaid or other insurance carriers; and Medicaid reimbursement of telemedicine.

States undertaking Medicaid-specific initiatives include Iowa and Wisconsin. Both states provide enhanced Medicaid reimbursement rates to providers in underserved areas [National Conference of State Legislatures (NCSL) 2001; HRSA 2001; Wisconsin Department of Health and Family Services 2002], with Wisconsin paying providers much as a \$20 bonus per Medicaid service in health professional shortage areas (HPSAs) (NCSL 2001).

The effectiveness of these and similar programs in alleviating physician shortages is not well researched. Most work has focused on the effectiveness of loan repayment programs. In fact, studies have found that while the National Health Service Corps (NHSC) and other loan repayment programs have succeeded in placing providers in needy rural and inner-city areas, the retention rate among these physicians after the conclusion of their service obligations is poor (HRSA 2001; Konrad et al. 2000; Rabinowitz et al. 2000; Singer et al. 1998). Limited studies exist on the effectiveness of Medicaid incentive payments to physicians, although GAO (1999) determined that Medicare incentive payments in underserved areas have a negligible impact on access among Medicare beneficiaries. While some state officials believe that strategies such as Medicaid reimbursement of telemedicine, the provision of substitute physicians, and support for health professions education in

underserved areas are effective, these programs have not undergone formal evaluation (HRSA 2001).

Barriers to more study include insufficient data on key variables, such as community needs, retention rates, and physician perceptions and practice issues related to Medicaid, and the absence of targeted appropriations for evaluation in program-authorizing legislation, particularly in the states (HRSA 2001). However, a number of states (such as Illinois, Utah, Texas, and Washington) are improving their data collection and studying the performance of loan repayment programs (HRSA 2001).

## **B. PROVIDER PARTICIPATION IN PUBLIC PROGRAMS**

### **1. Why Provider Participation Is Relevant**

For appropriate access, physicians not only have to be well located in relation to where public program participants reside, but they also need to be willing to participate in Medicaid and/or SCHIP. Provider participation in public programs operates hand-in-hand with physician supply in determining the supply of care available to the publicly insured. If there are insufficient physicians in an area, then the pool of available physicians to participate in Medicaid may be inadequate. Even with plenty of physicians in an area, however, low participation rates are likely to mean that access to care for publicly insured beneficiaries will be limited.

The development of managed care programs in both Medicaid and SCHIP must be factored into assessing the adequacy of provider participation in these two programs. Under managed care, providers may be affiliated with one or more plans, or none. An enrollee in that plan typically will have access only to those providers who agree to participate in that plan. In some cases, enrollees may not even have access to the full network of physicians, such as when they are assigned to primary care physicians who are restricted to referrals within a subnetwork of the plan. At the same time, although limited provider choice implies that access is constrained, it does not necessarily mean that access is poor. Methods of assessing and ensuring network adequacy are central features of state oversight of managed care.

### **2. Research on Determinants of Provider Participation in Medicaid**

Considerable research exists on the levels and determinants of physician participation in Medicaid. However, some of the research is historical and may not necessarily reflect the current environment. In addition, investigations on the factors that lead to physician participation in Medicaid managed care or SCHIP are more limited.

### Box 3: Level of Provider Participation

In a 1998 study of California physicians that is now being updated, Bindman et al. (2002) found that 55 percent of surveyed physicians in the 13 largest urban counties of California participated in Medi-Cal, including 55 percent of primary care physicians and 57 percent of specialists. On average, Medi-Cal patients comprise 11 percent of the practice of participating primary care physicians and 7 percent of specialists. On average, the ratio of primary care physicians available to Medi-Cal patients in 1998 (38 per 100,000) is below HRSA's workforce standards (60 to 80 primary care physicians per 100,000 patients). Physicians from underrepresented minority groups, Spanish speaking physicians, and physicians practicing in community clinics were more likely to be participating whereas board certified physicians were less likely to be participating.

Low payment rates combined with physician attitudes on the Medi-Cal program and those enrolled in it appear important to low rates of physician participation in the Medi-Cal program. There is less specific information available now on Healthy Families.

The adequacy of physician payment rates in California has been an issue for some time (Prestowitz and Street 2000). Medi-Cal's fee-for-service payments rate 37<sup>th</sup> (unadjusted) and 42<sup>nd</sup> (adjusted for geographic cost factors) among all 51 Medicaid programs nationwide (Lewin Group 2001). Payment were particularly low for evaluation and management services, maternity/delivery, psychiatry and vision. Payments were increased on August 12,000 to bring Medi-Cal from 58 percent to 65 percent of Medicare rates. These increases (and further increases) are in jeopardy by fiscal constraints applying to the 2002-2003 budget (Medi-Cal Policy Institute 2002). Low payment rates also apply to Med-Cal managed care—for example, a 1998 Urban Institute study showed that California's \$83 per month capitation rate was 52 percent lower than the national average (Holahan et al. 1999). Payment rates under Healthy Families maybe higher.

Physicians in California have negative views of the Medi-Cal program, regardless of whether they participate. Concerns include difficulties caring for patients, obtaining tests and specialty consultations, prompt payment and burdensome paperwork (Bindman et al 2002). Two thirds or more of physicians say Medi-Cal patients have complex clinical and/or psycho-social problems, are non-English speaking, require extra time for explanations and education and/or are noncompliant. More than a quarter say their other patients are unsettled by seeing Medi-Cal patients in the waiting room, that Medi-Cal patients are ungrateful for care and/or they risk being sued. On most measures, specialists are slightly more negative than primary care physicians. Participating physicians are at least as likely to report negative views as non-participants.

Low participation rates by physicians in Medicaid, compared with private insurance, have been well documented (Bindman et al. 2002; Cohen 1993; Cohen and Cunningham 1995; Gifford 1997; Mitchell 1991). Medicaid participation also varies by practice specialty and other physician characteristics. In the American Medical Association Socioeconomic Monitoring System survey conducted in 1996, the specialties with the highest levels of Medicaid participation (on multiple measures) were pediatrics, OB/GYN, radiology, anesthesiology, and emergency medicine (Center for Health Policy Research 1997). In California, pediatrics, OB/GYN, family practice, surgery, and internal medicine also figured prominently among specialties with the highest percentage of practice composed of Medicaid enrollees (Bindman et al. 2002). Research also shows that the other physician characteristics associated with higher participation in Medicaid include status as an international medical graduate, lack of board certification, and membership in a minority group (Bindman et al. 2002; Perloff et al. 1995, 1997). In contrast, physicians who choose to practice in locations away from low-income populations, in high-income areas and/or in more racially segregated cities are less willing to participate in Medicaid (Fossett and Peterson 1989; Gifford 1997; Perloff et al. 1997).

The research highlights three factors that play an important role in physicians' reluctance to participate in Medicaid: Medicaid fees, which are typically (though not always) low in relation to other payers; administrative paperwork associated with Medicaid participants; and physician attitudes about Medicaid and the characteristics of individuals enrolled in the program.

Past research found that higher Medicaid fees were associated with higher participation (Cohen 1993; Cohen and Cunningham 1995; Mitchell 1991); however, more recent work indicates either no relationship or that the impacts are much smaller than previously thought (Berman et al. 2002; Coburn et al. 1999; Perloff et al. 1995, 1997). For example, one study found that an increase in Medicaid fees to Medicare levels would result in a rise in participation of only 7.5 percentage points (Perloff et al. 1995). Though the magnitude of influence may be subject to debate, research shows that low Medicaid fees pose a barrier to physician participation in public programs.

Physicians are also concerned about the burden of paperwork associated with Medicaid participation. Research using a national survey of pediatricians indicates that both low fees and high concerns about paperwork limit participation in Medicaid (Berman et al. 2002).

Fewer studies have explored the influence of physician attitudes—as opposed to the influence of rates—on Medicaid participation. Generally, the concern is that physicians avoid Medicaid patients for any of a number of reasons, including particularly demanding health care needs, concern over poor compliance and its effects on outcomes, and fears about both litigation and the impact on their private practice of changing the mix of patients in the waiting room (Sloan et al. 1999). For example, over half of all surveyed physicians in California agreed that the Medicaid population has complex clinical problems and complex psycho-social problems and thus requires extra time for explanations and patient education (Bindman et al. 2002). In addition, over two-thirds of primary care physicians believe that Medicaid patients are noncompliant, with a higher proportion of specialists demonstrating the same belief. Specialists are more likely than primary care physicians to report that non-Medicaid patients are unsettled by seeing Medicaid patients in the waiting room and that Medicaid patients are ungrateful for the care they receive (Bindman et al. 2002).

Research specifically on what determines physician participation in managed care within public insurance programs is more limited. However, it is likely that some of the same concerns apply in the case of managed care as for participation in traditional Medicaid programs. In addition, studies show that administrative requirements associated with involvement in managed care may discourage physician participation, particularly among physicians for whom public patients represent a smaller share of the practice (Aizer, Gold, and Schoen 1998; Berman et al. 2002; Gold, Mittler, and Lyons 1999).

### **3. Mechanisms to Improve Physician Participation in Public Programs**

Potential interventions to bolster participation in public programs include increasing payment rates, monitoring plan networks coupled with incentives for improvement, limiting administrative burden, prompt payment, and state mandates on participation. Within the

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traditional Medicaid program, the most common strategy for increasing participation has been to raise physician fees, either across the board or selectively in areas of perceived care shortage (such as antepartum care) (Gold and Mittler 2000; Wisconsin DHFS 2002). Unfortunately, little research has specifically evaluated the effectiveness of these incentive payments.

On occasion, the plans themselves may impose mandates on provider participation. For example, during the implementation of Tennessee's 1115 waiver (known as TennCare), Blue Cross, the largest TennCare managed care organization, required its providers to participate in the TennCare PPO in order to tap into its commercial PPO, which served state employees (Aizer, Gold, and Schoen 1998; Wooldridge et al. 1997). The scale of the Blues product eventually led to more physicians participating in TennCare than would have been the case in the early years, when provider opposition to TennCare was strong (Aizer, Gold, and Schoen 1998). However, the mandate did not eliminate all shortages, such as for orthopedists, and opposition ultimately led to elimination of the mandate (Aizer, Gold, and Schoen 1998; Wooldridge et al. 1997).

Structurally, the introduction of managed care changes the relationship between the state and providers. Under traditional Medicaid, the state commits to paying providers for medically necessary care and is subject to certain federal requirements that seek to ensure appropriate payment rates to encourage access. In this case, the state itself has no obligation to ensure that needed care is available. In contrast, when states contract with managed care plans on a risk basis, plans accept capitation fees contingent on contracts that require achievement of a certain level of access to health care services.

Contracts between states and plans typically mandate specific standards for provider participation in plans' networks, along with more direct access standards (e.g., waiting time for appointments, travel times). Nearly all states with Medicaid managed care contracts contain at least one primary care network standard, such as sufficient numbers of physicians, maximum enrollee-to-physician ratios, or time and distance standards [Felt-Lisk et al. 2001; Center for Health Services Research and Policy (CHSRP) 2001]. Fewer states have standards for specialist network adequacy; 16 states have specialty-to-population ratios compared with 31 states with primary care-to-population ratios (CHSRP 2001). States also impose quality-of-care criteria, such as banning plans' use of incentive payments to providers in order to reduce the amount of care delivered (CHSRP 2001). In many cases, the same criteria apply to SCHIP programs that represent Medicaid expansions, though stand-alone SCHIP programs (15 states) generally impose fewer standards (Rosenbaum, Shaw, and Sonosky 2001).

Managed care plans may transfer some of the risk to provider entities. For example, a national study of large managed care organizations participating in Medicaid and SCHIP found a substantial amount of financial risk sharing, with three-quarters of the organizations using either global capitation or professional services capitation contracts (Gold et al. 2002). Some of these plans delegate responsibility to these risk-bearing entities for provider selection, credentialing, and payment. Especially in these circumstances, managed care plans may have to include in their provider contracts the same types of standards to which the

states hold them. Further, a few plans require their commercial providers to participate in public insurance programs, though more often for SCHIP than for Medicaid (Gold et al. 2002).

The effects of the above provisions on participation and access in Medicaid/SCHIP have not been well researched. Qualitative studies suggest that the effectiveness of the standards depends in part on the willingness and ability of the state to monitor and enforce them (Brown et al. 2001; Holahan et al. 1998). Indeed, overly rigorous standards may backfire. For example, unrealistic, burdensome, or hard-to-meet standards could discourage plans from participating or otherwise impose a hardship on providers that affect their willingness to contract with managed care (Aizer, Gold, and Schoen 1998; Gold, Mittler, and Lyons 1999). Research has found that a collaborative effort between states and plans in the design of monitoring systems is likely to be important.

### C. FINANCIAL ACCESSIBILITY

#### 1. Why Financial Accessibility Is Relevant

The financial accessibility of health care—whether insurance covers care, and what care costs the patient in relation to income—has long been recognized as a major determinant of access to care (IOM 2002b; Perry, Kannel, and Dulio 2002; Safran et al. 2002). Indeed, Medicaid evolved largely in response to financial concerns, with a goal of providing financial protection to individuals who might otherwise not be able to afford care (Davis and Schoen 1978; Stevens 1998). Historically, benefits under Medicaid have been relatively comprehensive (despite variation by state), with minimal cost sharing and no premium required for enrollment. Preventive services and low cost sharing have been viewed as critical for prevention (Rosenbaum et al. 2001).

Medicaid's history means that financial access typically has not posed a barrier to care under public insurance programs. This may change, however, as states respond to concerns about costs. SCHIP expands eligibility for coverage but allows states somewhat more flexibility in benefits and cost sharing than Medicaid (Rosenbaum et al. 2001). As state revenues have slowed, states have pursued changes under waiver authority [initially via 1115 waivers and, more recently, through the Health Insurance Flexibility and Accountability (HIFA) option]. Sought-after changes can include added cost sharing, a narrowed scope of benefits, and limits on the enrollment of groups seen as less vulnerable (Mann 2002).

#### **Box 4: Financial Accessibility for Medi-Cal and Healthy Families Enrollees:**

Financial access does not appear to be an issue for those enrolled in Medi-Cal. The program imposes no premiums, and copayments are waived for children under 18 and are in any case limited by federal law. However, eligibility turnover is high, so care is less likely to be equally accessible over time. Though Healthy Families requires nominal monthly premiums and copayments, researchers concluded after the first year of operations that these do not appear to create a barrier to access (Fox et al. 2001). (Premiums in 2002 were \$4 to \$9 per child up to a maximum of \$27 per family. Adults pay a monthly premium of \$7 to \$20. Most services have a \$5 copayment, with a maximum out-of-pocket liability for families of \$250 per year. However, families must keep track of their spending.

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## 2. Research on Effects of Financial Barriers on Care Access

As highlighted above, a well-documented set of literature shows that lack of insurance coverage (one financial barrier to care) is a major barrier to access (IOM 2000; Hadley 2002). Because of measurement difficulties, fewer studies have focused directly on specific features of cost sharing. The best known of these studies, the national RAND Health Insurance Experiment, found, for example, that the greatest decrease in utilization and medical expenditures occurred with the jump from free care to a 5 percent coinsurance rate rather than with the increase from 5 to 10 percent. Recent studies suggest that even minor cost-sharing provisions can impose a financial burden on low-income families, reducing utilization for both primary and specialty care (Newhouse 1996; Rice and Gabel 1996). Required premium contributions also can discourage enrollment in public programs (Gold 1999; O'Brien et al. 2000).

## 3. Mechanisms for Reducing Barriers to Financial Access

The Medicaid and SCHIP programs have improved access to care for low-income people who otherwise might not be able to afford insurance (Davis and Schoen 1978; Gabel et al. 1998). On the margin, states can further limit financial barriers through the design of their benefits and cost-sharing such as imposing income-related maximums on out-of-pocket spending. However, access is substantially better among public program participants than among the uninsured (GAO 1998). At the same time, access to particular services, notably for specialists, has not reached the levels achieved by the privately insured (GAO 1998; Skaggs et al. 2001), suggesting that the provision of public insurance is important but does not overcome all barriers to access.

### D. SYSTEM ACCESSIBILITY

Even with adequate provider supply and participation in public programs, care systems could be designed in such a way that beneficiaries find it difficult to use the available resources. For example, physicians could close their panels or limit office hours to the standard work day/week, thereby making it hard for patients to schedule appointments at convenient times. Managed care's infrastructure may add additional processes that affect ease of access. For example, referral or gate-keeping rules could be structured in ways that make it difficult for patients to negotiate the system or gain access to providers. Conversely, managed care mechanisms such as care reminders and coordination mechanisms may improve accessibility. Though states typically exercise limited control over system accessibility in traditional Medicaid, accessibility issues have been of great concern as states move to managed care. To address these concerns, states traditionally have included minimum access provisions in their contracts and plan monitoring systems.

**Box 5: System Accessibility for Medi-Cal and Healthy Families:**

Under Medi-Cal, AFDC/TANF eligible enrollees typically are required to enroll in a capitated managed care plan. The managed care model varies by county and capitation generally is restricted to mainly urban counties (Draper, Gold, and Hudman 1999). Managed care enrollment is voluntary for SSI beneficiaries. Healthy Families relies on managed care plans even more heavily (Kaiser Commission on Medicaid and the Uninsured 2000). Most plans require members to have a primary care physicians and to get a referral from a primary care physician before seeing a specialists though there are selected exceptions (e.g., the Blue Cross and the Blue Shield exclusive provider organizations in Healthy Families).

With only limited exceptions, managed care plans must meet California's general regulatory requirements for risk bearing plans (The Knox Keene Act as amended). Under the act, the Department of Managed Healthcare monitors and reviews availability and access against specific guidelines in the state. Standards call for one primary care provider for every 2,000 enrollees and a provider within 30 minutes travel time or 30 miles. All California enrollees have a right to receive an authorization from the health plan for referral to a specialist within three business days of when the request is made and information is provided and the referral must then be made within four business day (Foundation for Taxpayer and Consumer Rights 2001). Enrollees must be notified within 30 days in advance of a primary care physicians' termination from a plan and provisions exist for continuing coverage with that physician for a period of time if serious illness or pregnancy exists.

Medi-Cal contracts include additional requirements (e.g., an initial health assessment within 120 days of enrollment, ability to change primary care physicians every 30 days).

**1. Research on System Accessibility as a Barrier to Access**

Research suggests that Medicaid enrollees experience difficulty in accessing care, even when it is available. They encounter problems across a wide range of care when seeking providers who are willing to schedule appointments, when obtaining appointments in a timely manner, and when getting transportation to the appointments; in addition, they must often endure excessive wait times (Gifford 1997; Medicaid Access Study Group 1994; Mofidi et al. 2002; Skaggs et al. 2001). At times, private primary care practices refer enrollees to the hospital emergency room in lieu of providing an appointment (Medicaid Access Study Group 1994), exacerbating the problem of “inappropriate” patterns of care. Furthermore, some evidence suggests that the ability to obtain appointments with specialists is substantially worse for Medicaid recipients than for the privately insured (Skaggs et al. 2001).

The role of managed care in public insurance programs demonstrates mixed results with respect to system accessibility. The 1990s evidence on accessibility indicated that Medicaid managed care reduced emergency room use and specialist care and had no effect on physician visits but led to only minimally increased preventive care (Hurley and Zuckerman 2002). However, the 1990s studies were based on the groups that first enrolled in managed care; such groups did not include the elderly or disabled (Hurley and Zuckerman 2002). More recent studies in Tennessee show that the disabled and vulnerable subgroups did not fare better under managed care (Brown et al. 2001). At the same time, managed care appears to increase affiliation with a “medical home” or primary care provider. Medicaid and SCHIP managed care plans almost always require enrollees to choose a primary care provider and to obtain primary care referrals to specialists, though self-referrals are often allowed for some

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specialty services, such as OB/GYNs generally or internal medicine subspecialists for those with special health care needs (Gold et al. 2002).

## **2. Mechanisms to Improve System Accessibility**

States using managed care in public programs can have a greater influence on system accessibility than under transitional systems, such as through specific access standards, and incentives based on good performance (measured through monitoring systems). Almost all states with Medicaid managed care require plans to meet some type of access standard (Rosenbaum et al. 1999). The most frequently reported access measures in managed care or prepaid Medicaid programs were maximum waiting times for appointments and 24-hour coverage (Kaye 2001). Illinois, for example, in its 1115 Medicaid demonstration, requires plans to have the following: (1) sufficient provider networks to guarantee access to care within 30 minutes or 30 miles of an enrollee's residence, which may be greater in rural areas; (2) maximum expected waiting times for emergency care as the situation dictates, urgent care within the same or next day, and non-urgent care within three weeks of enrollee request; (3) maximum in-office waiting time of no more than an hour on a routine basis; and (4) maximum referral appointment times with specialists of 48 hours for urgent care and 30 days for routine care (Rosenbaum and Darnell 1997).

States use many different tools to monitor system access. Arizona uses "secret shoppers" who pose as Medicaid enrollees trying to schedule appointments with primary care physicians and specialists (Felt-Lisk et al. 2001). Some states use beneficiary surveys, such as Oregon's survey of parents of special needs children. Other tools involve tracking complaints; requiring plans to report on the number, mix, and geographic distribution of providers; or requiring an explanation from plans if their provider turnover is above a certain threshold (Felt-Lisk et al. 2001).

However, the imposition of more criteria on plans does not necessarily ensure better access for public insurance beneficiaries. Some plans have extensive experience in providing high-quality care and are better accorded broad discretion in how to design and monitor their own health care systems. At the same time, in providing that flexibility, states need to work closely with plans to make their expectations clear (Rosenbaum 1998).

## **E. PATIENT KNOWLEDGE AND SUBGROUP ACCESSIBILITY**

### **1. Why Patient Knowledge and Subgroup Accessibility Are Relevant**

Although ensuring an adequate supply of care is necessary, enrollee access can be undermined by the lack of knowledge of how to navigate the health care system. Such knowledge has become crucial with the move of public insurance toward managed care, which is predicated on understanding the built-in incentives to coordinate care and save money. One study concluded that, primarily as a result of confusion over how to obtain services, Medicaid managed care users have experienced more difficulties in access to care than participants in the fee-for-service system (Fox et al. 2001). The assurance that managed care organizations will deliver high-quality care may depend on the ability to "vote with your

feet” when beneficiaries are dissatisfied (Kaplan et al. 2000), but the essence of this mechanism depends on beneficiaries’ understanding that they can and will switch plans. For certain subgroups, access may pose a particular challenge, making knowledge particularly important for them.

**Box 6: Patient Knowledge and Subgroup Accessibility in California:**

Research on how well patients understand the way Medi-Cal and Healthy Families systems work is limited, with more information on eligibility and enrollment processes than care delivery. In general, studies show knowledge higher for Medi-Cal than the newer Healthy Families (Lake Snell Perry and Associates 2001). Within Medi-Cal, knowledge of long-standing features is higher than of new features.

Cultural diversity is extensive in California, creating needs to handle multiple languages and ethnic preferences. In Healthy Families for example, plans produce patient materials such as evidence of coverage booklets, member handbooks, welcome letters, newsletters and brochures and medical care reminders. All plans produce these materials in Spanish as well as English. The first three kinds of material are available in selected other languages that vary by plan. For example, seven plans produce the materials in Chinese, three in Korean, and two in Vietnamese. Additional languages that may be used in newsletters, brochures and reminders include Hmong, Russian, Khmer, Lao, Farsi, and Armenian. Medi-Cal managed care has a Cultural Competency Task Force with extensive requirements for linguistic services and translated materials. However minority subgroups still report difficulty accessing services. Latino, Asian, and African American beneficiaries, for example, were less likely to receive care at their preferred location than others.

In California, both Medi-Cal and Healthy Families allow referrals to state sponsored programs operated at the county level that provide specialized health care and case management services for children under 21 with selected conditions and children diagnosed with a serious emotional services. In a study of the first year of Healthy Families, researchers concluded that access to these kinds of services was a problem both in plans and outside of them (Fox et al. 2001). Access problems were spurred by physician shortages and limited participation in the face of low fees.

**2. Research on Patient Knowledge and Subgroup Accessibility as a Barrier to Access**

Education efforts directed at helping publicly insured individuals negotiate care systems must overcome several hurdles. First, the publicly insured group tends to have low education and literacy rates such that multisyllabic terms commonly used in managed care—“gatekeeping” and “network”—may be difficult to read and understand (Fox et al. 2001; Kaplan et al. 2000). Second, Medicaid and SCHIP enrollees often have multiple service needs that go beyond just health care (Gold et al. 2002) and often have many demands on their time. In addition, Medicaid enrollees are often unaware of recent changes to the program as well as how the SCHIP program differs from Medicaid (Lake Snell Perry and Associates 2001); their ignorance of SCHIP is particularly troubling as the program’s income standards for eligibility sit directly on top of Medicaid and some families may transition between programs because of income fluctuations. Finally, beneficiary education about managed care may need to undo past patterns of inappropriate care seeking (such as ambulatory emergency room use) learned from navigating the fee-for-service Medicaid system (Kaplan et al. 2000).

The broad diversity of the Medicaid and SCHIP populations presents additional challenges in communicating knowledge about managed care. Many Medicaid enrollees are chronically ill or have special health care needs. They may require access to specialists and different patterns of health care use from other enrollees. The influence of Medicaid managed care on access for this group differs by state. In Tennessee, access did not improve after the introduction of managed care (Brown et al. 2001). On the other hand, the special needs population in Oregon reported higher satisfaction with access and greater ease in obtaining specialist referrals after managed care implementation (Leichter 1999).

Further, those in Medicaid are highly diverse both ethnically and racially, leading to additional language and cultural barriers that influence the person's use of and satisfaction with care. Minorities, blacks in particular, tend to mistrust the health care system (Collins et al. 2002; IOM 2002a; Kaplan et al. 2000; LaViest et al. 2000). In addition, they follow belief systems that dictate not going to the doctor unless something hurts (Dyer 2002; LaViest et al. 2000) or relying on prayer to heal disorders (LaViest et al. 2000). Further, they are more likely to delay or refuse treatment, especially invasive procedures (IOM 2002a; LaViest et al. 2000). Minorities also have problems in communicating with their doctors and demonstrate less satisfaction without racial concordance (Collins et al. 2000; Cooper-Patrick et al. 1999; IOM 2002a). These issues are magnified for non—English-speaking minorities since a direct language barrier may exist. In particular, many common terms, such as “routine care” and “mammogram” have no equivalent in languages like Chinese or Vietnamese (Kaplan et al. 2000).

### **3. Mechanisms to Address Patient Knowledge and Subgroup Accessibility as Barriers to Access**

States may fund outreach and education programs for public insurance enrollees (or vulnerable subgroups) or impose educational requirements on the plans for enrollees and/or providers. Unfortunately, efforts to educate beneficiaries about Medicaid managed care have generally fallen short. A case study of educational materials about managed care for Medicaid enrollees in 13 cities found that, in almost all cases, the materials were poorly suited to the enrollees. Beneficiaries had little input into the materials' development while the information tended to be designed to accommodate other interests, such as plans' concerns about bias (materials favoring one plan over another) and advocates' concerns about sufficient breadth of information (Kaplan et al. 2000). In addition, as often required by the states, beneficiaries receive most of the educational materials during Medicaid enrollment in order to facilitate plan selection; yet, many states presume that the plans will continue to provide beneficiaries with information during their term of enrollment. In fact, given the high enrollee turnover attributable to lack of continuous eligibility, the plans might have little incentive to continue distributing information (Kaplan et al. 2000).

Another complication is that Medicaid enrollees value the choice of particular providers as primary care providers rather than particular plans per se (Maloy et al. 1999; Molnar 2001). However, the provision of a provider directory is expensive, difficult to keep up-to-date, and often of overwhelming volume for beneficiaries (when available); moreover, specialist participation is rarely listed (Maloy et al. 1999). In many states, a primary care

provider and plan often may be assigned rather than chosen, providing indirect indicators that some basic information is *not* getting transmitted (Maloy et al. 1999). When this auto-assignment occurs, cultural or linguistic considerations may not be taken into consideration, and preference may go to the lowest-paid plans, reducing incentives for quality based on competition for enrollment (Molnar 2001).

Monitoring systems that examine total performance may not be sensitive to access issues that vary systematically, such as by subgroup. Barriers to more effective subgroup monitoring include administrative data (such as enrollment files) that do not accurately or completely capture some types of subgroup membership (e.g., racial and ethnic characteristics, health status); technical barriers when the incidence of a problem is low and/or the subgroup is small, making it hard to identify patterns (e.g., complaint data, condition-specific access measures); and cost considerations that apply to techniques such as oversampling, which typically are needed in survey designs to ensure the satisfactory measurement of access for small subgroups.

## **F. CONCORDANCE BETWEEN PATIENT PREFERENCES AND SYSTEM DESIGN**

### **1. Why Patient Preferences Are Relevant**

Regardless of the availability of resources and enrollee understanding of how to obtain care, what publicly insured beneficiaries prefer and what the system provides may not be fully congruent, as we discuss later. Enrollees may prefer certain types of providers or providers who speak their native languages or are of the same race or ethnicity. Preferences also may vary by subgroups, racial or ethnic minorities, and special health care needs. States and managed care plans have made some inroads to address these issues.

#### **Box 7: Patient Preferences and System Design**

Medi-Cal patients prefer a doctor's office but are more likely to be seen in a clinic (Lake Snell Perry and Associates 2000). Though only 17 percent prefer a clinic, 40 percent rely on a clinic as their usual source of care. Medi-Cal beneficiaries in managed care were more likely to receive care at their preferred location than other beneficiaries (65 percent versus 59 percent.) However, managed care patients were more likely to experience difficulty finding doctors located nearby who would treat them (61 percent versus 51 percent).

California's Office of the Patient Advocate (2002) prepares an HMO report card for plans under its jurisdiction in northern and southern California which takes into account results from a consumer survey and other sources. However, the report does not provide results specific to Medi-Cal or Healthy Families enrollees and is not specifically targeted on physician access. In 2001, Healthy Families contracted for a CAHPS survey involving over 20,000 families. The survey included ratings dealing with getting needed care for your child and getting care quickly for your child. Performance varied by plan.

### **2. Research on Patient Preferences as a Barrier to Access**

Enrollees may have preferences for specific types of providers or types of locations. Beneficiaries may prefer a specific type of provider such as a specialist as their primary

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source of care, especially if they have special health care needs. In addition, most Medicaid enrollees, even those who usually receive care in a hospital emergency room or a clinic, may in some locales prefer to receive care in a private doctor's office (Lake Snell Perry and Associates 2000).

Racial and ethnic subgroups may have different preferences than nonminority groups for types of providers. For example, minorities are more satisfied with their care if there is racial concordance between them and their provider (IOM 2002a; Cooper-Patrick et al. 1999). African Americans, Hispanics, and Asian Americans were more likely than whites to report that they experienced problems in communicating with their doctors, that their doctors did not listen to everything they said, that they did not fully understand their doctors, or that they had questions during the visit but did not ask them; these communication problems were exacerbated among non-native English speakers (Collins et al. 2002).

### **3. Mechanisms to Improve Congruence Between the System and Patient Preferences**

The mechanisms that states may use to resolve differences between system design and patient preferences include minimum access standards by subgroup, cultural competence requirements, and incentives predicated on monitoring. Most states with Medicaid managed care require selection of a primary care physician, often allowing OB/GYNs or other specialists to act as primary care providers (PCPs) on the state level (as in Indiana) or at plan option (as in New York) (CHSRP 2001). Some Medicaid managed care plans allow direct referral for some types of specialists, with more flexibility for those with special needs (Gold et al. 2002). New Mexico uses its Medicaid claims database to identify whether individuals have special needs and then forwards the information to plans when individuals enroll, thereby helping the plans identify appropriate providers inside or outside of network (Felt-Lisk et al. 2001).

To address language and other cultural barriers, most states have imposed some type of cultural competency requirement; in some cases, plans have voluntarily gone beyond the state's minimal standards. SCHIP contracts tend to impose more cultural competency requirements than Medicaid (Rosenbaum, Shaw, and Sonosky 2001). The most common state requirements call for the provision of enrollment materials in different languages and interpreter services for enrollees (Youdelman and Perkins 2002). At the opposite extreme, California has a detailed set of cultural competency requirements for Medicaid managed care plan contracts (Coye and Alvarez 1999). Although Medicaid and SCHIP managed care plans do not appear to document the cultural or racial characteristics of providers or enrollees (Gold et al. 2002), some plans have taken the initiative in these areas. Notably, Blue Cross in California has set up community resource centers to help enrollees with appointment scheduling and to remind them about preventive care. Individuals who represent the community ethnically and linguistically staff the centers. The plan also operates with "any willing provider" provisions and thus accepts almost any provider with a Medi-Cal patient base. The result is an expanded network that includes many minority

physicians who previously did not have access to Medicaid managed care contracts (Coye and Alavarez 1999).

An innovative data collection effort is CAHPS, the Consumer Assessment of Health Plans, which was developed in 1995 and, though not a requirement of Medicaid, has been used by 20 states in 1998 as part of their quality monitoring efforts (Felt-Lisk 2000). CAHPS is a consumer-based survey that has been adapted specifically for use by Medicaid beneficiaries. It asks about waiting times, access to specialists, and interpersonal relationships with physicians, among other issues (Epstein 1998; Felt-Lisk 2000). Not only can it provide valuable feedback to states, but Medicaid enrollees have found CAHPS report cards useful in deciding how to choose plans (Fox et al. 2001).

## CHAPTER IV

### ASSESSMENT, ACTION, AND COLLABORATION TO ENHANCE ACCESS TO PHYSICIAN CARE IN PUBLIC PROGRAMS

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In this concluding chapter, we review the key factors that influence access to physician services for publicly insured populations. For each factor, we review specific measures and ways in which the factor can be monitored as well as the most relevant potential interventions. We conclude by highlighting the importance of collaboration among key stakeholders—government, providers, health plans, and consumers—to achieve better access.

#### **A. FRAMEWORK FOR MEASURING, MONITORING, AND ACTING ON BARRIERS TO ACCESS**

Table 3 illustrates how states might apply the framework to assess access to physician services on a continuing basis within public programs and what steps might be taken if problems are identified. Specifically, states seeking to address these issues will need to:

- Identify concrete measures of key barriers to physician access
- Monitor performance against these measures on a regular basis
- When problems are identified, take action that is appropriate to the specific problem

States that are proactive in anticipating problems may be able to avoid them or limit their scope.

#### **B. COLLABORATION FOR SUCCESS**

Achieving equitable access to physician services within public insurance programs is more likely to be achieved if all parties that need to be involved share equitable access as a goal and commit themselves to taking those steps needed on their part to improve access. Key participants in physician access are government, providers, health plans (when managed

**Table 3: Variables that Influence Access to Physician Services For Publicly Insured Low-Income Populations**

| Variable  | Description and Measures   | Mechanism of Action  | Monitoring Information   | Potential Interventions   |
|---|--|--|--|---|
| Provider supply   | Number and type of physicians in appropriate proximity to population, physician-to-population ratio  | Whether physician care is available in the geographic area   | Physician licensure data, any surveys on practice characteristics (e.g., hours, specialty)   | Payment policy may support relocation (e.g., bonuses, higher payments) or alternative ways of delivering care (e.g., telemedicine)  |
| Provider participation in public programs                 | Share of physicians participating in programs in managed care plans, physician-to-enrollee ratio, physician availability to see new patients, any capacity constraints | Whether physician care is specifically available to the subgroup of insured enrollees in public programs   | Provider participation measures (traditional program), network adequacy measures (managed care), provider councils and focus groups  | Levers include payment rates, network monitoring with incentives for improvement, limiting administrative burden, prompt payment, participation incentives or mandates        |
| Financial accessibility                                   | Rate of turnover in program eligibility; benefit exclusions, limits, and cost-sharing amounts and any aggregate limits   | Whether the structure of public coverage removes the financial barriers that otherwise would exist for low-income populations seeking access to physician services | Special studies to estimate financial impact of cost sharing and exclusions, financial impact on program of discontinuous enrollment | Structuring benefits and cost sharing to limit financial barriers to care (e.g., no cost sharing for highly valued services, income-related limits on out-of-pocket spending) |
| System accessibility                                      | Office hours, availability of appointments, transportation, policies on how access to specialty services is obtained   | Whether providers, provider networks, and care plans are structured to make available physician care accessible to patients  | Transportation benefits and access, monitoring access standards in contracts, and monitoring plan performance (managed care)         | Effective standard setting and monitoring, rewards for good performance, adequate payment; influence higher in managed care than traditional programs                         |
| Patient knowledge and vulnerable subgroup accessibility   | Awareness of how to access care system, measures of access and awareness for subgroups of the population, extent and types of complaints and grievances                | Whether there are sufficient mechanisms to build knowledge among covered individuals about how to access physician services effectively within the program         | Consumer surveys, focus groups, reports of MCO education activities, subgroup and disparities monitoring                             | Funded outreach and education for covered populations, MCO education requirements for enrollees and providers   |
| Concordance between patient preferences and system design | Consumer reports of system accessibility, satisfaction with types of providers available and their characteristics   | Whether available physician care meets the preferences of the insured population   | Consumer surveys, focus groups, demographic profiling of providers and enrollees   | Minimum access standards, incentives, and requirements for cultural competence  |

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care is employed), and individuals insured under the program (consumers). The framework and literature reviewed in this paper suggest that collaboration for success will be more likely if each party takes on responsibilities appropriate to its role. Based on the analysis presented here, the following commitments by the following players appear most relevant to achieving a collaborative environment in which to monitor and improve physician access:

- **Government.** Responsible for “equitable” payment and good business practices to encourage stable and broad-based provider participation organized in ways that create access to beneficiaries. This means that payment levels are set by adopting appropriate standards that, to the extent feasible, result in predictable levels of payment over the years (regardless of the budget pressures) and timely reimbursement of claims. It also means that government works to help all of the involved parties establish effective means of communication and two-way interchange.
- **Providers.** Responsible and willing to treat patients on a nondiscriminatory basis. This means that providers should be willing to provide effective feedback to plans and providers on what they need to make participation feasible, to take their fair share of publicly insured patients as long as reasonable conditions are met, and to educate themselves sufficiently to understand accurately the needs of their patients.
- **Health Plans.** As the agent of the state, responsible for structuring payment and practices in an equitable way to encourage stable and broad-based provider participation and access. Health plans assume many of the same responsibilities as the state by either serving as a substitute for that state or complementing state action.
- **Consumers.** Responsible for being informed, assuming an appropriate system and infrastructure to support education and access. This means that consumers need to be willing to learn how to use systems, particularly when those systems aim to accommodate their needs and preferences and when appropriate education is provided.

Collaboration will obviously be easier in communities where the style of interaction and engagement already meets the above conditions. However, even where the style of interaction and engagement do not meet the above conditions, much can be gained through communication structured to identify solutions that work from the perspective of all stakeholders.

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**PRINCETON OFFICE**

PO Box 2393  
Princeton, NJ 08543-2393  
(609) 799-3535  
Fax: (609) 799-0005

**WASHINGTON OFFICE**

600 Maryland Avenue, S.W., Suite 550  
Washington, DC 20024-2512  
(202) 484-9220  
Fax: (202) 863-1763

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(617) 491-7900  
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