

Physician Participation in the Oregon Health Plan

Final Report

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September 25, 2001

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The research presented in this report was performed under Health Care Financing Administration (HCFA) Contract No. 500-94-0056, Paul Boben, Project Officer. The statements contained in this report are solely those of the authors and no endorsement by HCFA or ASPE should be inferred or implied.

Table of Contents

	<u>Page</u>
Executive Summary	ES-1
Chapter 1 Introduction	1-1
Chapter 2 Background Issues	2-1
2.1 The Oregon Health Plan	2-1
2.2 Previous Studies	2-6
Chapter 3 Methods and Data	3-1
3.1 Methods	3-1
3.2 Data	3-5
3.3 Validation	3-12
Chapter 4 Physician Opinions Concerning OHP	4-1
4.1 Comparisons to the Baseline Survey	4-1
4.2 Physician Participation in Medicaid	4-8
4.3 Physician Opinion of the Priority List	4-21
4.4 Patient Understanding	4-28
4.5 Physician Opinion of Individual OHP Plans	4-40
4.6 Treating OHP Members with Disabilities	4-49
4.7 How is OHP doing?	4-61
References	R-1
Appendix A Classification of HMOs into Groups	A-1

Table of Tables

Chapter 3

Table 3-1	Sample Strata	3-4
Table 3-2	Unweighted Characteristics of Physician Respondents	3-6
Table 3-3	Practice Characteristics of Physicians Completing OHPPS Unweighted, participants and non-participants	3-8
Table 3-4	Do Practice Characteristics Vary by Specialty?	3-10
Table 3-5	Validation of Respondent Characteristics with OMA Survey	3-13

Chapter 4

Table 4-1	Compare Responses to Baseline Survey	4-3
Table 4-2	Percent of Oregonians without Health Insurance 1993:1997 US Statistical Abstract	4-6
Table 4-3	Weighted Mean Characteristics of MDs Who Participate in OHP v. MDs Who Do Not Participate in OHP	4-10
Table 4-4	Reasons for Participation Decision	4-13
Table 4-5	Extent of Participation How Many Plans in a County Does a Physician Contract With?	4-16
Table 4-6	OLS Regressions for Number of Plans	4-18
Table 4-7	Physician Opinion of the Priority List	4-22
Table 4-8	How Has the Priority List Affected Aspects of Treatment or Care	4-27
Table 4-9	OHP Patients' Understanding of Managed Care Weighted	4-30
Table 4-10	Logistic Regression Results for Fair or Poor Patient Understanding of Four Aspects of Managed Care Odds Ratios and Significance	4-32
Table 4-11	Logistic Regression Results for Patient Understanding Worse than Other Patients Odds Ratios and Significance	4-36
Table 4-12	Contracting and Administrative Dealings with Plans	4-41
Table 4-13	OHP Plan Ratings Weighted	4-44
Table 4-14	Logistic Regression Results for Fair or Poor Plan Interactions Odds Ratios and Significance	4-46
Table 4-15	Logistic Regression Results for Plan Interaction Worse than Other Plans Odds Ratios and Significance	4-50
Table 4-16	Treating OHP Members with Disabilities	4-52
Table 4-17	How Good is OHP at Meeting the Following Needs of People with Disabilities?	4-54
Table 4-18	How do OHP Members with Disabilities Fare?	4-60
Table 4-19	Participant Relation to OHP/Medicaid	4-62
Table 4-20	Summary of Open-Ended Opinions of OHP	4-66

Executive Summary

The Oregon Health Plan (OHP), Oregon's Medicaid program, is available (sometimes with a premium) to Oregonians at 100 percent of poverty or below who meet asset requirements. OHP is available to children and pregnant women up to 170 percent of poverty in part due to the SCHIP expansions, many of which are organized through Medicaid in Oregon. As part of the state's strategy to fund Medicaid services to an expanded population, OHP requires almost all beneficiaries to enroll in managed care plans and ration care through a priority list of condition/treatment pairs. OHP was first implemented in 1994 for the TANF and expansion populations, and in 1995 for SSI beneficiaries both over and under 65 (including Medicare/Medicaid dual eligibles), and children in foster care.

This paper reports physicians' perceptions of the Oregon Health Plan as identified in a mailed survey of 1329 physicians. The survey was conducted by Health Economics Research, Inc. (HER) and Research Triangle Institute (RTI) in 1998, and sampled physicians who were likely to be in office-based specialties and over-sampled physicians in fields that care for many people with disabilities. We asked physicians to report their view of the concept of OHP, their reasons for participation, and to comment on specific operational and access to care issues. Our sample includes 794 physicians (60 percent of the sample responded and worked full-time). The sample included both participating physicians (91 percent of the weighted respondents) and nonparticipating physicians (9 percent).

Physicians generally liked the concept of the Oregon Health Plan and commented favorably about several aspects of the program. They reported that fewer of their patients are uninsured since the program's inception, that quality had not substantially declined, and that people with disabilities were not more adversely affected than others as a result of managed care enrollment or because of the priority list. More primary care physicians report that they are seeing persons with disabilities than before OHP. Many physicians reported providing care regardless of the priority list restrictions.

Physicians were critical of the OHP reimbursement rates, administrative hassles of dealing with managed care plans generally, and report confusion about what is covered by the priority list. They also report that their Medicaid patients have less understanding of managed care processes than their other patients enrolled in managed care plans. Mental health and substance abuse treatment stand out as areas in which they believe OHP restrictions are problematic.

Treating the Uninsured

- Physicians are treating fewer uninsured patients. 56 percent of physicians responded that the number of uninsured patients they see has decreased and only 5 percent reported an increase. The rest said it was about the same. The baseline study by OMAP found that many physicians felt there was a rise in the number of uninsured patient they saw in the years prior to OHP. There is clearly a change in physician opinion before and after OHP.

Participation and Extent of Participation in OHP

- Our survey indicates high participation among physicians in Medicaid. 91 percent of physicians participate, confirming previous studies that find high participation in Oregon. Access problems arising from physician availability are no more of a problem for Medicaid patients than for other patients in the state.
- Access to psychiatrists is a potential problem because psychiatrists are least likely to participate in Medicaid.
- There has been an 11 percent net gain of physicians serving Medicaid patients after implementation of OHP.
- Very few respondents report participating in Medicaid managed care to access non-Medicaid patients. Only 16 percent of physicians answer that access to a managed care plan's commercial clients was a very important reason why they participate in Medicaid and 22 percent answer that it is somewhat important. Three quarters of physicians participate in Medicaid for altruistic reasons. While there is a survey bias to giving the socially correct answer, it is still interesting that so many do cite this answer as a very important reason why they participate.
- Physicians who do not participate cite low reimbursement, administrative hassles and having enough patients as the most important reasons why they do not participate in Medicaid. In addition, 21 percent of non-participating physicians indicate that they were de-selected by an OHP health plan and 29 percent of non-participants have no managed care contracts at all. These findings indicate that while reimbursement rates are very important to physicians, raising rates alone will not greatly increase the number of physicians who serve Medicaid.
- Physicians contract with an average of 1.7 plans in rural areas and over 3 plans in urban areas. In rural areas, this results in some physicians contracting with plans outside their county of service. In urban areas other than Portland, physicians often contract with all available plans. Portland physicians contract with about 50 percent of the plans available to them. This indicates significant overlap in physician networks in all areas of the state.
- Factors other than geography that explain the extent of contracting include being a specialist rather than a primary care physician, being in a single specialty practice, and being in a for profit practice.

Physician Opinion of the Priority List

- Physicians are concerned about knowing what is covered under the priority list and two-thirds report difficulty knowing what is covered. While this is a source of stress for physicians, many are delivering uncovered care anyway. When physicians do not provide the uncovered care, only 11 percent think the patient usually or always suffers significantly.
- Most physicians were neutral, and some were negative about the effects of the priority list on various features of their practice. Most were unhappy about the administrative burden. It was not clear from the additional comments what burden the list itself creates in addition to Medicaid managed care more generally.

Patient Understanding of OHP

- Physicians are concerned that Medicaid patient understanding of managed care is poor. The majority answer that Medicaid patients understand less than other patients enrolled in managed care plans. Despite these responses to our questions, there was no physician comment that managed care is inappropriate for the Medicaid population.
- The experience reported by physicians varied more with type of specialty than along the lines of primary care physician and specialist. Pediatricians in Oregon are more likely to feel their patients have a good understanding of managed care than other physicians.

Physician Opinion of Interaction with the Medicaid Plans and OMAP

- Interaction with Medicaid plans compares well to the interaction physicians have with other plans. Reimbursement rates were the only area where Medicaid plans fell substantially short of other managed care plans in the eyes of physicians. These results held both for plans with other lines of business and those that focus on Medicaid. In particular, physicians perceive no difference in access to referrals and the ability to provide needed care between Medicaid and non-Medicaid plans.
- Pediatricians are more likely than other physicians to say that features of plan interaction are good.
- Communication between physicians and OMAP could be improved. 60 percent felt that communication about changes in OHP was fair or poor.

This complaint is likely related to the fact that physicians are confused about what is covered and uncovered under the priority list. The point may be moot because the list probably will not change in the future.

Treating Members with Disabilities

- The majority of participating physicians treat members with disabilities, though for most, members with disabilities make up a small percentage of the practice. Psychiatrists are the most likely to have a high percentage of patients who are disabled.
- A large minority (34 percent) of primary care physicians feel they see more patients with disabilities since the start of OHP. Only 15 percent of specialists say they now see more OHP patients with disabilities. This could imply people with chronic conditions are now more likely to be managed by a primary care physician than before OHP.
- Surveyed physicians who treat the disabled feel that persons with disabilities fare similarly to others under Medicaid managed care.
- Physicians expressed concerns about restrictions in mental health and substance abuse treatment and therefore these patients in particular do worse under managed care. This is the only area identified where physicians feel quality has notably declined. Again, this is interesting in light of the expanded number of conditions covered under OHP and the expanded population that is now eligible for mental health benefits.

1

Introduction

In this paper we address how physicians interact with and view three types of Medicaid managed care players in Oregon. These players are the State, plans in the system and clients in the system. The Oregon Health Plan (OHP) is the state Medicaid managed care program; the office that runs the OHP is the Office of Medicaid Assistance Programs (OMAP). Plans include a variety of traditionally commercial plans and ‘home grown’ plans that only serve the Medicaid population. Some of these plans were formed by traditional Medicaid providers, a trait that is common in many of the plans serving Medicaid in other states as managed care grows. Clients in managed care in Oregon are a more complex group than those in many other states because they include dual eligible, disabled and elderly people as well as an expansion population that is relatively new to Medicaid.

The OHP is innovative and uniquely features a ‘priority list’ meaning there are specific treatment/condition categories that Medicaid does not pay for. Part of the rationale for the list is to allow Oregon to expand the population served by Medicaid. Development of the plan was an inclusive process, drawing on the opinions of policy makers, managed care plans, physicians, recipients, advocates and many others.

Physician opinion and interactions with OHP and OMAP will illustrate lessons learned about implementing a major Medicaid overhaul. We study physician opinion of OHP, participation in OHP and contracting with OHP plans. Physicians provide insight

about the quality of OHP plans overall and compared to commercial products. Physician opinion of patient understanding and interaction with patients will help to address the appropriateness of managed care for these populations.

We surveyed office-based physicians in Oregon and will use responses to answer several specific policy questions.

How is OHP doing?

Why do physicians participate in Medicaid?

To what extent do physicians participate in Medicaid?

How are physicians most likely to contract with Medicaid?

Do physicians like the priority list?

How do physicians feel that people with disabilities fare under OHP?

How do physicians see the local managed care plans?

Do physicians report that managed care works for the Medicaid patient population?

2

Background Issues

To understand the policy relevance and implications, we provide a summary of Oregon policies and previous studies. Section 2.1 covers specific aspects of the OHP, including the setting of Oregon, unique features of the plan and physician general response to and involvement with the OHP. We describe several types of relevant previous studies in Section 2.2

2.1 The Oregon Health Plan

Oregon has an 1115 waiver that implements managed care for Medicaid and expands the population served by Medicaid to low income adults and children not traditionally eligible for Medicaid. The expansion population and the traditional low income groups including the aged, blind and disabled are all enrolled into managed care plans with the following exceptions. The exceptions are available to beneficiaries in areas with insufficient provider capacity, or who are (1) Native Americans, (2) dual enrollees in a Medicare HMO without a companion OHP plan, (3) enrollees for whom continuity of care would be disrupted in a Medicaid HMO, or (4) enrollees with significant third party coverage.

Oregon has a high managed care penetration rate (47 percent overall, 41 percent Medicare, Interstudy, 1998) despite being a relatively rural state. Portland is a major metropolitan area and there are several smaller cities along the Willamette Valley and in Southern Oregon. The uninsured rate is low (13 percent in 1997, U.S. Census Bureau)

compared to the rest of the nation (16 percent, Ibid). One positive expected outcome of the Medicaid expansion would be that physicians will see fewer uninsured patients than before implementation of the program.

2.1.1 Priority List

The Oregon Health Plan features a priority list which clearly rations the provision of certain health care services. A hierarchical list of condition/treatment pairs was carefully developed and Oregon does not cover services below a certain point on the line. Initially, the list was meant to be a tool to help control costs on a continuing basis. Whether the priority list will be used in the future as a budgetary tool is unclear. Concerns have been raised about the possible impact of further reductions in the benefit package on the availability of needed medical care. A change in the funding line has not been approved for OHP since 1998.

2.1.2 Plans and Providers

There are a variety of managed care plans that participate in the Oregon Health Plan, though many of the more rural counties only have one plan and the population size in these countries will generally not support more than one plan. Despite the lack of plan choice, clients in counties with one plan still face mandatory enrollment in managed care except for the reasons listed above.

One way doctors have responded to managed care penetration in general and to Medicaid managed care in particular is to form Independent Practice Associations (IPAs) to contract with plans. Physicians find that they have more contracting power in larger

groups and that a larger organization facilitates contracting with multiple plans. Many plans and IPAs developed specifically to serve in the expanded Medicaid managed care program, OHP (Mitchell, *et al.*, 2nd Interim Report, 1998). The Oregon Medical Association (OMA) identifies 16 IPAs that formed after 1993 in response to OHP.¹

Some of the Medicaid managed care plans were also formed by groups of doctors in IPAs or clinics. These often serve the Medicaid population exclusively and are referred to as ‘home grown’ plans. Other states have experienced a similar phenomenon of Medicaid only plans, but little research has been done on the quality of these plans. We document physician opinion of the interactions with the plan they most commonly work with. When we ask about the managed care organization a physician contracts with most often, we classify the responses by whether the plan is a traditional commercial entity, IPA based or clinic based. Appendix A lists how each plan in the Oregon system is classified.

Many physicians helped to develop the Oregon Health Plan (OHP) and stand behind it as a way to insure more people and see the priority list as a way to clarify how health care will be rationed. Unfortunately, one complaint doctors have had is that it is difficult to learn about the specifics of the priority list and that communication between OMAP and the physician community is at times questionable. We ask questions directly pertaining to this issue to see how many doctors feel that communication was a problem or whether the press has focused on a vocal minority.

Physicians traditionally have trouble with the low rates that Medicaid pays and the complexity of the patient population. Physicians also object to the loss of clinical autonomy that is associated with some typical managed care rules. We are interested in differences in

¹ Personal communication with Joy Conklin, Oregon Medical Association.

plan-physician interaction with Medicaid-only plans as compared to commercially-based plans.

2.1.3 Issues in Mental Health

Mental health care benefits were very limited under Medicaid prior to OHP. Even since the start of OHP, mental health has not been the responsibility of all plans. To study the impact of managed care for mental health, the state ran a demonstration in 20 of Oregon's 36 counties, accounting for 25 percent of the state's population. The demonstration ended in June of 1997 and managed care contracts for mental health services became operational statewide in January of 1998.

Aside from the confusion of starting a new program for many physicians around the time of our survey, not all mental health is contracted the same way in all counties. Some counties have mental health carved-in, where physical health plans are responsible for mental health as well. When mental health is carved-in, the physical health plans either manage mental health care themselves or sub-contract out to a mental health organization. In other counties, mental health is carved-out so physical health plans are not responsible for mental health care. Instead, one mental health organization provides all the mental health care for Medicaid consumers in carve out counties. Substance abuse treatment is all carved-in, that is, service provision is the responsibility of physical health plans.

Furthermore, the new financing arrangement changes the distribution of mental health funds to be more equitable throughout the state. This means that payment is falling in urban areas and rising in rural areas of the state. The state was concerned about the integration of mental health into the managed care system and set up a task force to study

the issues. The Oversight Task Force on Mental Health Integration was formed to evaluate how the integration of mental health services proceeded. Starting in October of 1997 when the first HMO contracts were implemented, the group held meetings and spoke with stateholders.

The task force reported that primary care physicians complained that there were long waits for treatment after a referral had been made and that the primary care physicians were not hearing from the mental health provider after a referral (Mitchell, French and Khatutsky, 2000).

The new system of managed care is a fundamental change in the way mental health services are being provided to many low income individuals in the state. About one quarter of the disabled remain in fee-for-service, further complicating which patients get which services, and how. Both the traditional Medicaid psychiatrists and the primary care physicians are having difficulty adapting to the system. Many psychiatrists still do not participate in Medicaid, but access to care has improved for many Medicaid beneficiaries who were previously ineligible for any care and now can receive services. With some work on the part of the plans and providers and help from the state, the system should become easier to understand and work with over time.

2.2 Previous Studies

Several strains of previous literature are relevant to these issues and are organized in sub-sections. There are several surveys of Oregon physicians that document opinion of managed care, but do not analyze in depth the questions we seek to answer. Physician participation in Medicaid has been studied for decades, though there are fewer studies that

concern Medicaid managed care programs in particular. We also cover the limited available literature on physician perception of Medicaid managed care plans.

2.2.1 Oregon Surveys of Physicians

The Analysis and Evaluation group at OMAP developed a survey tool to establish baseline estimates of primary care provider Medicaid experience, specifically concerning managed care. The survey was sent to physicians in primary care specialties as well as nurse midwives, nurse practitioners, and physician assistants in 1994. An important issue before the implementation of OHP was poor payment rates. Providers found that rates were generally slightly less satisfying than other payers. In particular, providers had trouble with the low rates combined with clients who do not understand managed care policies and procedures. The providers were also asked about the provision of charity care and whether or not visits from uninsured clients had increased over the past few years. Fifty-one percent agreed or strongly agreed with the statement that charity care had increased in the past three years, with the majority of others answering that they weren't sure. Similar numbers agreed that the number of uninsured had increased over the past three years with slightly more weight toward those who weren't sure. The Oregon Health Plan should have reduced the number of uninsured overall and the number of uninsured patients that physicians see. In this paper, we provide further information on physician opinion of rates, clients and whether the number of uninsured a physician sees has fallen. It is important to note differences in physician experience that vary by predictable factors such as specialty and group size because policies may differ by physician characteristics. In Section 3.3 we note changes in physician opinion between our survey in 1998 and the baseline survey in 1994.

The Oregon Medical Association (OMA) has conducted surveys of all types of physicians regarding managed care in 1995, and 1997. While we focus more heavily on physician experience with OHP, these surveys provide more comparison data to validate the characteristics of our respondents and corroborate our findings.

In summary, these surveys raise several issues. First, physician experience varies by region. For example, physicians are more likely to maintain capitated contracts in Portland and the Willamette Valley than in more rural areas of the state. Second, specialty affects physician outcomes and opinions of the OHP. Third, the practice setting can change a physician's opinion of managed care. These findings inform our methods and choice of independent variables.

2.2.2 Medicaid Participation

While the OMA surveys find high participation in Oregon Medicaid, more general studies find a much lower participation rate. Perloff *et al.* (1997) use AMA national data to study Medicaid participation and find that 19 percent of primary care physicians do not participate. The sample covers 1993-1994 and 1,300 respondents. Using logistic regression, they find that payment levels do not explain patterns of participation. Community demographic and demand characteristics were the most powerful indicators of participation. This finding is in keeping with a study by Fanning and de Alteriis (1993) in New York that found that increasing Medicaid fees did not increase participation in the program by primary care physicians. In contrast, Adams (1995) finds that increasing Medicaid fees in Tennessee did lead to increased physician participation as measured by the number of doctors in a

county participating in Medicaid. This study was not limited to primary care physicians and the unit of observation was county rather than individual physician.

Two other studies find that reimbursement does affect physician participation in Medicaid. Ubokudom (1997) finds that financial variables provide the majority of explanatory power in the physician decision to participate in a Kansas Medicaid case management program. The program focuses on primary care case management through doctors, not health plans, that act as risk bearing entities. Silverstein and Kirkman-Liff (1995) find that reimbursement affects physician participation in Arizona Medicaid as well as satisfaction with the Medicaid program.

Watson (1995) documents that Medicaid can increase physician participation by tying access to commercially insured patients to serving Medicaid patients in the TennCare program.² However, he finds physicians are very unhappy with TennCare and that many felt coerced to participate. Watson does not quantify how many felt concerned. Sloan, Conover and Rankin (1999) also study physician participation in and satisfaction with the TennCare program. They also find a very high level of overall dissatisfaction among physicians (72 percent not at all or not very satisfied) and a perception that quality had declined, but that most physicians (86 percent) still participate because it is the ‘right thing to do.’

Margolis *et al.* (1992) study a slightly different outcome than the other studies. They analyze pediatricians who restrict Medicaid access versus those who take all comers. Initial findings indicate that those who receive a higher percent of their regular fee are more likely to participate, but these findings were muted once they controlled for the size of the community, attitudes toward payment, availability of other sources of care for Medicaid

² TennCare is Tennessee’s extensive Medicaid managed care program.

patients and their perceptions about how busy the practice is. Perloff, Kletke and Fossett (1995) also study physicians who limit their participation in Medicaid. The sample included all office-based physicians from national AMA data. They find that only about one third of primary care physicians accept all Medicaid patients. They find reimbursement to be a significant explanatory factor, but the marginal effects are small, confirming that raising reimbursement is likely to have small effects on the number of physicians participating and the number of patients those physicians accept.

Our study uses a cross-sectional survey, so we do not study whether or not payment increases participation. Though we do have other information that would determine participation, participation rates are so high that we do not have the power to estimate logistic regressions for participation. We ask physicians why they do or do not participate which can help explain why money alone may not increase participation and why previous studies have a variety of findings.

2.2.3 Physician Perception of Medicaid Managed Care Plans

Silverstein (1997) studies physician perceptions of Medicaid managed care plans compared to commercial plans in Arizona and finds that while physicians may be very unhappy with certain aspects of managed care, they are generally no more unhappy under the Medicaid system of managed care than in the commercial market. She does not find a significant difference in the adequacy of reimbursement rates between the Medicaid and commercial market, though only about 40 percent of physicians agree that reimbursement from either sector is adequate. Significantly fewer physicians agree with the statement “it makes economic sense to contract with these plans” when asked about commercial versus

Medicaid. It is somewhat surprising how many agreed with the statement at all; 72 percent agreed for commercial plans and 58 percent agreed for Medicaid plans. Physicians agree that Medicaid patients take significantly more of their time than private patients. She also hypothesizes that states with higher managed care penetration will have greater luck recruiting physicians to Medicaid. Oregon does have high managed care penetration rates (47 percent) and high participation in Medicaid (91 percent of physicians in our survey), but we don't test the theory rigorously.

There are no other studies of this and similar numbers from OMA surveys of this issue and no studies that address our other research questions. Documenting the physician option of the innovative OHP fills a gap in the literature that will help inform policy makers of how their programs work in the field.

3

Methods and Data

Results for this paper are derived from a survey of physicians fielded by Research Triangle Institute (RTI) in 1998. In Section 3.1 we discuss what questions our survey asked as well as the ranges of answers, the sample design and the survey strategy. Section 3.2 focuses on the overall un-weighted characteristics of the data as well as actual response rates.

3.1 Methods

3.1.1 Description of the Survey

The Oregon Health Plan Physicians' Survey (OHPPS) was designed to evaluate physician experience and satisfaction with the Oregon Health Plan. Physicians answered questions about their background, main medical group, patient load, and whether or not they participated in OHP. They were also asked open-ended questions about their opinion of OHP and why they participate or not. Physicians who participated in the program answered several additional sections that covered the physician relationship to the OHP and the OHP plan they deal with the most, the priority list and issues specific to patients with disabilities. They were also asked to comment on how managed care through OHP compared with commercial managed care plans and how Medicaid patients in managed care compared to commercial managed care patients.

Likert scales were used to structure answers to many of the questions. When physicians rated various aspects of OHP, patient understanding and plan interaction, we employ a 5-point scale from excellent to poor and have an additional category for ‘can’t evaluate.’ Questions that ask how often a physician does something are also rated on a 5-point scale from always to never. Comparisons to commercial groups or between time periods use a 3 point scale of better, same, worse and include ‘can’t evaluate’ as well. Finally, when asking how difficult or easy a particular task is, we use a 4-point scale of very difficult, somewhat difficult, somewhat easy and very easy.

3.1.2 Sample Design

We surveyed physicians across the state using strata based on specialty to ensure a wide variety of physician views. Our criteria for identifying physicians were that they:

- have a medical degree (MD or DO)
- are licensed in the state of Oregon
- are in selected specialties
- practice in an office based setting

We excluded hospital-based specialties such as emergency medicine, anesthesiology, radiology, pathology, neonatology and perinatology.¹ We focused on office-based specialties to exclude interns and residents as well as to find doctors who had more decision-making power. We also expect that office-based physicians have more information on the relation to the OHP because they treat patients directly and establish relationships with patients. Medical Marketing Service Incorporated (MMSI) provided current American Medical Association (AMA) files to us including only contact and specialty information on

¹ Obstetricians and gynecologists were also omitted from the sample and not surveyed.

physicians in the state of Oregon. The sample frame provides the total number of doctors who met our criteria in the state by specialty, reported as population size in Table 3-1.² For each of the seven strata, we randomly select 200 physicians for each specialty group except for one. We were interested in physicians who disproportionately care for people with disabilities. These mainly include psychiatrists, neurologists and physiatrists. Instead of combining all three of these specialties into a single stratum, we separated these specialists into psychiatry, who would dominate a single stratum, and other specialists. There are only 129 neurologists and physiatrists in the state and they form a separate strata.

3.1.3 Survey Strategy

The mail-in survey followed Dilman's principles (1978) for maximizing response rates. The survey was first mailed at the end of January, 1998. A reminder/thank you was mailed two weeks later. In March and April we sent a second and third mailing and in May we followed up by phone. We were not successful in conducting the interviews over the phone, but were able to convince more physicians to participate by mailing or faxing the survey at the time of a call. A few surveys were completed by telephone, but not enough (3 percent) to impact the integrity of the method.

² The Oregon Medical Association (OMA) reports approximately 5,800 physicians in all specialties in practice in Oregon.

Table 3-1

Sample Strata

<u>Specialty</u>	<u>Population Size (AMA)</u>	<u>Sample</u>	<u>Response Rate (%)</u>
Family/General	873	200	71%
Pediatrics	289	200	78
Internal Medicine	678	200	67
Psychiatry	282	200	67
Neurology, Physiatry, etc	129	129	75
Surgery	972	200	77
Other	421	200	68
Total	3,644	1,329	72

NOTES:

Response rates include total eligible and ineligible respondents divided by the sample size

SOURCE: 1998 OHPP Survey

3.2 Data

Response rates are good for a survey of physicians. Similar surveys by the Oregon Medical Association (OMA) have had response rates of 25-35 percent over the past several years (Oregon Medical Association Physician Managed Care Surveys, 1995 and 1997). Of 1,329 doctors surveyed, 28 percent did not respond, yielding a response rate of 72 percent.

We had very little information about non-respondents. There were no large differences in non-response weights across the strata and in analyzing by specialty, we did not feel there were large enough differences, or large enough samples of particular specialties to merit any additional adjustments to the weights. Psychiatrists and internists were the least likely strata to respond with a non-response rates of 33 percent compared to 28 percent overall. Pediatricians and surgeons were most likely to respond with response rates of 78 percent and 77 percent respectively.

Weights are based on the number of physician respondents relative to the total number of doctors in each stratum according to the AMA data. These weights are used in the calculation of results, though descriptive information on the sample is provided in this chapter un-weighted. The design effect across strata is 1.26. We used SUDAAN to make appropriate corrections in reported standard errors and statistical testing for these weights for results in Section 4.

Table 3-2 shows un-weighted sample characteristics for all returned surveys, including those who were ineligible to complete the survey. The original sample frame

Table 3-2

Unweighted Characteristics of Physician Respondents

<u>Unweighted</u>	<u>Eligible</u>	<u>Ineligible</u>	<u>Non-respondent</u>
Average age	48	52	---
% Female	22	21	---
Average years in practice	21	26	---
% Office based setting	73	39	---
Specialty (percent)			
Primary Care	47	54	45
Family and general practice	15	22	16
Internal medicine	15	15	18
Pediatrics	18	17	12
Medical Sub-specialties	10	7	12
Allergy	1	---	1
Dermatology	3	6	2
Gastroenterology	2	---	3
Hematology/oncology	1	---	1
Infectious disease	0	---	1
Pulmonary diseases	1	1	3
Surgical specialties	15	10	12
Cardio-thoracic surgery	1	---	1
Colon and rectal surgery	<1	---	---
General surgery	2	3	4
Neurological surgery	1	---	1
Ophthalmology	3	5	2
Orthopedic surgery	5	2	1
Otolaryngology	2	1	2
Plastic surgery	<1	---	1
Urological surgery	1	---	1
Mental health specialties	25	24	24
Psychiatry	15	12	16
Neurology	6	12	6
Physical medicine and rehabilitation	4	---	2
Other specialties	3	5	7
Region			
% practicing in the tri-county area	50	18	---
% practicing in other urban areas	37	10	---
% practicing in rural areas	13	8	---
County Missing	0	64	---
Number of Observations	794	157	378

SOURCE: 1998 OHPP Survey

eliminated military and other federal employees because they serve a defined population that does not include Medicaid recipients. We included screening questions in the survey to ensure those who responded were eligible; that is physicians were not military or federal personnel and were actively practicing. Of the respondents, 157 physicians were ineligible. Ineligible physicians had similar characteristics to eligibles in average age (around 50), percent female (around 20) and years in practice (21 for eligibles and 26 for ineligibles). Ineligible physicians were much less likely to be in an office-based setting, which is sensible since by definition, ineligible physicians either no longer practice or work for the government. Ineligible respondents were also less likely to be in the tri-county area and slightly more likely to be specialists.

Table 3-3 shows additional unweighted characteristics of the sample of 794 physicians who responded and were eligible to complete the survey. The majority (89 percent unweighted) currently serve Medicaid patients and still accept new OHP patients (86 percent). The average age of the practice group (25) is similar to the average years in practice (21) of eligible physicians from Table 3-2. Twenty-eight percent report being in a solo practice, but the average number of physicians in a practice group is 44.³ In addition, physician groups have an average of 8 extenders (nurse practitioners and physician assistants). The majority (65 percent) are in a single specialty practice and a few practices (6 percent) are medical school faculty practices. Seventy-nine percent of practices are

³ We omitted two outlier responses that listed group size of over 7,000. There are approximately 5,800 physicians in the state of Oregon. Solo practitioners are included in the average.

Table 3-3

**Practice Characteristics of Physicians Completing OHPPS
Unweighted, participants and non-participants**

% Currently serving Medicaid patients	89
% Accepting new OHP patients	86
Average group age	25
Average group size	44
% Solo practice	28
Average number of extenders	8
% Single specialty practice	65
% Medical school faculty practice	6
Profit Status	
Private, for-profit	79
Private non-profit	16
Public (Government)	5
Type of Ownership	
Single physician owner	33
Two or more physician owners	45
Corporate entity (insurance, HMO)	22
Employment Status	
Owner /equity shareholder	70
Salaried staff w/out profit share	12
Salaried staff w/profit share	14
Contract staff	1
Incentives/no salary	1
Other status	2
Number of Observations	794

SOURCE: 1998 OHPP Survey

private, for-profit entities and 78 percent were owned by physicians. The target respondents themselves are often (70 percent) the owner or an equity shareholder.⁴

While physicians were sampled across the state, there were no respondents from 6 counties: Columbia, Gilliam, Grant, Harney, Morrow and Wheeler. All are rural counties with lower reimbursement rates, plan participation and population. Table 3-2 shows that about half of the responding physicians are from the three counties that comprise Portland, 13 percent are from rural counties and 37 percent are from other MSAs in Oregon.

One assumption in all the analyses is that physicians are a heterogeneous group and that there are differences across strata. Table 3-4 shows mean practice characteristics across strata and a weighted average for total characteristics. Many of these variables are used as independent variables in regression analyses.

There are small differences in basic characteristics, such as more pediatricians are female and fewer surgeons are female. Surgeons and medical sub-specialists have on average a few more years of practice than other respondents. Regional distribution varies by specialty. Family practitioners are more likely to be in rural areas; medical sub-specialists and psychiatrists are less likely to be in rural areas.

Only 3 groups have a significant number of physicians who do not accept new patients: family practitioners, internists and psychiatrists. Pediatricians and internists are much less likely than other groups to be in a single specialty practice or solo practice.

⁴ Because 97 percent of the surveys were mailed, there is no guarantee that the physician filled out the survey personally. An office manager or other knowledgeable staff person may have filled out the survey in his or her place.

Table 3-4

Do Practice Characteristics Vary by Specialty?

Mean Characteristics	Family Practice	Pediatrics	Internal Medicine	Psychiatry	Neurology	Surgery	Medical Sub- Specialties	Wtd. Total
(N)	102	133	107	60	76	128	96	702
Physician age	48	45	46	46	48	51	48	48
Years in practice	20	19	18	19	20	24	23	21
% Female	20%	36%	20%	23%	22%	5%	17%	17%
% tricounty area	29%	45%	51%	63%	47%	52%	61%	47%
% other urban area	48%	42%	32%	23%	43%	27%	34%	37%
% rural	23%	13%	17%	14%	10%	21%	5%	16%
% not accepting new patients	20%	4%	30%	20%	0%	1%	2%	12%
% one-specialty group	63%	56%	39%	87%	68%	77%	65%	64%
% solo practice	27%	15%	17%	40%	21%	28%	21%	23%
% medium (2-9)	39%	44%	28%	46%	57%	48%	50%	44%
% large (10-49)	23%	19%	24%	7%	1%	13%	6%	14%
% very large (50+)	11%	22%	31%	7%	21%	11%	23%	19%
Patients per week	101	104	80	31	51	70	75	80
Age of group	24	29	26	19	23	25	26	25
% Medical school faculty practice	2%	10%	7%	7%	5%	3%	11%	5%
% equity owners	66%	63%	54%	55%	74%	87%	76%	70%
% in a corporately owned practice	23%	29%	29%	40%	14%	9%	19%	20%
% for-profit group	85%	75%	72%	58%	84%	90%	77%	81%
% in office setting	76%	74%	73%	65%	78%	78%	57%	76%
% capitated for some or all services by plan contract with most	56%	53%	56%	31%	18%	14%	18%	36%
% who contract most frequently with an IPA	16%	6%	9%	0%	13%	14%	8%	13%

SOURCE: 1998 OHPP Survey

Psychiatrists are the most likely to be in solo practice and therefore are also more likely to be in single specialty practices.

There is significant variation in how many patients a physician sees per week, based on the nature of the interactions. Generally primary care specialties see more patients than any of the specialist groups. Internists are closer to surgeons and medical sub-specialists in the number of patients they see per week, and psychiatrists and neurologists see far fewer patients.

Equity ownership, for profit status and the percent capitated for some or all services varies between strata as well. Surgeons are the most likely to be equity owners at 87 percent whereas only 54 percent of internists are equity owners. Psychiatrists are much less likely to practice in a for-profit group. Only 58 percent of psychiatrists are in a for-profit group, as opposed to 90 percent of surgeons. Whether or not a physician is usually paid by capitation for some or all services differs by primary care and specialty physicians as expected. Over half of primary care physicians receive at least some capitated payments from Medicaid plans. These differences are important to note as we try to explain why different physicians have varying opinions of OHP and Medicaid managed care in general. We hypothesize that physician type as well as practice characteristics will influence opinion and are important to understand for context.

3.3 Validation

Table 3-5 shows un-weighted sample characteristics of the OMA data compared to our survey (OHPPS), both completed in 1998. The samples have similar demographic composition, although the OHPPS respondents have more practice experience. OHPPS

physicians were more likely to be in a very large practice (50+) rather than merely a large practice of 10-24. Because psychiatrists are included as a primary care specialty in the OMA survey and we over-sampled psychiatrists, we have many more primary care respondents than the more general OMA survey⁵. Regional distribution is similar except that OHPPS physicians are a bit more likely to be from the Willamette Valley and OMA physicians are more likely to be from the South West area (the Medford-Roseburg area). These results show that our survey respondents have similar characteristics to other surveys of physicians in the state. While the type of physicians we focus on differs a bit, the basic survey characteristics are representative of physicians in Oregon.

5

In other results we classify psychiatrists as specialists. To be consistent with OMA classifications, we reclassify them as primary care physicians for this analysis.

Table 3-5**Validation of Respondent Characteristics with OMA survey**

<u>Characteristic</u>	<u>1998 OMA</u>	<u>1998 OHPPS</u>
Number of observations	308	794
% Female	18	22
Age (%)		
under 40	21	22
40-49	33	37
50-59	29	30
60 and over	16	11
Years in practice (%)		
under 4	10	0
4-5	6	2
6-10	14	15
11-15	17	16
16+	53	67
Practice Setting		
Solo	29	28
Small group (2-4)	25	24
Medium group (5-9)	15	19
Large group (10-24)	17	8
Large group (25-49)	3	5
Large group (50+)	11	17
Specialty Type (%)		
Primary care physician	36	62
Medical sub-specialist	17	18
Surgical sub-specialist	30	15
Other	18	5
Regions (%)		
Portland	52	50
Willamette Valley	17	24
Central Oregon	7	7
NW Oregon	4	2
SW Oregon	17	13
Eastern Oregon	3	4

SOURCE: 1998 OHPP Survey

4

Physician Opinions Concerning OHP

Chapter 4 is organized into discrete sections that each answer a particular research question or address a topic area of several research questions. Issues, results and discussion are presented in each sub-section for continuity. The first section compares questions on our survey with responses to OMAPs baseline physician survey. The other sections focus on our survey and cover physician participation in the OHP, characteristics of participants, opinion of the priority list, patient understanding, plan interaction, how well OHP works for the disabled and a general overview of how OHP is doing.

4.1 Comparisons to the Baseline Survey

In this section, we compare results from the 1994 OMAP survey of physicians at the beginning of the Medicaid program to responses on the 1998 OHPPS. The OMAP survey focused on primary care physicians and OB/GYNs from their own provider file, so the sample is different from the OHPPS in 1998. The questions are not asked with identical wording, but the concepts are similar and interesting. Comparisons between surveys is difficult at best. The 1994 survey is designed such that the respondent only had to choose from the same 5 options about whether they agreed with the statement. The 1998 survey phrases real questions and allows physicians to ‘rate’ issues more directly. Still, the magnitude of some of the differences should be interesting to OMAP and HCFA. The

concepts we compare are opinion on the uninsured, payment, client eligibility, client understanding and communication with OMAP. The questions are listed word for word on Table 4-1 as are the entire distributions of response frequencies.

One of the biggest differences in opinion across the two years is whether or not the number of uninsured patient visits had increased over the past 3 or 4 years. In 1994 43 percent of doctors agreed or strongly agreed with the statement that the number of office visits with no payment increased over the past three years. By contrast, when physicians were asked in 1998 if the number of uninsured patients had decreased, stayed the same or increased since OHP began in 1994, only 4 percent responded that the number of uninsured had increased.

The fact that physicians seem to think the number of uninsured has fallen after OHP and did not feel this way prior to OHP should be reassuring to the State of Oregon. Overall, the percent of the population that is uninsured has NOT undergone a steady decrease since 1994. Table 4-2 shows numbers from the 1997 Statistical Abstract of the United States that decline from 1993-1995, jump up in 1996, and fall again in 1997. The rate of uninsured is still higher in 1997 than in 1994. However if fewer uninsured are seeking care from physicians, we can infer that OHP has either had a beneficial effect by insuring those who use services or an adverse external effect such that access to care for those who are not covered by OHP has decreased. It is also possible that there is some churning among the OHP population: they may be on OHP and insured when they need care and otherwise be

Table 4-1

Compare Responses to Baseline Survey

Similar questions covering a variety of topics were asked in the 1994 Baseline Survey conducted by OMAP and the 1998 physician survey conducted by RTI.

1. Uninsured

1994 The number of monthly patient office visits with no payment increased over the past three years.

N	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
267	13%	31%	38%	15%	3%

1998 Has the number of uninsured patients you treat decreased, stayed the same, or increased since OHP began in February 1994?

N	Increased	Stayed the same	Decreased	Missing
690	4%	36%	54%	6%

2. Payment

1994 OMAP payments are adequate for the services I provide.

N	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
285	1%	10%	29%	28%	32%

1994 The managed health care plan I work with provides adequate capitation payments/claim payments for the services I provide.¹

N	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
282	6%	31%	29%	22%	12%

1998 How would you rate the managed care plan that accounts for the largest number of OHP patients on reimbursement rates?¹

N	Excellent	Very Good	Good	Fair	Poor	Can't Say
656	2%	3%	15%	36%	31%	11%
					(2% missing)	

¹Each of these questions refer to a specific managed care plan that the physician works with

Table 4-1 (continued)

Compare Responses to Baseline Survey

3. Client Eligibility

1994 Verification of client eligibility is readily accessible.

N	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
290	3%	28%	44%	17%	8%

1998 Thinking only about your OHP patients enrolled in the managed care plan that accounts for the largest number of your OHP patients, how easy is it to verify with the managed care plan that patients are enrolled in the managed care plan?

N	Very Easy	Somewhat Easy	Somewhat Difficult	Very Difficult	Missing
660	23%	40%	30%	4%	3%

4. Client Understanding

A. Preventative Services

1994 OMAP clients are aware of preventative services available to them

N	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
285	1%	17%	41%	34%	7%

1998 How would you rate OHP patients' understanding of the use of preventative care?

N	Excellent	Very Good	Good	Fair	Poor	Can't Say
702	0%	2%	14%	37%	32%	15%

B. Proper Emergency Room Use

1994 OMAP clients understand emergency room utilization limits

N	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
288	0%	7%	27%	42%	24%

Table 4-1 (continued)

Compare Responses to Baseline Survey

1998 How would you rate OHP patients' understanding of the appropriate use of the emergency room?

<u>N</u>	<u>Excellent</u>	<u>Very Good</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	<u>Can't Say</u>
703	0%	3%	8%	33%	41%	14%
					(1% missing)	

5. Communication with OMAP

1994 I have been well oriented to the policies and procedures of OMAP.

<u>N</u>	<u>Strongly Agree</u>	<u>Agree</u>	<u>Not Sure</u>	<u>Disagree</u>	<u>Strongly Disagree</u>
298	4%	32%	25%	29%	10%

1998 How would you rate the following aspects of communication about OHP?

a. The information you received about OHP before its implementation

<u>N</u>	<u>Excellent</u>	<u>Very Good</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	<u>Missing</u>
670	2%	7%	34%	41%	15%	1%

b. The information you have received about changes in OHP, including changes in the priority list.

<u>N</u>	<u>Excellent</u>	<u>Very Good</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	<u>Missing</u>
693	1%	8%	32%	39%	19%	1%

SOURCE: 1998 OHPPS.

Table 4-2

Percent of Oregonians without Health Insurance 1993

<u>Year</u>	<u>Percent Uninsured</u>
1993	14.7
1994	13.1
1995	12.5
1996	15.3
1997	13.3

SOURCE: 1997 Statistical Abstract

uninsured,

particularly the expansion population that must pay premiums to keep OHP coverage. It may only be worth paying premiums when the family needs care. Oregon is also concerned that more children are uninsured. Among physicians in 1998, pediatricians were the most likely to respond that the number of uninsured had decreased. Sixty-nine percent of pediatricians versus 54 percent of physicians overall report a decrease.

Physician opinion on payment may have changed some. Comparing the two more similar questions, it would appear that managed care payments are worse in 1998 than in 1994. Thirty-four percent disagree or strongly disagree that the managed care plan they work with provides adequate payments for the services they provide in 1994 and 37 percent agree or strongly agree. In 1998 67 percent answer that reimbursement rates are 'fair' or 'poor' and 5 percent say 'excellent' or 'very good.' The questions are worded differently and when

asked about OMAP payments in general in 1994, only 11 percent agree or strongly agree that payments are adequate and 60 percent disagree or strongly disagree. These numbers are closer to the numbers in 1998, but still imply slightly less negative answers in 1994. Other sources show that payments to physicians have been lowered over time. Henery & Associates (1999) report on the financial impact of OHP and note that physicians are receiving 7-8 percent less per service in 1997-1998 than they did in 1993-1994. They also note that physicians have stopped participating due to the real decline in rates.

The client eligibility question is difficult to compare because there is a middle categorical response that gets 44 percent of the answers in 1994 and no such category in 1998. If we therefore compare those with 'strong' feelings only, we infer that it might be easier to verify client eligibility in 1998 than it was in 1994. Only 4 percent report verification with managed care plans is very difficult in 1998 and 8 percent strongly disagree that verification of client eligibility is readily accessible in 1994. In 1998 23 percent felt verification is very easy and only 3 percent agree that verification is readily available in 1994. The 1998 results (unweighted) imply that 73 percent found verification somewhat or very easy.

The fourth concept we compare is client understanding. We investigate two separate aspects of understanding - preventative care and emergency room use. Physician opinion of both seems to have declined, though in both cases opinion on emergency room use is quite negative. In 1994, 18 percent of physicians agreed or strongly agreed that OMAP clients are aware of preventative services available to them and 41 percent disagreed or strongly

disagreed. In 1998, 69 percent rated patient understanding of preventative care as ‘fair’ or ‘poor’ and only 2 percent said ‘very good’ (none report excellent). For emergency room use, 66 percent disagree or strongly disagree in 1994 with the statement that OMAP clients understand emergency room utilization limits. Seventy-four percent rate patient understanding of appropriate use of the emergency room as ‘fair’ or ‘poor’ in 1998.

Finally, communication with OMAP rates worse in the 1998 survey than the 1994 survey. The 1998 survey compares communication before OHP with communication about changes in OHP once implemented and finds not much difference in the distribution of responses. Fifty-six percent rate communication ‘fair’ or ‘poor’ pre-OHP and 58 percent rate communication ‘fair’ or ‘poor’ about changes in OHP. The 1994 survey asks if physicians were well oriented to the policies and procedures of OMAP and only 39 percent disagree or strongly disagree. Perhaps in hindsight, physicians feel they did not truly understand the OHP or the wording of the questions accounts for the difference in responses.

4.2 Physician Participation in Medicaid

In this section we seek to answer several research questions.

- Who participates in Medicaid?
- Why do physicians participate in Medicaid?
- To what extent do physicians participate in Medicaid?

Weighted results show that 91 percent of doctors who responded to our survey participate in Medicaid and OHP. Those who do not participate are mostly psychiatrists, dermatologists or other specialists whose primary services have limited coverage under OHP.

Table 4-3 summarizes weighted characteristics of participants and non-participants. Fifty-three percent of participants are primary care providers where as only 45 percent of non-participants are primary care providers. Females make up a greater portion of non-participants and non-participants are slightly older. Non-participants are less likely to practice in a rural county (16 percent v. 27 percent) and are more likely to be in urban areas other than Portland (39 percent v. 25 percent). Because so many non-participants are psychiatrists who average lower patient loads than other physicians, patient load is much lower than that of participants (50 v. 80 per week).

Most (85 percent) participants served Medicaid prior to OHP, but only 45 percent of non-participants did. These percents are of different numbers. There is an inflow of 105 physicians and an outflow of 41, for a net gain of 64. Expressed as a percent of the total who previously participated (64 over $(702-105) = 597$), there is an 11 percent gain of physicians to Medicaid after OHP.

Comparing participants with nonparticipants, non-participants are slightly less likely to accept new patients at all (86 percent v. 92 percent for participants). While similar percentages of participants and non-participants are in office settings, more non-participants are in ‘other’ practice settings. Comments we received that describe these settings include ‘student health clinic,’ ‘prison’¹, and ‘residential care.’ The most striking difference is in the percent of all patients covered by managed care contracts. Those who do not participate in

¹ Physician practices at a correctional facility.

Table 4-3

**Weighted Mean Characteristics of MDs Who Participate in OHP
v. MDs Who Do Not Participate in OHP**

<u>Provider Characteristics</u>	<u>Average Participants</u>	<u>Average Non-Participants</u>
Age	48	51
% Female	17	33
# Years in Practice	21	24
Location^a		
% in Tri-County area	48	45
% in Other Urban area	25	39
% in Rural area	27	16
Practice Setting - %^a		
Group or staff HMO	7	4
Hospital clinic	7	3
Public clinic /health center	2	3
Free-standing clinic	4	6
Office	76	77
Other practice setting	4	7
% Accepting new patients	92	86
Patient Load		
Mean # of patients in average week	80	50
% Served Medicaid prior to OHP	85	45
% of Patient Load Covered by ANY Managed Care^a		
0	0	29
1-20	10	19
21-40	20	13
41-60	27	15
61-80	26	10
81-99	10	8
100	5	5
Missing	2	1

Table 4-3 (continued)

Weighted Mean Characteristics of MDs Who Participate in OHP
v. MDs Who Do Not Participate in OHP

Provider Characteristics	Average Participants	Average Non-Participants
Specialty - %		
Primary Care^b	53	45
Family and general practice	23	31
Internal medicine	20	14
Pediatrics	10	---
Medical Sub-Specialties^b	9	9
Allergy	1	---
Dermatology	3	3
Gastroenterology	2	---
Hematology/oncology	1	6
Infectious disease	0	---
Pulmonary diseases	1	---
Surgical Specialties^b	30	0
Cardiothoracic surgery	2	---
Colon and rectal surgery	1	---
General surgery	4	---
Neurological surgery	2	---
Ophthalmology	6	---
Orthopedic surgery	8	---
Otolaryngology	3	---
Plastic surgery	2	---
Urological surgery	2	---
Other Health Specialties^b	8	46
Psychiatry	5	44
Neurology	2	1
Physical medicine and rehabilitation	1	1
Other	3	1
N (Unweighted)	702	92
Weighted %	91	9

NOTES: ^a Columns sum to 100% within categories.

^b Columns sum to 100% by heading - subcategory numbers sum to the heading percent by columns.

SOURCE: 1998 OHPPS.

OHP are less likely to participate in any managed care contracts - 29 percent have no managed care contracts at all.

Each participant rated a list of reasons why they do or do not participate as ‘Not important’, ‘Somewhat important’ or ‘Very important.’ We show the distribution of doctors who gave each answer in Table 4-4. Few physicians list financial reasons as very important in the decision to participate, though about a third mention reducing bad debt and obtaining higher fees paid under OHP as somewhat important in the decision to participate. The two most common reasons why doctors participate are “to serve people who have trouble getting health care” or because “there is no one else to provide care for OHP patients”. While several individual comments indicate that some doctors feel forced to participate by their clinic or group, only 16 percent said managed care plan requirements were very important in their decision to participate; another 22 percent rated it as somewhat important.

For those not participating, we asked a different list of reasons about how they made their decisions. Rather than rate importance, physicians said ‘yes’ or ‘no’ to agree or disagree with the question/statement. Physicians could answer ‘yes’ to as many statements as appropriate and many (80 percent) wrote additional comments under the category ‘Other.’ The most commonly checked of the reasons that we provided for why physicians don’t participate are ‘reimbursement is too low’ (63 percent), ‘administrative hassles of OHP’ (59 percent), and ‘the medical group is busy enough’ (50 percent).

Many psychiatrists do not participate in the OHP and describe why in the comment section accompanying the question.

Table 4-4

Reasons for Participation Decision^a

Reasons to Participate^b	% Very Important	% Somewhat Important	% Not Important	% Missing
To serve people who have trouble getting health care	55	35	9	1
There is no one else to provide care for OHP patients	21	40	38	1
Was required by managed care plan in order to be able to serve their private patients	16	22	60	2
To maintain or increase patient load	13	26	59	2
To reduce bad debt from current patients	13	37	48	2
To obtain higher fees paid by Medicaid under OHP	8	31	59	2

Reasons for not serving Medicaid/OHP patients

Reason	% Mentioning
Medical reimbursement is too low	63
Administrative hassles of the OHP	59
Current medical group is busy enough	50
The population is difficult and/or time consuming to serve	42
Concerned about quality of care can provide for OHP patients	37
Feel would be giving up your independence	30
Don't know very much about the program	21
Dislike the priority list	24
Deselected by managed care plans contracting with OHP	18
Concern about liability	17
There are few OHP members in the geographic area	4
Other reasons	80

NOTES: ^aAll frequencies are weighted.

^bRows sum to 100%

SOURCE: 1998 OHPPS.

“Medical psychotherapy is not covered”
“Mental health (is treated) through county clinic”
“OHP does not reimburse private practice psychiatrists. Only through contracted agencies”

These comments indicate that private practice psychiatrists feel that OHP does not cover their services. A comment by a participant from the general question about how OHP is doing sums up physician opinion on the problems with mental health care and OHP.

“My experience in the provision of psychiatric services to OHP patients is fraught with frustration and confusion, primarily due to the specific (all different) systems for carving out and capitating mental health services. Everyone is massively confused.”

Another physician says that the new structure of mental health benefits is a ‘disaster.’ Psychiatrists criticize OHP for delays in referrals, poor coordination with PCPs, lack of coverage for important and innovative drugs and inappropriate referrals to state hospitals as well as the reimbursement.

The comments from psychiatrists are quite critical. It is important to note that the survey took place during a time of transition in the mental health system. While transition to the new system was confusing for many providers, we note a few important changes to the mental health system. First, more mental health services are covered after OHP than prior to it. Second, all beneficiaries are eligible for mental health services. Prior to OHP, only those who are a threat to themselves or others were eligible for those benefits. Finally capitation payments have “equalized” mental health funding around the state, to the consternation of urban physicians such as those in Portland and to the benefit of rural areas who receive relatively more funding now.

Two physicians who are not psychiatrists mention that OHP does not cover the service they provide in their open form comments to the question of why they do not participate. Both specialize in pain management. Five of the other comments reiterate the importance of reimbursement as the primary reason they do not participate and 2 mention concerns about privacy for their patients. Other physicians mention reasons that make them unlikely to ever participate in Medicaid. Six treat workers compensation patients exclusively and 4 said there wasn't any demand in their area – including one physician who said he/she is licensed in Oregon, but practices in Washington State.

4.1.1 Extent of Participation

Once a doctor has decided to participate in OHP, they also decide which health plans to contract with. This decision is highly dependent on where a physician practices and how many plans are available to contract with in that county. Table 4-5 shows that specialists contract with more plans on average than primary care physicians, but the difference is only significant in the 'other urban' region. The same pattern exists when the number of physician contracts is normalized to the number of plans in the county where the physician's primary practice is located. The percent of available plans that a specialist contracts with is higher than that of a primary care physician on average. Again the finding is only significant in other urban areas. Note that in some rural counties, physicians contract with more plans than are available in those counties. Specialists in rural areas contract on average with 106

Table 4-5

**Extent of Participation
How Many Plans in a County Does a Physician Contract With?**

	<u>Portland MSA</u>	<u>MSA other than Portland</u>	<u>Rural</u>
Average Number of Plans^a			
PCP	3.26	2.70	1.63
Specialist	3.71	3.96***	1.71
Percent of Available Plans^a			
PCP	47%	64%	89%
Specialist	52%	88%**	106%

*The difference in the mean number of plans and mean percent of available plans is tested for each region between PCP and specialist. The significance test results compare the specialist average to the PCP average above treating each region as an individual sub-sample.

** Two-tailed t-test is significant at 5%

*** Two-tailed t-test is significant at 1%

SOURCE: 1998 OHPPS

percent of plans available to them and the numbers are more dramatic for the most rural areas.

To understand what effect on the extent of plan participation is attributable to physician specialty as opposed to practice characteristics, we analyze a multivariate weighted least squares regression of the number of contracts on a series of independent variables in Table 4-6. The dependent variable in all cases is the number of plans a physician contracts with. Four specifications of independent variables are estimated for two sub-samples. Columns 1-4 pertain to the sample of all physicians contracting with at least one OHP plan and columns 5-8 shrink the sample to those physicians who serve counties with at least three plans to contract with.

The first specification in each sample is simply the primary care physician as compared to the specialists. In the first sample, the second specification adds dummies for being in the tri-county area (Portland) or other urban areas with the omitted group being rural areas. In the second sample, only the tri-county area is included because restricting the sample to counties with at least three plans eliminates most of the rural areas. The third specification uses the strata variables rather than PCP and includes the same geographical controls as specification (2). Finally, the fourth specification includes a limited range of practice characteristics to separate the effect of specialty from other physician and practice characteristics. The complete specification includes patient load, whether or not a physician accepts new patients, group age and size, whether the practice is a one specialty group and whether it is for-profit (versus non-profit or public) or corporately owned (versus owned by

Table 4-6

OLS Regressions for Number of Plans

	Number of plans contract with >0 (N=580)				Number of plans contract with >2 (N=280)			
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Intercept	2.60***	1.41***	1.66***	0.27	4.45***	4.24***	4.24***	4.07***
Specialist	0.67***	0.57***	---	0.37*	0.22	0.20	---	0.07
Geography								
Portland	---	1.78***	1.83***	1.91***	---	0.37	0.41	0.19
Other MSA	---	1.59***	1.56***	1.59***	---	Omit	Omit	Omit
Rural		Omit	Omit	Omit		Omit	Omit	Omit
Strata								
Family Practice	---	---	0.10	---	---	---	0.15	---
Pediatrics	---	---	-0.50*	---	---	---	-0.38	---
Internal Medicine	---	---	-0.45	---	---	---	-0.03	---
Psychiatry	---	---	0.13	---	---	---	0.63	---
Neurology/Physiatry	---	---	0.85**	---	---	---	0.53	---
Surgery	---	---	0.30	---	---	---	0.09	---
Medical Subspecialty	---	---	Omit	---	---	---	Omit	---
Characteristics								
Patient load	---	---	---	0.08	---	---	---	-0.03
No new patients	---	---	---	-0.37	---	---	---	-0.59
One specialty practice	---	---	---	0.69***	---	---	---	0.52
Age of practice	---	---	---	-0.13	---	---	---	1.17
Size of practice	---	---	---	0.02	---	---	---	0.02***
For profit practice	---	---	---	0.84**	---	---	---	-0.34
Corporate entity	---	---	---	0.20	---	---	---	0.37
R²	0.024	0.153	0.158	0.208	0.003	0.011	0.018	0.045

NOTES: ***Marginal effect is significant at 1% in two-tailed t-test.
 **Marginal effect is significant at 5% in two-tailed t-test.
 *Marginal effect is significant at 10% in two-tailed t-test.

SOURCE: 1998 CHPPS

physicians). We expect that physicians who do not accept new patients or who have a high load of patients will contract with relatively fewer plans because they do not need more clients. A high patient load or a group not accepting new patients may also indicate a busy practice that contracts with many plans and is therefore full. The sign and significance of the coefficient will tell us if either argument is supported empirically. Single specialty practices may contract with more plans to enhance referral activity and patient base. An older practice is likely to have more established patient relationships and not need to contract with all plans. We expect that larger, for-profit, and corporately owned practices will contract with relatively more plans to maintain a large patient base and rely on volume of business to increase profits.

Results from the sample of doctors who contract with at least one plan show that being a primary care physician is an important indicator of how many plans a physician contracts with, though significance is reduced when controlling for region and other characteristics. The third specification shows that much of the difference is attributable to neurologists and physiatrists who contract with significantly more plans than medical sub-specialists. The strata variables do not provide significant additional explanatory power over the specification with an indicator for primary care provider.² To conserve degrees of freedom and efficiency, we use only the specialist identifier in specification (4). For the larger sample, for-profit and single specialty practices contract with significantly more plans

² An F-test yields a chi-square statistic of 0.93 between columns (2) and (3), which is insignificant with 5 degrees of freedom. The statistic is similarly insignificant between columns (6) and (7).

(by almost 1 plan for each variable) than non-profit or multi-specialty groups. In all specifications where physicians contract with at least one plan, the 2 regional variables are significant, adding an average of 1.5 to 2 plans more than those than rural areas. Once we remove physicians in counties with fewer plans, geography and being a specialist become insignificant factors in the regression and the only significant variable is practice size. In the restricted regressions, the larger the practice, the more plans you contract with, but the net effect of .02 plans per 100 extra physicians is small. There are some very large practices in our sample, but a practice would need to have 5,000 doctors before contracting with 1 more plan on average than solo practitioners.³

Explanatory power in this model is low due to the limited sample and because the explanatory variables are not reported by all physicians. It may not be surprising that the region and primary care indicator variables are no longer significant. Both the Portland area and other MSAs have significantly more plans and more specialists than rural areas. However, Portland and other MSAs do not appear to be significantly different from each other and are not a significant prediction of the number of contracts. Similarly, the differences between PCPs and specialists appears not to be important in urban areas where there are plenty of plans.

³ The coefficient indicates that for every 100 extra doctors, the practice contracts with 0.02 more plans. To figure out how many doctors you need to contract with a full plan: $1.00/0.02=50*100=5,000$. This is outside the range of observations and close to total doctors surveyed in the state.

4.3 Physician Opinion of the Priority List

The priority list is a unique feature of the Oregon Health Plan. The list determines what conditions and treatments are covered under OHP. We asked participants various questions about their opinion of the priority list and what effect it has had on their medical practice. Table 4-7 documents these physician opinions with weighted response frequencies separated by those who self report they are mainly primary care physicians and specialists. The questions are on the table exactly as they were worded in the survey.

One of the problems physicians have with the priority list is difficulty knowing which condition/treatment pairs are not covered. Seventy-four percent of primary care physicians and 62 percent of specialists report it is either very or somewhat difficult to know which pairs are covered. Almost all physicians feel that it is somewhat or very important to know if a condition/treatment pair is covered - 84 percent of primary care physicians and 76 percent of specialists.

Primary care physicians may feel the need to be more aware of what is covered for two reasons. First, the condition/treatment pairs NOT covered by OHP are things that by definition have less priority in treatment and may be more likely to be treated by a primary care physician. Serious conditions treated by certain types of specialists are not among the uncovered services. Specialists who tend to focus on treatments that are below the line or otherwise are not included in OHP (e.g. psychiatrists, allergists) are less likely to participate in OHP at all. A second factor is that the primary care physician is often responsible for

**Table 4-7
Physician Opinion of the Priority List^a**

Question		Answer	
		<i>Primary Care Physician</i>	<i>Referral Physician</i>
A. When you decide which treatment to provide, how important is it to know whether or not a condition/treatment pair is below the line (i.e., not covered for treatment by OHP)?	Not Important	15	21
	Somewhat Important	37	28
	Very Important	47	48
	Missing	1	1
B. How difficult or easy is it for you to know which condition/treatment pairs are <u>not</u> covered by OHP?	Very Difficult	24	18
	Somewhat Difficult	50	44
	Somewhat Easy	21	28
	Very Easy	5	7
	Missing	0	3
C. How concerned are you about legal liability for failing to provide a treatment that is not covered by OHP?	Not Concerned	38	36
	Somewhat Concerned	39	36
	Very Concerned	22	27
	Missing	1	1
D. When you diagnose a condition that is not covered by OHP, how often do you deny treatment?	Never	41	53
	Rarely	26	16
	Sometimes	21	18
	Usually	9	8
	Always	2	2
	Missing	0	3
E. When you have denied treatment for a condition that is not covered by OHP, how often do you think the patient has suffered significantly because treatment was denied?	Never	22	18
	Rarely	37	29
	Sometimes	32	33
	Usually	5	15
	Always	1	2
	Missing	3	3

**Table 4-7 (continued)
Physician Opinion of the Priority List^a**

Question		Answer	
		<i>Primary Care Physician</i>	<i>Referral Physician</i>
F. When you provide a treatment that is not covered by OHP, how often do you submit a claim or encounter form to the managed care plan?	Never	25	26
	Rarely	16	13
	Sometimes	12	12
	Usually	14	14
	Always	29	29
	Missing	4	4
G. When you provide a treatment that is not covered by OHP, how often do you bill the patient?	Never	50	48
	Rarely	20	12
	Sometimes	8	9
	Usually	12	17
	Always	5	8
	Missing	5	6
H. Prior to the start of OHP, how did you feel about the concept of priority list as a way to fund the expansion of Medicaid coverage to the uninsured?	Did not like at all	16	21
	Like a little	44	45
	Like a lot	36	31
	Missing	4	3
I. How do you feel now about the priority list as a way to fund the expansion of Medicaid coverage to the uninsured?	Did not like at all	15	17
	Like a little	45	47
	Like a lot	38	34
	Missing	2	3

NOTES: ^a Answers to each question sum to 100% by column.

SOURCE: 1998 OHPPS

specialty referrals and may feel they need to know what is covered before referring a patient to a specialist.

While a reasonable percent of physicians are not concerned about legal liability for failing to provide care that is not covered by OHP (35 and 36 percent for PCPs and specialists, respectively), most are somewhat or very concerned (62 percent) about liability for failing to treat. There is no significant variation between primary care physicians (61 percent) and specialists (63 percent). Many physicians, particularly specialists, answer that they never deny treatment that is not covered by OHP. Fifty-three percent of specialists and 41 percent of primary care physicians never deny treatment and another 16 percent and 26 percent respectively rarely deny treatment. For those who do deny treatment, only a few usually or always think the patient suffers significantly. Specialists are more likely - 17 percent v. 6 percent to report the patient usually or always suffers significantly. For those that do provide treatments, most do not bill the patient; 70 percent of primary care physicians and 60 percent of specialists rarely or never bill the patient and only 17 percent and 25 percent respectively usually or always bill the patient.

The survey does confirm anecdotal evidence from our site visits that many patients are often receiving care for uncovered services. Many physicians report providing treatment for uncovered care reasonably often. General comments on OHP also yielded concerns about the priority list. Physicians disagree strongly with limiting treatment for such conditions as adult hernias, skin diseases and allergies and have moral dilemmas with limiting care. One explains “*the patients demand the treatment for conditions that are not covered, and I have*

come to ignore the list.” Physicians are also unhappy that they “*have to carry the brunt of patient dissatisfaction*” when treatment is denied. In the general comments, a few physicians express moral concern with some of the services that ARE covered under the priority list, such as abortions and assisted suicides.

We also asked whether or not physicians submit a claim or encounter form to a managed care plan when they provide a treatment not covered by OHP. The result for both specialty and primary care physician is a U-shaped response with 25/26 percent responding that they never submit a claim and 29 percent responding that they always do. Discounting the 4 percent missing, the other responses are fairly evenly distributed. One could roughly infer that OHP plans are capturing at least 30 percent of this type of utilization and maybe closer to 40 percent overall. Patient loads vary significantly by physician, so this would be a very rough average.

Physicians were asked several questions about the impact the priority list in particular had on their practice. Physicians were asked to focus on the priority list alone and not OHP. Table 4-8 lists these responses. While we have no way of knowing how well physicians were able to separate the issues, we believe on average they did read this question correctly because so many (49 percent PCPs and 64 percent specialists) answered that there was no impact on the financial status of their main medical group.

While a surprising majority of physicians said the priority list had no impact on any of the quality of care features noted, very few answered that the priority list had either a good or very good impact on the quality of care. Given that few physicians deny treatment, it is

not surprising that most (64 percent) feel that the priority list has not compromised the quality of care they are able to deliver to their OHP patients. More physicians state that the priority list has badly impacted the range of services rather than quality of care, but the majority, 50 percent and 52 percent for PCPs and specialists respectively, report no impact on the range of services.

The priority list has confused physician understanding of what Medicaid will pay for. Primary care physicians are more likely to report understanding as bad or very bad (part E on Table 4-8 shows 41 percent for PCPs versus 30 percent for specialists). A larger percentage of both specialists and PCPs think the priority list has had a good impact on their understanding of what Medicaid will pay for compared to the other aspects we questioned. The priority list appears to have introduced some additional disputes between physicians and managed care plans with 34 percent of primary care physicians and 22 percent of specialists reporting a bad or very bad impact on feature F in Table 4-8. However the majority of physicians report no impact (57 percent and 70 percent respectively).

The worst impact of the priority list is under administrative burden where 65 percent of PCPs and 59 percent of specialists feel there is a bad or very bad impact due to the priority list. This is higher than the percent of respondents in a 1997 survey by the Oregon Medical Society (OMS) that found 44 percent of physicians found OHP (general) paperwork unacceptable. Primary care physicians were more likely than other specialists to say the paperwork was unacceptable (53 percent in the OMS survey), but this number is still lower

Table 4-8

How Has the Priority List Affected Aspects of Treatment or Care

(Percent responding)

What impact has the OHP priority list had on the following aspects of your medical care for OHP patients? Please think about the priority list specifically, not OHP in general, when you answer.

Feature			Answers					
			Very Bad	Bad	No Impact	Good	Very Good	Missing
A.	The quality of care you deliver to your OHP patients	PCPs	1	15	63	13	7	1
		Referral MDs	2	18	65	9	5	1
B.	The range of services you deliver to your OHP patients	PCPs	1	28	50	13	5	3
		Referral MDs	2	32	52	10	3	1
C.	The financial status of your main medical group	PCPs	8	28	49	10	1	4
		Referral MDs	4	20	64	9	1	2
D.	The administrative burden for your main medical group	PCPs	19	46	26	4	1	4
		Referral MDs	12	47	36	3	0	2
E.	Your understanding of what Medicaid will pay for	PCPs	5	36	35	19	1	4
		Referral MDs	6	24	43	22	1	4
F.	The frequency of disputes between managed care plans and your main medical group	PCPs	4	30	57	3	1	5
		Referral MDs	2	19	70	5	0	4

NOTES: All rows sum to 100%

SOURCE: 1998 OHPPS

than the portion who we find think priority list administration has a negative impact on quality of care.

Finally, physician general opinion of the concept of the list is somewhat mixed, as shown at the end of Table 4-7. Prior to OHP, 36 percent of PCPs and 31 percent of specialists liked the concept of the priority list a lot and another 44/45 percent liked it a little. Those numbers increase slightly when physicians were asked how they feel now. Less than 20 percent of participating physicians do not like the priority list at all. This understates true physician opinion since many non-participating physicians do not participate because their services are not included above the priority list line and may have very negative opinions of the list.

The priority list does cause some problems for physicians and patients. It is important to weigh the effect on physicians and patients against the financial savings from having the list before passing ultimate judgement on the priority list.

4.4 Patient Understanding

Many physicians and advocates question using managed care techniques for the Medicaid population. Physicians and advocates express concern that patients do not understand the system and therefore cannot use it properly. One argument is that without adherence to managed care rules, managed care goals of better medicine for lower cost cannot be reached. Whether or not managed care works for the Medicaid patient population

is an open policy question and therefore we surveyed physicians to get a representative estimate of how well physicians think their patients understand managed care concepts.

We asked the physicians about patient understanding of 4 features of managed care. The question read “How would you rate OHP patients’ understanding of the following aspects of managed care?”

- The role of the primary care provider
- The referral process for specialty care
- The appropriate use of the emergency room
- The use of preventative care

Physicians answer using a 5-point Likert scale from ‘poor’ to ‘excellent’ and could also respond ‘can’t evaluate.’ We combine ‘very good’ and ‘excellent’ to a single category and ‘fair’ and ‘poor’ into a single category to display the results in Table 4-9. A second question asked “Do OHP patients understand these aspects of patient care worse, about the same, or better than other managed care patients?” We include a column that shows the percent of physicians who respond ‘worse’ to this question in Table 4-9 as well.

Very few doctors answered either ‘Very good’ or ‘Excellent’ for any of the 4 concepts. Table 4-9 shows the worst overall ratings of patient understanding were for ER use and the referral process. For ER and preventative care, significant minorities (14 and 15 percent) answered that they couldn’t rate patient understanding. Specialists were more likely to answer that they couldn’t rate understanding. Of the specialists, surgeons and medical sub-specialists were less able to rate aspects of patient understanding when compared to neurologists and psychiatrists. The groups that have an easier time rating patient

understanding are sensible. Neurologists and psychiatrists spend more time per visit with a patient than other specialists, as evidenced in their weekly patient load (Table 3-4). Primary care physicians track patients over time and have a responsibility to manage the health of their patients. In some cases they may be at risk for specialist visits or emergency room visits or at least act as a gatekeeper and give authorization for health care visits to professionals other than themselves.

Table 4-9
OHP Patients' Understanding of Managed Care
Weighted

(Percent Responding)	<u>Doctor Rating of Patient Understanding¹</u>				<u>Worse Than Other Managed Care Consumer (%)</u>
	Excellent/ Very Good	Good	Fair/ Poor	Can't Rate	
Managed Care Concept					
Role of Primary Care [^] Provider (N=701)	6	19	67	8	46
The Referral Process [^] (N=701)	4	15	78	3	50
Appropriate Use of the ER [^] (N=696)	3	6	77	14	61
Use of Preventive Care [^] (N=696)	2	10	73	15	53

NOTES: ¹ Percents sum to 100% by row.
[^] First 4 columns sum to 100%. Last column answers a separate question.

SOURCE: 1998 OHPPS

Physicians also compared OHP patient understanding of managed care concepts to the understanding of commercially insured managed care patients. Most doctors (61 percent)

state that OHP patients have a consistently worse understanding of appropriate ER use. About half think patients comprehension of the role of the primary care provider, the specialty referral process and the use of preventative care are worse for OHP patients than for commercially insured patients and about half say it is the same. Only 1-3 percent of physicians think that OHP patients have a better understanding of any of these concepts than commercially insured patients⁴.

We noted that for most of these questions, there were significant differences in the rating distribution between primary care doctors and specialists. Upon closer inspection, there were also differences within these two classifications that encouraged us to run regressions to determine why doctors felt patient understanding was so poor and to see if there were any defining characteristics of the half that felt OHP patients had less understanding than commercial patients.

We defined 2 dependent variables for each of the 4 patient understanding concepts. Table 4-10 shows results of logistic regressions for 4 dependent variables corresponding to the 4 aspects of patient understanding. Each dependent variable equals 1 when the physician responds ‘fair’ or ‘poor’ and 0 for ‘good’ or better. We estimate 3 specifications for each dependent as described below. In Table 4-10, the dependent variable associated with each patient understanding concept equals 1 when the physician responds that OHP patient understanding is ‘worse’ than that of commercial patients and 0 for ‘about the same’ or

⁴ Full results are not shown in Table 4-9 and are available upon request.

Table 4-10

Logistic Regression Results for Fair or Poor Patient Understanding of Four Aspects of Managed Care
Odds Ratios and significance

Independent Variables	Role of PCP			Referral Process			ER Use			Preventative Care		
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)
PCP	1.27	----	----	0.96	----	----	2.55***	----	----	0.58**	----	----
Specialist	Omit	----	----	Omit	----	----	Omit	----	----	Omit	----	----
Strata												
Family Practice	----	2.44**	3.20***	----	1.53	1.58	----	5.68***	5.02***	----	1.46	1.19
Pediatrics	----	1.07	1.17	----	0.88	0.79	----	3.01***	2.11	----	0.28***	0.24***
Internal Medicine	----	2.43**	2.75**	----	2.46**	3.31**	----	11.23***	10.05***	----	3.00**	3.20*
Psychiatry	----	1.63	2.65**	----	1.71	3.16**	----	1.19	0.99	----	1.40	1.30
Neurology/Physiatry	----	1.62	2.24*	----	1.39	1.90	----	3.28**	3.45*	----	1.33	1.05
Surgery	----	2.11**	2.40**	----	2.07*	2.54**	----	4.91***	5.86***	----	4.10***	3.56**
Medical Subspecialty	----	Omit	Omit	----	Omit	Omit	----	Omit	Omit	----	Omit	Omit
Physician Characteristics												
Female	----	----	0.71	----	----	1.17	----	----	2.15*	----	----	0.57
Years in Practice (00s)	----	----	2.57	----	----	0.96	----	----	0.23	----	----	0.01***
Tri-county area	----	----	1.14	----	----	1.78	----	----	1.52	----	----	0.58
Other urban area	----	----	0.64	----	----	1.15	----	----	1.05	----	----	0.68
Rural area	----	----	Omit	----	----	Omit	----	----	Omit	----	----	Omit
Practice Characteristics												
Largest OHP plan pays on capitated basis	----	----	1.04	----	----	1.06	----	----	0.90	----	----	0.75
Patient Load (00s)	----	----	1.90**	----	----	2.36**	----	----	1.48	----	----	1.10
Size of Group (00s)	----	----	1.06	----	----	1.02	----	----	1.08	----	----	1.10
Office Based Practice	----	----	1.53	----	----	0.82	----	----	1.53	----	----	1.68
Largest OHP plan is IPA based	----	----	0.57	----	----	0.72	----	----	0.29*	----	----	0.37**
Largest OHP plan is clinic based	----	----	0.62	----	----	1.23	----	----	0.77	----	----	1.32
For-profit medical group	----	----	1.22	----	----	1.98	----	----	0.53	----	----	0.50
Group owned by a corporate entity	----	----	1.37	----	----	0.83	----	----	1.02	----	----	0.66
Medical school faculty practice	----	----	1.81	----	----	1.66	----	----	1.28	----	----	1.53

NOTES:

*** Chi-square test significant at 1%

** Chi-square test significant at 5%

* Chi-square test significant at 10%

SOURCE: 1998 OHPPS

‘better.’ Again, the regressions are estimated with the logistic model and we report odds ratios and significance.

Odds ratios give more information than coefficients in a logistic regression. The magnitude of the coefficients from a logistic have no real interpretation. Odds ratios are 1.00 for the reference group. For example, a ratio of 2.00 would mean that the associated independent variable makes it twice as likely that a physician rated the patient understanding concept as ‘fair’ or ‘poor’. Values below 1 are the opposite; an odds ratio of 0.5 means that the physician is half as likely as the reference group to have rated the concept as ‘fair’ or ‘poor’, controlling for the other independent variables. The associated significance level is from the Chi-Square test of the coefficient.

For each dependent variable, Table 4-10 shows 3 specifications of independent variables⁵: (1) dummy for primary care physician alone (2) strata dummies alone (3) strata dummies with other characteristics. Primary care is a meaningful distinction for opinion of ER use and preventative care, but surprisingly less so for understanding the role of the primary care physician and the referral process. Generally speaking, primary care physicians are more critical than specialists, with internists being the most critical, family practitioners similarly critical and pediatricians less critical. Surgeons are significantly more critical of all patient understanding categories than medical sub-specialists. Psychiatrist and neurologist/physiatrist categories are intermittently significant as compared to medical sub-specialists. Controlling for other variables does detract from the significance of the strata,

⁵ All include an intercept term as well, which is not reported.

but most of the strata variables maintain significance even when controlling for practice and personal characteristics. In specification (3), at least one added variable is significant and all the chi-square tests show that these variables add significant explanatory power to the regression over specification (2).

Family practitioners, internists and surgeons were more likely to rate understanding of the role of the primary care provider as ‘fair’ or ‘poor.’ Adding practice characteristics increase the size and significance of the strata variables so that psychiatrists and neurologists were also significantly more likely to complain than medical sub-specialists. Only internists and surgeons had a particularly poor opinion of patient understanding of the referral process; the effect was even larger when controlling for patient load and other characteristics, and psychiatry became significant.

Patient load is significant in explaining physician rating of both patient understanding the role of the primary care physician and the referral process. Those with 100 more patients than average are about twice as likely (odds ratios of 1.90 and 2.36) to rate patient understanding as ‘fair’ or ‘poor.’

Internists, family practitioners and surgeons have the worst opinion of OHP patient understanding of ER use, followed closely by neurologists/physiatrists. Pediatrician opinion is insignificantly different from medical sub-specialists once characteristics are added, though the odds ratio is still large. Physician attributes with marginal significance include being female, which makes one more likely to rate patient understanding of ER use poorly,

and working most often with an IPA based plan, which makes one less likely than those who usually work with a commercial plan to complain about inappropriate ER use.

Again, surgeons and internists are the most critical and pediatricians have the best opinion of OHP patient understanding of preventative care. The longer a physician is in practice, the less critical they are of patient understanding of preventative care. As with ER use, physicians in IPA based plans are less critical of patient understanding of preventative care.

Table 4-11 shows logistic results for which physicians thought OHP patient understanding is worse than that of commercial patients. Variables for the percent of total patients that come from OHP were added to specification (3); these were not significant in any of the ‘fair’ or ‘poor’ runs for patient understanding and were therefore omitted. All physicians are fairly critical of OHP patient understanding compared to that of commercial patients and often controlling only for primary care v. specialist physician does not explain the difference between those who think OHP patients were worse and those who think they were about the same as commercial patients. The exception is for ER use, where all PCPs are much more critical than specialists. This is true with the PCP indicator or strata variables. The odds ratios for the strata variables are similar whether controlling for other characteristics or not. Across all 4 concepts, strata variables also have less explanatory power for the ‘worse’ regressions when compared to the ‘fair/poor’ regressions in Table 4-10 and more of the practice characteristics are significant than in the ‘fair/poor’ regressions .

Table 4-11

Logistic Regression Results for Patient Understanding Worse than Other Patients
Odds Ratios and Significance

Independent Variables	Role of PCP			Referral Process			ER Use			Preventative Care		
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)
PCP	1.14	----	----	1.35	----	----	2.42***	----	----	0.95	----	----
Specialist	Omit	----	----	Omit	----	----	Omit	----	----	Omit	----	----
Strata												
Family Practice	----	1.41	1.77	----	1.76*	2.06*	----	4.12***	4.85***	----	1.47	1.52
Pediatrics	----	0.84	1.02	----	0.81	0.97	----	2.22**	3.99***	----	0.57*	0.79
Internal Medicine	----	1.78*	2.25**	----	1.54	1.96*	----	2.93***	3.45**	----	1.93*	1.92
Psychiatry	----	1.02	1.04	----	0.80	0.77	----	0.73	0.68	----	0.98	0.63
Neurology/Physiatry	----	1.70	1.58	----	2.05**	1.92	----	1.80	0.57	----	1.95	1.44
Surgery	----	1.31	1.41	----	1.06	1.08	----	1.87*	1.98	----	1.91*	1.96
Medical Subspecialty	----	Omit	Omit	----	Omit	Omit	----	Omit	Omit	----	Omit	Omit
Physician Characteristics												
Female	----	----	0.70	----	----	0.63	----	----	0.63	----	----	0.62
Years in Practice (00s)	----	----	2.11	----	----	1.39	----	----	0.39	----	----	0.64
Tri-county area	----	----	1.19	----	----	0.72*	----	----	1.11	----	----	0.45**
Other urban area	----	----	0.88	----	----	0.61**	----	----	0.77	----	----	0.50*
Practice Characteristics												
Largest OHP plan pays on capitated basis	----	----	0.63*	----	----	0.53***	----	----	0.77	----	----	0.80
Patient Load (00s)	----	----	0.86	----	----	0.83	----	----	0.53**	----	----	0.56**
Size of Group (00s)	----	----	0.95**	----	----	0.95*	----	----	0.95**	----	----	0.95**
Office Based Practice	----	----	1.19	----	----	1.50	----	----	1.87*	----	----	1.65
Largest OHP plan is IPA based	----	----	0.91	----	----	0.45*	----	----	1.04	----	----	0.35**
Largest OHP plan is clinic based	----	----	1.39	----	----	1.21	----	----	2.37*	----	----	0.84
For-profit medical group	----	----	1.59	----	----	1.93	----	----	0.67	----	----	0.55
Group owned by a corporate entity	----	----	2.04	----	----	2.28*	----	----	1.20	----	----	0.93
Medical school faculty practice	----	----	1.47	----	----	3.92**	----	----	1.19	----	----	0.72
20-40% patients are OHP	----	----	0.64	----	----	0.74	----	----	0.39***	----	----	0.53**
>40% patients are OHP	----	----	0.74	----	----	0.85	----	----	0.34**	----	----	0.77

NOTES:

*** Chi-square test significant at 1%

** Chi-square test significant at 5%

* Chi-square test significant at 10%

SOURCE: 1998 OHPPS

Internists are the most likely to find that OHP patient understanding of the role of the PCP is lacking in comparison with commercial patients. The effect is somewhat mitigated for physicians in a large practice or who are capitated by the plan accounting for the largest number of OHP patients.

Practice characteristics outweigh the importance of the strata variables for comparing patient understanding of the referral process between OHP and commercial patients. Physicians in a medical school faculty practice are very critical, where as those who most often deal with a plan that pays them capitation have the best opinion. Those in 'other urban areas' (Metropolitan Statistical Areas - MSAs - other than Portland) are more likely to feel like their OHP patients have as similar understanding of the referral process to their commercial patients than physicians in either the tri-county (Portland) or rural areas. Portland doctors are marginally less critical of the understanding of the referral process than rural doctors. Larger group size also increases the chance that you feel OHP patients have a similar understanding of the role of the PCP and the referral process. Again, having a large number of patients from an IPA based plan mitigates negative feelings significantly. Two strata variables are marginally significant. Family practitioners are the most critical of understanding the referral process once other characteristics are added in and internists are also more likely to be critical.

As mentioned above, primary care providers are the most critical of OHP patient understanding of appropriate ER use when compared to commercial patients. Primary care physicians are likely to deal with the ER and may be financially liable for inappropriate use

by patients depending on the gate keeping arrangements. In the regression for ER use, several variables other than the strata are significant. The greater the number of OHP patients you serve, the less critical you are of their ER use when compared to commercial patients. By definition, these physicians have fewer commercial patients and may be less likely to be harsh in comparisons, but this finding is not significantly consistent across the four measures of patient understanding. High patient load alone indicates a less critical opinion as well. Large groups are also less critical. Office-based physicians and those who most often deal with a clinic-based plan are marginally more likely to have a poor comparative opinion of ER use than others.

There are moderate differences among specialties for preventative care in specification (2), but the marginal significance disappears when practice and physician characteristics are added. Those in the tri-county area or other MSA have a better opinion than those in rural areas as do those who most regularly deal with an IPA based plan or who have 20-40 percent of their patients from OHP.

Clearly physicians feel that OHP patients do not have a very good understanding of managed care concepts and many feel that OHP patients have less understanding than commercial patients. Physicians who have more contact with adult patients by nature of their specialty have the worst opinions of OHP patients, though those with high patient loads and a large percent of OHP patients are less critical. This is sensible in that physicians with higher patient loads controlling for specialty have less ability to keep track of a single patient

and those who have many OHP patients either prefer to serve the Medicaid population or have fewer complaints about doing so.

In the general comment section, physicians mention other problems that they have with Medicaid patients, though it is unclear that any of these complaints are new to managed care. Examples include:

“OHP patients are also my most challenging, demanding and least appreciative patients...the small minority...who chew up the most time and resources”

“Do not take responsibility for their own health care, do not have respect for the system, non-compliant, miss appointments, don't take meds...”

“Come with a laundry list of wants and needs far exceeding non-OHP new members”

The problem with managed care and the added demands of OHP patients for physicians is that physician time is being squeezed by managed care plans and reimbursement, yet the patients take even more time because they don't understand the system. Another view provides some insight as to how the OHP can help educate patients is voiced by another physician:

“It is good to be able to deny superfluous services. Too many OHP patients see it as an entitlement and try to ‘bilk’ the system or at least be irresponsible in its use. Denying unnecessary services, ER visits, etc...is slowly teaching more responsibility...”

While patients may not fully understand managed care concepts, even after 4 years of OHP, physicians like the fact that OHP encourages the use of preventative care and appropriate use of medical services. And even though the patients may not have a firm grasp

of managed care concepts, some physicians are happy with the program because there is a PCP, there is continuity of care and preventative care can happen.

4.5 Physician Opinion of Individual OHP Plans

Several of the plans that serve Medicaid patients serve Medicaid patients only. Some of these plans were formed by physician Independent Practice Associations (IPAs) or clinics that traditionally treat the Medicaid population. Medicaid-only plans are common in many states even when the requirements to form a managed care plan are uniform across possible populations. Prior to our study, little research has been done on the administrative capacity and ease of physician contacting of these plans; we approach these issues from the perspective of physicians who work with the plans.

In order to focus on specific plans, we asked physicians to focus on “the managed care plan that accounts for the largest number of OHP patients that you see through your main medical group.” The questions in this section all refer to this plan. Physicians name a specific plan and we classified these plans as IPA based, clinic based, commercial and behavioral. Only psychiatrists primarily contract with behavioral health plans, so we do not separate these plans in our analysis.

Table 4-12 summarizes questions about general contracting issues. About 20 percent of physicians said they felt pressure to take on new patients. PCPs were more likely to say plans pressured them; 32 percent of PCPs answered ‘yes’ to the question versus 10 percent

Table 4-12

Contracting and Administrative Dealings with Plans

(Percent Responding)

All the plan specific questions refer to the managed care plan that accounts for the largest number of OHP patients that you see through your main medical group.

			Yes	No			
1.	Do you feel that this managed care plan pressures your main medical group to accept new OHP patients that you do not want to accept^a?	PCPs	32	68			
		Specialists	10	90			
		Total	22	78			
			Clinic Based	15	85		
		IPA Based	24	76			
		FFS w/ Incentives	FFS w/o Incentives	Capitation All Services	Capitation Some Services	Salary	
2.	Which payment methods account for the largest amount of revenue your main medical group receives from this managed care plan^a	PCPs	27	11	34	25	3
		Specialists	33	45	13	5	4
		Total	30	28	24	15	3
3.	Thinking only about your OHP patients enrolled in this managed care plan, how difficult or easy is it to verify with the managed care plan...			Very Difficult	Somewhat Difficult	Somewhat Easy	Very Easy
		A. That patients are enrolled in the managed care plan^a	PCPs	5	32	43	20
			Specialists	4	29	39	28
			Total	5	30	41	24
		B. The name of the patient's Primary care physician^a?	PCPs	8	26	45	21
			Specialists	6	21	42	31
			Total	7	24	43	26

Table 4-12 (continued)

Contracting and Administrative Dealings with Plans

4. Is this managed care plan's performance for its OHP members worse, about the same or better than the performance of managed care plans in general on the following aspects of patient care? (sud04.out)		Worse	About the Same	Better	Can't Say
A. That patients are enrolled in the managed care plan^a	PCPs	5	66	14	15
	Specialists	11	64	12	13
	Total	9	65	13	14
B. The name of the patient's Primary care physician^a?	PCPs	4	66	13	17
	Specialists	13	66	9	12
	Total	9	66	11	14

NOTES: ^aEach row sums to 100%

SOURCE: 1998 OHPPS

of specialists. Physicians who most often contracted with a clinic based HMO were less likely to feel this pressure (15 percent v. 24 percent for IPA based or commercial).

It is not surprising, given the different contracting mechanisms between specialties that there is so much variation in physician opinion of and experience with the Oregon Health Plan. Capping patient services is less relevant for specialists because they don't see a given patient regularly, and the referral process itself limits the number of patients a specialist will see at all. Responses to question 2 on Table 4-12 shows that 59 percent of primary care physicians are subject to some form of capitation with the plan through which they see the largest number of OHP patients whereas only 18 percent of specialists have any form of capitation.

Very few physicians feel it is 'very difficult' to verify that a patient is in a particular OHP plan (5 percent) or to identify their primary care provider (7 percent). Most answered that it is 'somewhat' or 'very' easy to verify that a patient is in a particular plan (65 percent) and identify their primary care provider (69 percent). Only 9 percent feel it is worse than verifying either plan enrollment or identifying the primary care physician with commercial plans. Specialists have a better opinion of these verifications than primary care providers though the difference in distribution is not significant.

In rating quality and access for managed care patients, physicians generally said that the plan they most often contract with provided at least good access to specialty referrals, inpatient care and quality assurance processes.⁶ Table 4-13 shows the distribution of

⁶ Many physicians (20 percent) found it difficult to rate plan quality assurance processes. Because many didn't provide a valid answer or were missing information on independent variables, we do not analyze opinion of QR/UR further.

Table 4-13

**OHP Plan Ratings
Weighted**

<u>Managed Care Feature</u>	<u>Doctor Rating of Medicaid Plan</u>				<u>Worse Than Other Manged Care Consumers</u>
	<u>Excellent/ Very Good</u>	<u>Good</u>	<u>Fair/ Poor</u>	<u>Can't Rate</u>	
Access to Specialty Referrals (N=659)	32	37	25	6	11
Access to Inpatient Care (N=654)	41	34	14	11	4
Quality Assurance/ Utilization Review Procedures (N=645)	22	33	25	20	7
Reimbursement Rates (N=641)	4	16	70	10	45
Ability to Provide Necessary Care (N=657)	24	30	44	2	18
Timely ID of Primary Care Physician (N=640)	18	30	37	15	9

NOTES: * Rows sum to 100% in first four columns. Last column reports the answer to a separate question.

SOURCE: 1998 OHPPS

physician ratings of plan features. Overall, ratings of OHP plans are better than ratings of OHP patients. Opinion of reimbursement rates is an exception. Physicians not only feel that rates were generally inadequate (70 percent answered ‘fair’ or ‘poor’), but also 45 percent answer that OHP rates were worse than commercial rates. Many of the general comments about OHP discussed in Section 4.7 also concern low rates and reimbursement.

Reports by Milliman and Roberts (1998) and Henry and Associates (1999) confirm that physicians are receiving less per service between 1993-1994 and 1997-1998. “A greater portion of OMAP dollars continues to flow to hospitals. Physicians received little, if any, of the 10 percent increase in state allocated resources in FY1997-1998.” (Henry and Associates, 1999). The Henry report also confirms that OHP physician payments are 50-65 percent of commercial payments (ibid) and hypothesizes that low rates could explain why some physicians have stopped serving OHP patients.

Physicians are somewhat negative about their ability to provide necessary care and the timely identification of a primary care doctor, where 44 percent and 37 percent respectively answer ‘fair’ or ‘poor.’ Less than 20 percent feel either is worse than commercial plans. Access to referrals and inpatient care is generally good. Other than rates, most physicians feel that OHP plans rated similarly to commercial plans for these measures.

Table 4-14 shows logistic regression results that build upon the frequency analyses for whether or not a physician rated plans ‘fair’ or ‘poor’ along these dimensions. Definition of the dependent variables and specification of the regressions is the same as for the patient understanding regressions. The first column shows the plan characteristics solely as a

Table 4-14

Logistic Regression Results for Fair or Poor Plan Interactions
Odds Ratios and significance

Independent Variables	Access to specialty referral			Access to inpatient care			Adequacy of Rates			Clinical Autonomy			Timely ID of PCP		
	(1)	(2)	(3)	(1)	(2)	(3) ^a	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)
PCP	0.42***	----	----	0.47**	----	----	0.96	----	----	0.83	----	----	1.53**	----	----
Specialist	Omit	----	----	Omit	----	----	Omit	----	----	Omit	----	----	Omit	----	----
Strata															
Family Practice	----	0.45**	0.27***	----	1.18	----	0.61	0.56	----	0.91	0.50*	----	3.28***	2.28**	
Pediatrics	----	0.29***	0.13***	----	0.28**	----	0.38**	0.33**	----	0.37***	0.16***	----	1.44	0.85	
Internal Medicine	----	0.31***	0.31***	----	0.39	----	0.63	0.52	----	0.78	0.69	----	1.39	1.31	
Psychiatry	----	1.73	1.83	----	1.92	----	0.38**	0.44	----	1.37	1.46	----	2.67**	2.13	
Neurology/Physiatry	----	1.21	0.95	----	1.33	----	3.00	3.06	----	1.49	1.27	----	1.40	0.79	
Surgery	----	0.74	0.47**	----	1.58	----	0.57	0.53	----	0.71	0.61	----	1.38	1.42	
Medical Subspecialty	----	Omit	Omit	----	Omit	----	Omit	Omit	----	Omit	Omit	----	Omit	Omit	
Physician Characteristics															
Female	----	----	0.87	----	----	----	----	1.35	----	----	1.96**	----	----	1.80*	
Years in Practice (00s)	----	----	4.11	----	----	----	----	0.16	----	----	0.77	----	----	0.41	
Tri-county area	----	----	0.67	----	----	----	----	1.15	----	----	0.59	----	----	1.56	
Other urban area	----	----	0.44*	----	----	----	----	0.62*	----	----	0.57	----	----	1.41	
Practice Characteristics															
Largest OHP plan pays on capitated basis	----	----	0.63	----	----	----	----	0.83	----	----	0.89	----	----	1.22	
Patient Load (00s)	----	----	0.56	----	----	----	----	1.29	----	----	1.45	----	----	0.79	
Size of Group (00s)	----	----	0.54*	----	----	----	----	0.59***	----	----	0.54***	----	----	0.74*	
Office Based Practice	----	----	1.34	----	----	----	----	1.10	----	----	1.09	----	----	1.04	
Largest OHP plan is IPA based	----	----	0.30**	----	----	----	----	0.45	----	----	0.42*	----	----	1.13	
Largest OHP plan is clinic based	----	----	0.83	----	----	----	----	0.82	----	----	0.98	----	----	1.61	
For-profit medical group	----	----	3.37*	----	----	----	----	2.56	----	----	5.77***	----	----	2.80*	
Group owned by a corporate entity	----	----	1.32	----	----	----	----	1.87	----	----	2.97**	----	----	0.88	
Medical school faculty practice	----	----	3.49*	----	----	----	----	0.84	----	----	1.79	----	----	1.41	
OHP makes up 21-40% of patients	----	----	1.13	----	----	----	----	0.91	----	----	1.31	----	----	2.11**	
OHP makes up >40% of patients	----	----	0.84	----	----	----	----	0.31**	----	----	0.89	----	----	1.34	

NOTES:

*** Chi-square test significant at 1%

** Chi-square test significant at 5%

* Chi-square test significant at 10%

^a Not enough variation in the dependent variable to estimate full model.

SOURCE: 1998 OHPPS

function of primary care physician status and the second uses strata dummies as compared to medical sub-specialists. While primary care provider alone is not always significant, at least one strata variable is significant for each feature and specification. Using the strata variables can also explain details that are not inherently obvious from the PCP/specialist division. The third column contains the full specification of characteristics. Again, we report odds ratios and significance. The relation between independent and dependent variables can be made by comparing the size and significance of these ratios against the r e f e r e n c e g r o u p .

Starting with how physicians rate access to specialty referral, primary care providers are less likely (odds ratio significantly less than 1) to rate access as ‘fair’ or ‘poor.’ This is sensible since PCPs often control access to specialty care by acting as a gatekeeper. The specification with only strata variables, (2), shows that *all types* of primary care providers are more likely to have a better opinion of access to specialty care than medical sub-specialists and there are no significant differences between medical sub-specialists and other types of specialists. Adding characteristics, in the third specification of access to specialty referral, surgeons are also less critical than medical sub-specialists. Also from that specification, physicians using an IPA based plan, in MSAs other than Portland, or in a larger group, are less likely to complain about access to specialty care. Those in for-profit groups and medical school faculty practices are more likely to rate specialist access as ‘fair’ or ‘poor.’ Other than the effect of IPA physicians, these variables have marginal significance though the odds ratios would indicate a fairly large effect.

For access to inpatient care, all had a relatively good opinion of access, and pediatricians had a particularly good opinion of their access to inpatient care. Psychiatrists are most likely to give a low rating, but their ratings are not significantly different from those of medical sub-specialists. There are too few (N=57) who answered 'fair' or 'poor' to include the full specification for access to inpatient care.

The reimbursement rate findings from the frequency analysis of opinion of rates is confirmed in the multivariate analysis of strata. Medical sub-specialists are more likely than every group, other than neurologists/physiatrists, to answer 'fair' or 'poor,' though the difference is only significant for psychiatrists and pediatricians, and only pediatricians once practice characteristics are added. Groups that had better opinions of rates included those who were in larger groups and had a large percentage of OHP patients. Physicians in other urban areas had a slightly better opinion than either physicians in the Portland area or rural counties, though the difference had marginal significance.

Pediatricians were significantly less likely to rate clinical autonomy as 'fair' or 'poor' than other physicians. They are even less likely (smaller odds ratio) when controlling for practice characteristics. Female doctors, doctors in small groups and doctors in for-profit or corporately owned groups had a much greater propensity to complain about autonomy.

Family practitioners were most likely to complain about the timely identification of a primary care provider for new patients. With strata only, psychiatrists are also likely to rate PCP identification as 'fair' or 'poor,' but the significance diminishes when additional

controls are added. Physicians in for-profit groups and groups with 20-40 percent of patients from OHP were the most likely to complain.

The regressions for ‘worse’ plan interactions in Table 4-15 have less explanatory power than other regressions. Differences between primary care practitioners and specialists are small, as are differences between strata other than timely identification of a primary care practitioner. Access to inpatient care and timely identification of a primary care practitioner have too few responses to run robust regressions. The most important finding from this table is that the rural doctors fare the worst when compared with commercial plans for rates and clinical autonomy. Another important finding is that those with a high percentage of OHP patients are *less* likely to complain about the adequacy of rates in comparison to commercial plans.

4.6 Treating OHP Members with Disabilities

Because Oregon requires its disabled population to enroll in Medicaid managed care plans, we asked physicians specifically about their experience treating this population. We are concerned not only with how well the OHP is treating patients in general, but have a special interest in whether or not managed care serves the needs of the disabled as other states consider requiring their disabled Medicaid population to enroll in managed care plans. The priority list and other features of managed care, such as gatekeepers, may affect access to certain types of care that are more commonly used by the disabled population than other

Table 4-15

Logistic Regression Results for Plan Interaction Worse than Other Plans
Odds Ratios and significance

Independent Variables	Access to specialty referral			Access to inpatient care			Adequacy of Rates			Clinical Autonomy			Timely ID of PCP			
	(1)	(2)	(3)	(1)	(2)a	(3)a	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)a	(3)a	(2)
PCP	1.04	----	----	1.33	----	----	1.00	----	----	0.99	----	----	0.61	----	----	----
Specialist	Omit	----	----	Omit	----	----	Omit	----	----	Omit	----	----	----	----	----	----
Strata																
Family Practice	----	1.10	0.58	----	----	----	----	0.83	0.75	----	1.22	0.75	----	----	----	8.30**
Pediatrics	----	0.61	0.32*	----	----	----	----	0.68	0.97	----	0.47*	0.21***	----	----	----	14.78**
Internal Medicine	----	1.49	1.32	----	----	----	----	0.92	0.71	----	0.93	0.68	----	----	----	7.05*
Psychiatry	----	1.76	2.60	----	----	----	----	0.50*	0.46	----	1.04	1.04	----	----	----	6.66
Neurology/Physiatry	----	2.28	1.96	----	----	----	----	1.04	0.64	----	0.75	0.55	----	----	----	8.77**
Surgery	----	1.22	0.85	----	----	----	----	0.88	0.67	----	0.98	0.89	----	----	----	5.83
Medical Subspecialty	----	Omit	Omit	----	----	----	----	Omit	Omit	----	Omit	Omit	----	----	----	Omit
Physician Characteristics																
Female	----	----	0.38*	----	----	----	----	----	1.60	----	----	1.42	----	----	----	----
Years in Practice (00s)	----	----	0.40	----	----	----	----	----	0.27	----	----	0.35	----	----	----	----
Tri-county area	----	----	0.41	----	----	----	----	----	0.20***	----	----	0.26***	----	----	----	----
Other urban area	----	----	0.57	----	----	----	----	----	0.25***	----	----	0.28***	----	----	----	----
Practice Characteristics																
Largest OHP plan pays on capitated basis	----	----	1.16	----	----	----	----	----	0.74	----	----	0.96	----	----	----	----
Patient Load (00s)	----	----	1.35	----	----	----	----	----	0.76	----	----	1.22	----	----	----	----
Size of Group (00s)	----	----	0.96	----	----	----	----	----	0.75*	----	----	0.98	----	----	----	----
Office Based Practice	----	----	1.62	----	----	----	----	----	0.98	----	----	1.47	----	----	----	----
Largest OHP plan is IPA based	----	----	0.81	----	----	----	----	----	0.78	----	----	0.40*	----	----	----	----
Largest OHP plan is clinic based	----	----	1.39	----	----	----	----	----	0.67	----	----	0.93	----	----	----	----
For-profit medical group	----	----	2.60	----	----	----	----	----	0.54	----	----	0.84	----	----	----	----
Group owned by a corporate entity	----	----	1.28	----	----	----	----	----	0.58	----	----	0.93	----	----	----	----
Medical school faculty practice	----	----	3.92	----	----	----	----	----	1.52	----	----	1.24	----	----	----	----
OHP makes up 21-40% of patients	----	----	1.76	----	----	----	----	----	0.81	----	----	1.60	----	----	----	----
OHP makes up >40% of patients	----	----	1.43	----	----	----	----	----	0.24***	----	----	0.46	----	----	----	----

NOTES:

*** Chi-square test significant at 1%

** Chi-square test significant at 5%

* Chi-square test significant at 10%

^a Not enough variation in the dependent variable to estimate full model.

SOURCE: 1998 OHPPS

Medicaid recipients. Since people with disabilities represent a minority of patients, it is possible to lose their experience by only looking at the average OHP client.

Most physicians in our survey treat persons who are disabled; 94 percent of primary care physicians and 87 percent of specialists respond that they treat OHP members who are disabled. For this sub-sample of physicians, we asked several questions related to caring for the disabled and report results in Table 4-16. The disabled do not make up the majority of OHP patients for the physicians who serve disabled OHP members. Ninety percent of primary care physicians and 79 percent of specialists report that 1-20 percent of their OHP patients are functionally disabled. For the mental health and neurology/physiatry strata, the distribution is significantly different. Only 46 percent say that people with disabilities make up 1-20 percent of their OHP patients. Twenty-one percent report that people with disabilities make up 21-40 percent of their patients, 10 percent say 41-60 percent, 16 percent answer 61-80 and 7 percent answer 81-100 percent. These numbers are even higher for psychiatrists alone where 45 percent respond that disabled patients compose 81-100 percent of their OHP patients.⁷

The majority of physicians feel that the number of people with disabilities seeking care at their medical group is the same as before OHP, but a substantial minority of primary care physicians report an increase. Fifty-eight percent of primary care physicians and 80 percent of specialists report about the same number of disabled and 34 percent of primary care physicians and 15 percent of specialists report an increase. Psychiatrists are more likely

⁷ Within strata, numbers are not weighted. All other numbers are weighted.

Table 4-16

Treating OHP Members with Disabilities^a

				Yes	No
Do you treat persons whose ability to function is limited by physical, mental or developmental disabilities?	Primary Care Physicians			94	6
	Referral Physicians			87	13
Approximately what percentage of your patients of your patients are functionally limited by physician, mental or developmental disabilities?	1-20%	Physicians	Specialty Physicians	Psychiatrists, Neurologists & Psychiatrists	Psychiatrists
	21-40%	90	79	46	17
	41-60%	5	7	21	13
	61-80%	1	4	10	12
	81-100%	1	3	16	12
	Missing	0	6	7	45
	3	1	0	1	
Has the number of disabled patients seeking care from your main medical group decreased, stayed the same, or increased as a result of OHP coverage for persons with disabilities?	Decreased	Physicians	Specialty Physicians	Psychiatrists	
	Stayed the same	1	3	5	
	Increased	58	80	64	
	Missing	34	15	30	
		7	2	1	
Have you made any accommodations in your office (e.g., modifying office space, or hiring new staff) as a result of OHP coverage for persons with disabilities?	Primary Care Physicians	Yes	No	Missing	
	Specialty Physicians	14	82	4	
		8	91	1	

NOTES: ^a Answers to each question sum to 100% in each column.

SOURCE: 1998 OHPPS

to report an increase than other specialists with 30 percent within the strata reporting an increase in the number of OHP disabled patients they see. Very few physicians (1 percent of PCPs and 3 percent of specialists) experience a decrease in the number of disabled seeking care at their main medical group.

Several physicians note that they have made accommodations in their office for OHP persons with disabilities - 14 percent of primary care physicians and 8 percent of specialists. Most of the physicians who answered 'yes' to this question (49 out of 65) also wrote in responses as to what type of accommodations they made. Twenty-four physicians indicated that they hired new staff as a result of OHP coverage for persons with disabilities. The staff listed were mostly administrative to deal with additional paperwork such as billers, claims specialists, and insurance specialists. Two practices added medical staff (a nurse practitioner and a physician). Some physicians indicated the new staff was temporary. Several physicians also made changes to office space such as providing wheelchair access, adding railings in the bathrooms and widening doors.

Physicians were asked to rate specific aspects of care that are relevant for people with disabilities on a Likert scale of 'excellent' to 'poor'. Many specialists respond 'can't say', which was an additional option. The question asks how good OHP is at meeting the needs of people with disabilities and Table 4-17 lists the results. A rating of fair or poor would mean that the physician feels that OHP does not do a good job of meeting the needs of disabled people who require these services. Across all the features we asked about, very few physicians give a rating of 'very good' or 'excellent'. The best ratings were for prescription

Table 4-17

How good is OHP at meeting the following needs of people with disabilities?

	Poor	Fair	Good	Very Good	Excellent	Can't Say	Missing
A. Referrals to medical specialists							
Primary Care Physicians	3	24	46	14	6	6	1
Referral Physicians	7	21	32	7	4	28	1
B. Home health care							
Primary Care Physicians	4	22	41	9	2	19	3
Referral Physicians	3	12	18	7	2	57	1
C. Rehabilitation Services (e.g. physical, occupational, or speech therapy)							
Primary Care Physicians	12	32	33	7	3	11	2
Referral Physicians	8	15	15	6	2	52	2
D. Care coordination							
Primary Care Physicians	6	38	33	6	2	13	2
Referral Physicians	6	16	17	8	2	50	1
E. Prescription medicines							
Primary Care Physicians	11	25	38	13	5	6	2
Referral Physicians	8	16	22	11	4	39	0
F. Durable medical equipment							
Primary Care Physicians	7	28	38	9	2	15	1
Referral Physicians	5	17	14	6	2	55	1
G. Transportation services							
Primary Care Physicians	7	21	28	7	2	31	4
Referral Physicians	5	14	17	7	1	55	1
H. Outpatient substance abuse treatment							
Primary Care Physicians	15	28	16	6	1	31	3
Referral Physicians	5	8	7	3	1	75	1

Table 4-17 (continued)

How good is OHP at meeting the following needs of people with disabilities?

	Poor	Fair	Good	Very Good	Excellent	Can' t Say	Missing
I. Inpatient substance abuse treatment							
Primary Care Physicians	20	21	15	4	0	36	4
Referral Physicians	6	7	5	2	1	77	2
J. Outpatient mental health treatment							
Primary Care Physicians	25	37	21	4	1	11	1
Referral Physicians	7	9	7	5	1	71	0
K. Inpatient mental health treatment							
Primary Care Physicians	19	25	21	5	1	26	3
Referral Physicians	4	8	7	5	2	73	1
L. Emergency medical care							
Primary Care Physicians	2	16	48	17	11	6	0
Referral Physicians	1	11	29	10	5	43	1

NOTES: All rows sum to 100%.

SOURCE: 1998 OHPPS

medicines (E) and emergency medical care (L). Twenty-eight percent of PCPs and 15 percent of specialists report that emergency medical care was ‘very good’ or ‘excellent’. Eighteen percent of PCPs and 15 percent of specialists report that OHP is ‘very good’ or ‘excellent’ at meeting the needs of people who require prescription medicine. The modal answer of most other questions from primary care physicians is ‘good’ and among specialists is ‘can’t say’.

Overall, a large number of specialists can’t rate how well OHP meets the needs of the disabled population. This is sensible because most of the statements concern services that would be referred by a PCP. Those that can answer generally give middling to poor answers to all aspects of care. However, physicians do not agree that people with disabilities fare worse under managed care or the priority list than other OHP members (Table 4-18). Seventy-eight percent of both primary care and specialists report that OHP members with disabilities fare about the same as those without and 85 percent of PCPs and 76 percent of specialists report members with disabilities fare about the same under the priority list and managed care as members without disabilities. We did not ask generally about quality of care under OHP, but did ask physicians to document whether or not the priority list affected the quality of care they are able to provide their patients. The difference is subtle, but many of the needs described in Table 4-17 are met by other providers than the physicians themselves.

The worst ratings by primary care providers are for inpatient and outpatient mental health (J and K). Forty-four and 62 percent of PCPs rate the respective types of mental health as ‘fair’ or ‘poor’. Physicians also consider inpatient and outpatient substance abuse treatment (H and I) to be relatively poor with 41 percent and 43 percent respectively answering ‘fair’ or ‘poor’. Forty-four percent of primary care physicians also rated rehabilitation services (C) as ‘fair’ or ‘poor’.

The general free-form comments from physicians support the notion that patients with severe mental health problems do worse under OHP. They allege that patients lose long-time providers, are denied extensive therapy and are managed by professionals who are not supervised by psychiatrists. Physicians view the separation of physical and mental health care as detrimental for the patients and expensive for the state in the long run. As mentioned in Section 4.1 on participation, psychiatrists feel the mental health system is a mess. There were only 2 positive general comments about the mental health system, both related to improved access to medications. Still, others criticize the OHP for not covering important drugs for mental health patients.

While physicians are clearly concerned about the state of mental health, it is important to keep a few things in mind. The designers of OHP aimed for mental health parity which would bring mental health coverage up to that of physical health. Most private insurance would not meet this standard and access to any mental health coverage is not typical of any insurance. The lofty goal of covering mental health and integrating it with physical health is laudable, but one must remember that this goal has not been accomplished

in any general way and the necessary ties between mental and physical health professionals are not developed instantly. The mental health system had just started statewide managed care at the time of the survey, so there may have been confusion on the part of plans and physicians about requests for referrals and denials of those referrals.

OHP expanded the range of benefits covered and who was eligible to receive those benefits. Previously, only those who were a danger to themselves or others qualified for mental health services. Now, anyone in the traditional or expansion population can receive care for the 38 of 50 condition treatment pairs that are above the line.

It is also possible that the most severely mentally ill patients have been lost in the shuffle of managed care. It is problematic that any physicians comment that clients are losing long term providers. Maintaining relationships with existing providers and continuity of care are issues that would allow a person to be exempt from managed care and remain in the fee-for-service system. If for some reason this is not happening for people with mental illness it would be cause for concern at enrollment.

Using professionals other than psychiatrists to manage many mental health needs may be a good way of getting care to a more general population, but may be an inadequate level of attention for severe cases. It is not obvious from the survey how widespread this problem might be since this complaint occurred more in the comments and not in a direct question. Denial of extensive therapy could also pose more problems for the population with on-going needs. The state may further wish to investigate these issues once the managed care system

has been integrated across the state for a period of time and ascertain the level of the problem.

Free-form comments give insight as to why physicians give the answers they do. Physicians who think that disabled patients have an advantage over regular OHP patients provide reasons such as:

- Expansion and better coordination of services
- Higher likelihood of diagnoses of the disabled being above the priority line
- Receive added attention due to disability status

Physicians also note that the disabled fare better under OHP than commercial insurance because they feel the government acts as a good advocate for those with disabilities. Those who say disabled patients are at a disadvantage compared to regular OHP members list several reasons:

- Limited scope of services
- Reimbursement is insufficient to cover the needs of these patients.
- Difficult to get adequate durable equipment, rehabilitation services and mental health services, which disabled patients require more of
- Uncovered conditions such as allergies or musculo-skeletal pain have a stronger negative impact on a disabled person compared to a relatively healthy individual
- Patients cannot navigate the system and advocate for themselves to receive needed services
- PCPs lack adequate expertise to manage complex medical cases that are common among the disabled Medicaid population

Some of these points are diametrically opposed such as the expanded v. limited scope of services, but there are more negative comments than positive ones. Overall, there are some problems obtaining necessary services, particularly for mental health. However, Table 4-18

Table 4-18

How do OHP Members with Disabilities Fare?

		Primary Care Physicians	Specialty Physicians
Do OHP members with disabilities fare about the same, worse or better <u>in managed care plans</u> than OHP members without disabilities?	About the Same	78	78
	Worse	13	9
	Better	7	5
	Missing	2	8
Do OHP members with disabilities fare about the same, worse or better <u>under the priority list</u> than OHP members without disabilities?	About the Same	85	76
	Worse	8	10
	Better	4	4
	Missing	6	10

NOTES: Answers to each question sum to 100% by column.

SOURCE: 1998 OHPPS

shows that there is no consensus that disabled OHP patients fare worse under OHP per se than others. Clearly anyone in need of some of the services listed in Table 4-17, no matter what their eligibility group, will have concerns under OHP.

4.7 How is OHP doing?

This section addresses general issues about how physicians work with OHP and view the program in general. The specific questions pertain to participants and we also summarize some of the general opinions that were solicited from all respondents. Guidelines, communication with OMAP, and physician experience with uninsured patients over the past few years are issues of wide ranging importance that are covered in this section.

Most physicians participating in OHP had previously participated in Medicaid, 94 and 98 percent for primary care and specialists respectively (Table 4-19). Significantly fewer primary care physicians are currently accepting new patients (79 percent) and even fewer accept new OHP patients (68 percent) compared to specialists. For most participating physicians, OHP patients make up 1-20 percent of their overall patient load, though primary care specialists are more likely to have OHP make up 20-40 percent of their patient load.

Physicians are generally less likely to make OHP patients sign a form assuming financial liability for uncovered expenses than they are to make privately insured patients sign such a form. Table 4-19 shows that 47 percent of responding physicians never have patients sign a liability form and 19 percent rarely do, where as 29 percent never have privately insured patients sign a form and 20 percent rarely do. While 65 percent of doctors

Table 4-19

Participant Relation to OHP/Medicaid

	<u>Primary Care</u>	<u>Referring</u>	<u>Total</u>
% Accepted Medicaid pre-OHP and were in practice in Oregon	94	98	96
% Accepting new patients	79	97	88
% Accepting new OHP patients	68	97	83
% of physicians who see _____ OHP as a % of practice^a			
1-20%	68	82	75
21-40%	24	12	18
41-60%	5	4	4
61-80%	2	1	2
81-100%	1	1	1
% of physicians usually or always able to identify OHP patients	76	60	69
% physicians who have OHP patients sign for financial liability of uncovered services^a			
Never	41	52	47
Rarely	22	15	19
Sometimes	14	9	11
Usually	8	9	8
Always	15	15	15
% of physicians who have commercial patients sign for financial liability of uncovered services^a			
Never	25	32	29
Rarely	27	13	20
Sometimes	16	13	14
Usually	12	15	14
Always	20	27	23
% of physicians who think the number of uninsured they see has^a			
Increased	4	6	5
Stayed the same	37	41	39
Decreased	59	53	56

Table 4-19 (continued)

Participant Relation to OHP/Medicaid

	<u>Primary Care</u>	<u>Referring</u>	<u>Total</u>
% of physicians implementing new guidelines in response to OHP			
	10	11	10
How would you rate communication about OHP?			
Information received about Pre-implementation^a			
Poor	17	15	16
Fair	46	38	42
Good	32	36	34
Very Good	4	9	7
Excellent	1	2	1
Information received about changes in OHP^a			
Poor	20	19	20
Fair	45	34	40
Good	30	35	32
Very Good	4	10	7
Excellent	1	2	1

NOTES: ^aSums to 100% by column within category

SOURCE: Weighted Results from 1998 OHPPS.

have the same policy for OHP and commercial patients, 27 percent are more lenient for OHP patients and only 9 percent are more likely to have an OHP person sign for liability than a commercial patient.⁸

Very few (5 percent) thought that the number of uninsured patients they saw had increased since the implementation of OHP. Fifty-six percent (56 percent) said the number had decreased and the rest thought it was about the same. A chi-square distribution test shows no significant differences between the responses of primary care physicians and specialists.

Only about 10 percent of respondents (689 answered the question) said they implemented formal guidelines for care of certain conditions in response to OHP. About 66 percent of physicians mention specific conditions (44 of 67).⁹ Asthma (11) is the most common response. Diabetes (7), hernias (6) and musculo-skeletal problems (7) were mentioned by several. A few highlighted mental health, allergies, and cardiovascular problems.

We also asked physicians to rate communication about OHP, both before implementation and receiving information about changes. Again, a majority (58 percent) answered fair or poor and a significant minority, about 34 percent said ‘good’. Primary care providers are more likely to have a worse opinion of communication than specialty providers,

⁸ Cross tabulation is not shown, available from author upon request.

⁹ These counts are un-weighted.

with 63 percent of primary care physicians saying ‘fair’ or ‘poor’ and only 52 percent of specialists saying the same.¹⁰

All surveyed physicians were asked to write a free form opinion of how they feel OHP is working. Nearly 60 percent of respondents wrote a comment in the space provided.¹¹ Except for the few physicians who give OHP a mixed review, most of the answers are either very positive and supportive of OHP, or extremely negative. Interestingly, this dichotomy exists among both participating and non-participating physicians. Results are presented in Table 4-20. The most common negative answers given were related to reimbursement rates, priority list and ‘below-the-line’ conditions, mental health coverage, and particular characteristics of OHP patient population. There are an approximately equal number of physicians evaluating OHP positively as negatively (159 positive vs. 172 negative responses among participating physicians). However, those who support the plan tend to produce more general comments such as “*OHP does a good job considering limited funding*” or “*better than having nothing*” and discuss larger issues of access and equity. Those who assess OHP negatively are more likely to provide precise complains about burdensome paperwork, specific medical conditions (such as allergic rhinitis and hernias) that are not covered under the OHP, and difficulty in working with OHP patients.

¹⁰ The chi-square distribution tests are significant at 5 percent for communication pre-implementation and 1 percent post-implementation.

¹¹ We did not weight the counts of individual comments in this section.

Table 4-20

Summary of Open-Ended Opinions of OHP

Unweighted Counts			
<u>Comment</u>	<u>Participants</u>	<u>Comment</u>	<u>Non-Participants</u>
Positive			
Overall good job	94	Overall good job	14
Improved access	29	Improves access	2
Better than alternatives	18	Honest approach	1
Priority list is a positive development	10	Quality of care	1
Needs expansion nationally	8		
Total	159		18
Negative			
Financial loss	55	Low reimbursement	10
Priority List limits	43	Priority List limits	3
Problems with mental health	29	Mental health	3
Burdensome paperwork	14	Difficult patients	3
Complex and difficult patients	19	Used by other states	1
Need for cost-sharing	9	Need for co-pays	1
Mandatory participation	3	Too much paperwork	1
Total	172		22
Ambiguous responses	63		31
Total # of responses	394		71

SOURCE: 1998 OHPPS

Supporters of OHP see it as a way to expand access and coverage to indigent populations, and the best effort yet in reforming Medicaid. They perceive OHP as a precursor to universal coverage and an “*honest*” way to deal with the issues of care rationing, especially if more uninsured gain access to health care. Additionally, the OHP model is praised for encouraging preventive medicine, education, reducing stigma associated with Medicaid, and forging closer ties between providers and patients.

OHP critics are forceful in voicing their unhappiness with low reimbursement rates.

Comments include:

“It is killing us financially”

“I lose money when caring for OHP patients”

“Does not cover overhead costs and pays MD’s nothing”

“Way underfunded- we frequently pay to take care of these patients”

“We would love to get out of OHP because of the incredibly low levels of reimbursement, which does not even cover our office expenses, let alone our pay”

Among those who do not participate in OHP, there is a higher concentration of specialists who provide treatments that are not covered or are limited by the priority list, such as psychiatrists, psychoanalysts, dermatologists, and physiatrists. Basic issues remain the same across positive and negative assessments of OHP, with the only difference that non-participating physicians choose not to accept the low reimbursement rates rather than face real financial loss, suffered by participating physicians.

Another issue that raises a lot of negative comments is the new structure of mental health benefits, which is referred to as a “*disaster*.” There are only two positive comments about the mental health services, both related to improved access to medications. However, the list of negative comments is pretty extensive, including such general ones as low

reimbursement, fragmentation and bad coordination of services. Psychiatrists criticize OHP for delays in referrals, poor coordination with PCPs, lack of coverage for important and innovative drugs, and inappropriate referrals to state hospitals. There seems to be a great deal of misunderstanding regarding the way the new system works: *“My experience in the provision of psychiatric services to OHP patients is fraught with frustration and confusion, primarily due to the specific (all different) systems for carving out and capitating mental health services. Everyone is massively confused.”*

There is a perception that patients with severe mental health problems do worse under OHP, as they lose long-time providers, are denied extensive therapy, and are managed by professionals who are not supervised by psychiatrists. Physicians also view separation of physical and mental health care as detrimental for the patients and expensive for the state in the long run.

Physicians often bring up the issues of the OHP patient population being particularly difficult to work with. The general consensus is that these cases are time-consuming and complicated, requiring additional resources in both time and money. A few physicians suggested that OHP is not an appropriate system to serve complex medical cases, which require longer and more frequent visits, as well as a vast amount of medical education and assistance.

However, a surprising amount of negative opinion is voiced over OHP patients being manipulative, non-compliant, and abusive of the system:

“OHP patients are also my most challenging, demanding and least appreciative patients...the small minority...who chew-up the most time and resources”

“People who run their lives by crisis”

“Over-utilize the system”

“Do not take responsibility for their own health care, do not have respect for the system, non-compliant, miss appointments, don’t take meds...”

“Come with a laundry list of wants and needs far exceeding non-OHP new members”

“Come with their own agenda- I want this drug or that...”

Both participating and non-participating physicians provide some recommendations on how the OHP system can be improved. Instituting co-payments, however small, was the most common measure offered. In addition, physicians ask for regular updates on priority list cut-off conditions, and suggest that Medicaid cards should display the name of the primary care provider. Physicians also request better coordination with case managers. Physicians stressed the need for a major education effort in order to train patients how to use OHP appropriately, for example, what constitutes a reasonable cause for ER visit, and how to deal with referral system. Severe time constraints make it impossible for physicians to fit education into each visit’s agenda.

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Appendix A

Classification of HMOs into Groups

Appendix A
Classification of HMOs into Groups

Commercial

- 8= 'Good Health Plan'
- 10= 'Kaiser Permanente'
- 13= 'ODS Health Plan'
- 15= 'PACC Health Plan'
- 16= 'PacifiCare of Oregon'
- 17= 'QualMed'
- 18= 'Regence HMO Oregon'
- 19= 'SelectCare'

Clinic Based

- 1= 'CareOregon'
- 2= 'Cascade Comprehensive Care'
- 4= 'Columbia Managed Care'
- 5= 'Coordinated Health Care Network'
- 6= 'Evergreen Medical Systems'
- 7= 'FamilyCare'
- 9= 'InterCommunity Health Network'
- 11= 'Medford Clinic'
- 14= 'Oregon Health Management Service'
- 21= 'Tuality Health Care'
- 22= 'PrimeCare'
- 24= 'Student Health Services'
- 26= 'Federal Health Clininc'

IPA style

- 3= 'COIHS'
- 12= 'Mid-Rogue IPA'
- 20= 'SureCare'
- 30= 'COIPA'
- 33= 'Doc's IPA'

Behavioral

- 23= 'CAAPCare'
- 25= 'Mid-Valley Behavioral'
- 27= 'LaneCare'
- 28= 'GOBHI'
- 29= 'Behavioral Health'
- 31= 'ABHA'
- 34= 'CERES'
- 35= 'JBH'