MaineHealth Access Project: Findings from Physician Interviews

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EXECUTIVE SUMMARY

This study reports findings from a series of physician interviews organized and conducted during the months of April and May 2000 in Cumberland, Kennebec, and Lincoln Counties. Semi-structured interviews with nineteen physicians were conducted to collect information on: 1) the experiences of these physicians in providing care to people without health insurance in their practices, 2) their referral practices for uninsured patients needing specialty care, diagnostic services, and prescription medication, 3) their impressions of the uninsured populations in their areas, 4) their impressions of the difficulties faced by the uninsured in obtaining care, and 5) their recommendations for the development of a program to serve the uninsured.

Key findings from these interviews include:

- Few physicians report that they limit their practices in any way to the uninsured. The use of sliding fee scales is limited primarily to institutionally based practices. Office staff are responsible for discussing payment issues with patients and arranging for payment plans.

- With the following exceptions, physicians report that it is relatively easy to refer uninsured patients to many forms of specialty care. Dermatology, orthopedics, ophthalmology, and behavioral health services were reported to be among the more difficult services for their uninsured patients to obtain.

- Very few specialists will refuse to accept an uninsured patient when contacted by another physician. More difficulty is encountered when the patient contacts the office on their own.

- Although most physicians are able to refer uninsured patients to specialty care, they are unaware of how payment issues are handled once the referral is made.

- Prescription medications are a big problem for the uninsured. Samples are used frequently for acute problems. The indigent care programs offered by pharmaceutical companies are
used for chronic and long term conditions. Practices devote a great deal of time to the paperwork associated with enrolling patients in these programs.

- Physicians consider a patient’s health insurance status when recommending specialty care, diagnostic studies, and medications.

- Patients will often self select the conditions for which they seek care. Primary and preventative care are most often delayed or ignored.

- The underinsured (those with catastrophic health care coverage and high deductibles) behave similarly to the uninsured by making decisions to self select care and to avoid primary and preventative services below their deductible levels.

- The MATCH program in Kennebec County is well liked by most physicians and was recommended as a model for MaineHealth to consider in developing their program.

- The program developed by MaineHealth for the uninsured should: 1) assist patients in enrolling for benefit programs for which they qualify such as indigent drug programs, CubCare, and Medicaid; 2) minimize required paperwork and other burdens on the physicians’ offices; 3) focus on patient education and preventative services; 4) address problems in obtaining prescription drugs; 5) equitably distribute the burden of providing care to the uninsured among physicians; 6) address patient behaviors such as high no-show and cancellation rates; and 7) educate patients as to the benefits available under the program to avoid confusion.

- Case management was rarely mentioned by physicians when asked for their program recommendations. When prompted, many thought it would be helpful as long as it is relatively simple and imposes minimal burdens on their offices. It will be necessary to distinguish between medical case management and benefit management to avoid potential confusion.
The need to address specialty care within the program was raised by almost all primary care physicians.

It will be necessary for MaineHealth to clearly explain its goals and involvement in the program as some suspicions exist around its motivations.

PURPOSE
This project was undertaken in support of MaineHealth’s “Communities in Charge” planning grant from the Robert Wood Johnson Foundation. The Health Policy Institute of the Edmund S. Muskie School of Public Services was commissioned to conduct semi-structured interviews with physicians in Cumberland, Kennebec, and Lincoln Counties, the counties targeted for the proposed MaineHealth Access to Community Health program. These interviews were designed to collect information on the treatment of uninsured patients by physicians in these counties as well as the referral patterns of physicians for specialty care, diagnostic services, and prescription medications required by these patients. They were also designed to solicit physician input into the program planning process to secure physician buy-in and to maximize physician participation in the program.

APPROACH
Methodology
The agreement with MaineHealth originally called for staff from the Muskie School to conduct one physician focus group in each county. Each group was to consist of eight to twelve physicians representing a broad range of practice types and specialties. In response to initial physician concerns about the focus group methodology, an alternative plan was developed. In place of focus groups, individual physician interviews were to be conducted either face to face or by telephone. MaineHealth staff, with input from key staff within the hospitals located in each county, prepared lists of potential physician contacts. Calls were placed to all physicians on the three lists to schedule appointments to conduct the interviews. A total of twenty four appointments were scheduled. Nineteen physician interviews were conducted by the John Gale of the Muskie School and Phebe King of MaineHealth. The remaining five interviews could not
be completed due to unanticipated physician scheduling conflicts. Six physicians were interviewed from both Lincoln and Kennebec Counties respectively and seven were interviewed from Cumberland County. The overall group consisted of fifteen primary care physicians and four specialists.

A semi-structured interview guide was developed by the staff of the Muskie School with input from the staff at MaineHealth. The interview guide is included as Appendix A. Using this interview guide, individual interviews ranged from 20 to 30 minutes depending on each physician’s availability.

Limitations
Given the relatively small number of physicians interviewed (compared to the total physician population), it is not possible to make generalizations to all physicians in Cumberland, Lincoln and Kennebec Counties. Despite this fact, we obtained rich information that raised issues and questions that should be considered in MaineHealth’s planning process.

FINDINGS

The Treatment of the Uninsured within Individual Physician Practices
For the most part, physicians do not limit the number of uninsured patients within their practices nor do they turn patients away or otherwise refuse to provide services to patients without health insurance. Insurance information is routinely requested either when the appointment is booked or the patient presents for services. The physicians were quick to point out that this information is obtained in order to register the patients in their billing systems and/or for the pre-authorization of services for patients covered by managed care plans. It is not used to prevent uninsured patients from making appointments. When queried around these issues, all but three physicians described a process in which their staff review their fees and billing policies with patients who call for initial appointments but stressed that their offices do not refuse to schedule appointments for uninsured patients. Among the relatively few physicians who could identify the percentage of uninsured patients within their practices, the estimates ranged from 10% to 30% of their patient volume with the higher numbers reported by physicians practicing in clinic settings.
The responses to this line of questioning were consistent across the three counties. Two comments, however, highlight the impact of physician supply on access to care for the uninsured. Two physician practicing in Lincoln County noted that they could not refuse to treat patients given the nature of their small town practice with few other resources. Conversely, three physicians practicing in the Portland noted that the availability of free clinics made it easier for uninsured patients to obtain care and may serve to limit the number of calls the physicians receive in their practices. The availability of additional providers makes it easier for physicians to manage their uninsured patient load.

Previous work with physicians and other safety net providers as well as uninsured patients in a number of Maine communities suggest that these statements should be interpreted with some caution. While physicians may not formally close their practices to the uninsured, the approach and tone taken by their front desk staff when interacting with uninsured patients may serve to discourage them (the patients) from further attempts to schedule appointments. Three physicians noted that they only see patients who are willing to call their offices and, as such, suggested that the level of need for health care services among the uninsured is greater than indicated by the number of calls they receive.

None of the physicians in private practice discussed the use of sliding fee scales to reduce charges to patients who are uninsured. Their offices attempt to develop payment arrangements after the patient has been treated. If the patient is scheduled for an expensive procedure, they will attempt to address these issues in advance. One physician down codes services for patients who have financial difficulties. For the most part, physicians delegate responsibility for billing and collection discussions to their office staff. These individuals are charged with developing payment arrangements when possible, collecting insurance information, and managing the flow of scheduled patients. Among the physicians in private practice, the decision to write off care is made by the physician in conjunction with their office managers.
The implementation of sliding fee scales appears to be limited to institutionally based physicians (9 of the 19 physicians interviewed), many of whom adopted the policies established by the hospitals with which they are affiliated. The two emergency room physicians noted that they could not ask about these issues prior to rendering services. The institutionally based physicians included these two ER physicians, a physician employed by a rural health clinic, and six employed by hospital owned practices.

Referrals for Uninsured Patients Needing Specialty Care, Diagnostic Services, and Prescription Medications

With some exceptions, the physicians in Lincoln County did not think that it was particularly difficult to refer their uninsured patients to specialty or diagnostic care. Cumberland County physicians reported some difficulty in referring uninsured patients for dermatologic, psychiatric, ophthalmologic, and orthopedic care. They noted that Maine Medical Center’s various clinics are a valuable resource to their uninsured patients in obtaining specialty care. Most physicians stated that specialists rarely refuse to accept the referral of an uninsured patient when they (the referring physician) contact the specialists directly. A number reported that uninsured patients who attempt to arrange their own appointments experience greater difficulties. One Lincoln County physician was very direct in saying that he would not refer his commercial patients to any specialist who refused to accept one of his uninsured patients. In contrast, primary care physicians in Kennebec County, particularly in Augusta, reported more difficulty in obtaining specialty care, specifically orthopedic care. In explaining why this was the case, they noted that there seems to be less commitment to providing free care in that community.

Very few physicians could describe how the specialists handled billing arrangements with uninsured patients once a referral was made. Three clinicians from Maine Medical Center’s outpatient clinics expressed concern that specialists not associated with Maine Medical Center (specifically anesthesiologists and radiologists) routinely send bills to patients who qualify as free care patients in the MMC system. This was mentioned by a Kennebec County physician as well. Although specialists will accept referrals for uninsured patients, it is likely that these patients are being billed for the services they receive.
Many physicians consider a patient’s insurance status when making referrals for diagnostic services, specialty care, and medications. They will try, when clinically feasible, to recommend treatment alternatives that will limit the financial impact on uninsured patients. If, in their opinion, a particular diagnostic or specialty procedure cannot be delayed, physician will enter into discussions with patients to persuade them to follow their recommendations. A number of physicians offered anecdotal stories of particular patients who refused to follow their advice due to financial reasons.

Medications are a particular problems for the uninsured. All physicians reported using samples obtained from detail reps for patients with acute illnesses. With one exception, all work with patients to enroll them in indigent care plans offered by the pharmaceutical companies. The one exception preferred to prescribe less expensive drugs when possible as he believes the indigent care programs “hook” patients on the latest and most expensive medications. Without exceptions, physicians noted that the process of enrolling patients in these programs consumes a significant amount of staff and physician time in their offices. One physician reported that approximately one FTE employee from his practice is dedicated to completing paperwork for these programs.

**Physicians Impression of the Uninsured Population**

Surprisingly, most physicians could not estimate the size of the uninsured populations in their practices and communities nor could they offer more than a very limited description of the types of patients who are uninsured. For the most part, their described the working poor, seasonally employed patients (e.g. fisherman and people employed in tourist industries), young males, single mothers, people between jobs, and people who have either temporarily or permanently lost their Medicaid eligibility. Most offered the impression that the numbers seem to be growing.

Three physicians also discussed their experiences with patients who are undersinsured (i.e. patients with catastrophic plans and/or high deductibles). In their opinions, these patients are essentially uninsured for most routine medical services including preventative and primary care.
below their deductibles. As a result, they behave very much like the uninsured in that they delay care until it can not longer be avoided and are less likely to seek routine preventative and preventative care. Of the three physicians who raised this issue, all were in agreement that this population is growing, possibly faster than the uninsured population. They felt that the needs of these patients should be considered when developing the program.

**Physician Impressions of the Difficulties Faced by the Uninsured in Obtaining Care**

Despite access problems surrounding certain types of specialty care, most physicians from all three counties felt that it was possible for uninsured patients to obtain needed health care in their communities. It was difficult to obtain any sense from them whether or not the difficulties faced by uninsured patients seemed to be growing. Despite the fact that they could not accurately quantify the difficulties faced by the uninsured in obtaining care, a small number of the respondents recognized that patients make decisions regarding the types of problems for which they seek care and many will forego care for less serious conditions and routine preventative services. As a result, the difficulty experienced by the uninsured in obtaining the full range of health care services may be greater than generally recognized.

**Recommendations for the Development of a Program to Serve the Uninsured**

As can be imagined, this group of physicians had many and varied recommendations for a program designed to serve the uninsured. A number involved “big picture” changes to the health care system such as the development of a single payer system, implementation of major revisions to Medicaid and other entitlement programs, and drastic expansions in insurance coverage. Others were more practical and applicable to MaineHealth’s planning efforts. Their specific programmatic suggestions revolved around the following topics:

**Equity.** They thought the burden of providing services to the uninsured should be distributed as equitably as possible. Most primary care physicians stated that specialists needed to be included in the program, although many recognized that this may put an inordinate burden on certain types of specialists who may be in limited supply. A few suggested that a rotation system be
developed to assign patients to specialists. A number raised the issue that some physicians do more than their share, while others do not.

**Patient Education and Preventative Services.** This was another area raised by many physician. The described the need to educate patients on how to: 1) use the health care system effectively; 2) to develop acceptable patient behaviors (e.g. calling for appointments in a timely fashion as well as reducing no show rates, call-outs, and excess utilization); and 3) proper health behaviors (e.g. proper eating habits, reducing alcohol consumption, etc.).

**Rules to Enforce Patient Behaviors.** Physicians were concerned about the need for rules to insure that patients behave properly and do not abuse the system. Physicians were particularly concerned about high levels of missed appointments and cancellations. One physician in particular argued that while rules were necessary, it is important to allow for exceptions to them. Others felt that the program should clearly identify patient responsibilities. Conflicting comments were heard about the appropriateness of co-pays. Some thought that co-pays would help to control unnecessary utilization while others felt that they might discourage patients from seeking necessary services. One offered the opinion that the program itself should make the co-payments directly to the physicians.

**Avoid Additional Burdens on Practices.** Another common theme was the need to minimize any additional burdens placed on physicians and their practices. Additional paperwork should be streamlined and kept to a minimum. Policies and procedures should be streamlined as well. One physician suggested negotiating with indigent care drug programs to accept the program’s eligibility determinations and paperwork for patients requiring long term drug therapies. Multiple physicians mentioned the burden imposed on their offices by the paperwork related to these programs. They desired some way to take this responsibility out of their offices. At least two others suggested that the program should build on and extend existing efforts to enroll patients in indigent drug programs, CubCare, and Medicaid rather than replace them entirely. They thought that physician offices are the best place to conduct these eligibility assessments and that practices should be given the tools to manage the process. One suggested that the
program could help to pay for at least part of one person who was already doing this work in her office.

**Use of Formularies.** Four physicians suggested that the program should use formularies to assist patients in obtaining the medications they need. It was further suggested that MaineHealth could use its purchasing power and pharmacy to lower the cost of providing drugs to the uninsured. As a group, the physicians were consistent in their suggestion the provision of prescription medication had to be included in the program.

**Case Management.** Case management was not raised by many physicians unless prompted. Once the concept was raised, most were generally supportive. A small number were concerned that it must be kept very simple to avoid putting additional demands on their offices. One physician suggested that it might be used to empower patients through the development of agreements that clearly identify patient responsibilities. Others, as mentioned earlier, would like the program to build upon existing activities already underway in their offices. Two suggested that case management might not be as helpful as the conventional wisdom suggests. It also became clear that physicians have varying interpretations of what case management entails. For example, one physician thought that it might be very helpful in managing the medical needs of a number of his patients with chronic conditions and described his vision of a visiting nurse style case management program. As a result, it will be necessary to define and clarify what is meant by case management in the context of MaineHealth’s program development.

**The Inclusion of Specialty Care.** All of the primary care physicians were adamant that specialty care must be included in the program and that specialists should be involved in its development. The primary care physicians felt that they needed to be able to refer uninsured patients to specialty care that they could not provide. As the same time, they acknowledged but, did not have a solution to, the problem of access to the comparatively limited number of specialists in their areas.
They were also sensitive to the potential demands placed on particular types of specialists that are in short supply throughout the area and the MaineHealth system. The limited number of specialists that were interviewed shared these concerns. One in particular was concerned that the referral of patients for consultative services would result in an expectation by patients that specialists would become responsible for providing ongoing care.

**The MATCH Program.** This program was mentioned by all of the physicians interviewed from Kennebec County. It was generally thought to be a model that MaineHealth should emulate. It seemed very well received by the six respondents although they did raise some concerns. In particular, they noted problems related to the education of patients as to the benefits available to them through the MATCH program. When the program was transplanted to Augusta from the Waterville area, some patients mistakenly understood that specialty care was a benefit of the program. This created problems in the Augusta market and alienated some of the specialists. Out of fairness to all involved, the respondents clarified that the confusion took place at multiple levels in the process and that no one group can be held responsible for the problems that occurred. This suggests that MaineHealth should pay particular attention to clearly defining the benefits available to the participants and outlining the responsibility of the participating physicians. The individuals assigned to enrolling participants and explaining the available benefits to enrollees are critical to this process and must be careful to accurately describe the program.

The positive features of the MATCH program included the inclusion of pharmacy benefits, diagnostic services, and lab services through the participating hospitals, patient education efforts, the assistance provided to enrollees in finding a primary care physician, efforts to involve specialty physicians, and the preservation of social services needed by participants. Problems included the confusion described above as well as the cost of pharmacy benefits, the perception held by some of a two tiered system of care for those who participate in the program, and the fact that the MATCH does not track patients and their utilization throughout the health care system.
Outreach to the Underinsured or Patients Not Connected to the System. As mentioned earlier, some of the physicians were concerned about the underinsured who are functionally uninsured for services up until the point that they reach their deductible levels. These individuals frequently forego needed primary and preventative care. The physicians argued for their inclusion in the program. They were also concerned that the program may not reach individuals who do not attempt to access the health care system and described the need for strong outreach efforts to connect with these individuals.

Concerns about MaineHealth’s Role. Two physicians expressed some concern about MaineHealth's motivations in developing this program. They felt that the development of a program to serve the uninsured might be viewed as an effort to shift responsibility for caring for this population from MaineHealth to the physician community. Both stopped short of saying they themselves held this position but felt that it was necessary for MaineHealth to be very clear about its role and to identify the resources that it is committing to the program.

CONCLUSION
The respondents were generally supportive of MaineHealth’s efforts and had many suggestions as discussed above. It would make sense to include physicians from each of the three counties as well as staff members from their offices in the ongoing planning efforts. It would also make sense to keep the physician communities in each county well informed of the process and the program as it develops.
Appendix A

Physician Interview Instrument

Introductory Statements: I am here today on behalf of MaineHealth to learn about your experiences in providing care to people without health insurance. As a practicing physician, you have firsthand knowledge of the needs of your patients without health insurance and the difficulties they have in obtaining needed health care. I would like to talk to you about the level of need in ________ County, the impact of the uninsured on your practice, how you handle the provision of care to the uninsured within your practice, and your thoughts on potential strategies to address these issues.

MaineHealth has received a planning grant from the Robert Wood Johnson Foundation to improve access to health care services by people without health insurance in Cumberland, Kennebec, and Lincoln Counties. During this first year planning effort, MaineHealth will identify the scope of the problem, create links with providers and community stakeholders, design sustainable financing strategies, and develop a framework for health care delivery to the uninsured. The information gathered from this and other physician interviews will provide valuable input into these efforts. A written report will be forwarded to MaineHealth summarizing the information obtained during these interviews. We will not release the written transcripts from today’s interview nor will we identify comments from you.

On behalf of MaineHealth and the Health Policy Institute of the Muskie School of Public Service, thank you for your willingness to participate today. The whole interview should take no more than thirty minutes. Do you have any questions before we get started?

Questions:

1. Please describe the ways in which patients without health insurance access your practices? Probes: What is your screening process for new patients? How do you handle payment issues within your practices? What percentage of your patient populations are uninsured? Do you limit the number of uninsured patients within your practices? Do you have any other restrictions

2. How do you handle referrals for uninsured patients that need health care services, including prescriptions, that you do not provide? Probes: What types of health care services are most difficult for your uninsured patients to obtain? To whom do you refer these uninsured patients? Can you prioritize these health care services in terms of need?

3. What is the magnitude of the problem of the uninsured in ________ County? Probe: Can you describe the type(s) of patient(s) who are uninsured? What are the trends in the size of the uninsured population? Has the number gone up (down) during the past year? The past three years?
4. How difficult is it for people without health insurance to obtain health care in ________ County? Probes: Are they able to get care? If so, where? If not, what do they do? Is this situation getting worse (better) in your community? Why

5. How would you construct a program to better serve the uninsured in ________ County? Probes: What sort of support would help you to better serve uninsured patients within your practice? If these supports were available, would you be likely to participate in a program to serve the uninsured? Would the availability of these supports allow you to serve more uninsured patients? Of the support functions discussed, how would you prioritize them in terms of need or importance?
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