Perceptions of Physicians in Medicaid Managed Care Practices regarding Working with African American and Latino Patients

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Abstract

To address the concern that minority patients receiving Medicaid might be at a disadvantage, this study focuses on determining whether the profile of physicians in Medicaid managed care settings with a low caseload of minority patients differs from those with a high case load of minority patients. Data from the 2000 Maryland Study on Physician Experience with Managed Care was analyzed regarding the quality of care, access to specialists, and aspects of the management of the practice. Physicians practicing in Medicaid managed care settings with a high caseload of African American and Latino patients are more likely to be African American, more likely to earn less than other physicians and less likely to have input into making management decisions. This study suggests that better financial and administrative incentives are needed to encourage physicians to continue to work in Medicaid Managed care settings with a high caseload of African American and Latino patients.

Introduction

In the 1980s, researchers expressed concern about health care delivered in medical practices with large caseloads of indigent patients covered through Medicaid. These practices, called "Medicaid Mills," described health care settings where at least 15 percent of the patients received Medicaid (Mitchell & Cromwell, 1980, Cromwell & Mitchell, 1984). Some studies suggested that patients at these Medicaid Mills lacked access to qualified

physicians, saw physicians with high caseloads and waited for care in overcrowded offices (Mitchell & Cromwell, 1980; Cromwell & Mitchell, 1984). Other studies reported patients with Medicaid managed care had limited access to specialists (Backus, Osmond, Grumbach, Vranizan, Phuong, & Bindman, 2001), interpreters, and settings with evening and weekend services (Weiss, Haslanger, & Cantor, 2001). While studies were inconclusive regarding whether or not patients received a lower quality of care, concerns still exist today about the challenges facing physicians who commit to providing care to indigent patients.

Physicians who have practices where at least 10 percent of their caseload is comprised of Medicaid patients typically experience certain challenges in balancing their commitment to an indigent, largely minority population and the need for survival. These challenges include the lack of adequate reimbursement for services rendered to Medicaid patients relative to services provided to Medicare or private insurance patients, growing insurance liability issues in the practice of medicine that may make it difficult to serve a large Medicaid population, concerns about the "oversight" provided by managed care organizations that emphasize increasing patient caseload over quality of care, and administrative paperwork hassles (Flocke, Orzano, Selinger, Werner, Vorel, Nutting, & Strange, 1999; Berman, Dolins, Tang, & Yudkowsky, 2002; Waitzkin, Williams, Bock, McCloskey, Willging, & Wagner, 2002).

While patient satisfaction may not have suffered much because of Medicaid managed care, Medicaid managed care providers report a greater degree of dissatisfaction than non-Medicaid managed care providers (Flocke et al., 2002; Waitzkin, et al., 2002; Gazewood, Longo, & Madsen, 2000). Some physicians report feeling like a "double agent" because they are torn between their advocacy role for the patient and their gatekeeper role for the managed care organization (Gazewood, Longo, & Madsen, 2000). Such role conflicts have engendered stress and burnout among physicians (Waitzkin, et al., 2002).

Altogether, prior research shows physicians in practices with a large caseload of Medicaid patients encounter numerous challenges in rendering care that may be compounded by having a large caseload of minority patients (Gleid & Zivin, 2002; Komaromy, Grumbach, Drake, Vranizan, Lurie, Keane, & Bindman, 1996; Hargraves, Stoddard, & Trude, 2000). Given issues of care provision by physicians in Medicaid managed care settings, the purpose of this study was to determine whether the profile of physicians and the assessment of their practice in Medicaid managed care settings with a low caseload of minority patients differed from those with a high case load of minority patients.

Methods

In 1999, Maryland's State Legislature commissioned the Maryland Department of Health and Mental Hygiene (DHMH) to conduct a statewide study of Maryland physicians regarding their experiences in the managed care environment. The Maryland Study on Physician Experience with Managed Care was conducted by the Center for Health Program Development and Management on behalf of DHMH. Using data from the Board of Physician Quality Assurance Data file of the Maryland Health Care Commission, a population of 13,742 active physicians who worked in a managed care setting was identified. From this study population, a sample of 3,113 physicians was selected using a stratified sampling technique and an over sampling method in order to ensure adequate representation of African American, Latino and Asian physicians. Surveys were mailed to physicians in July 2000 and collected through November 2000. Of the 3,113 surveys sent to physicians, 1,650 surveys were returned, representing a response rate of 53 percent. The content of these surveys included topics pertaining to practice characteristics, reimbursement levels, administrative requirements, physician-patient relationship, perceptions of managed care, managed care contracts, physicians' commitment, physicians' satisfaction, practice settings, specialty type and demographics.

Data from the Maryland Study on Physician Experience with Managed Care were used in conducting the analyses in this

paper. An IRB exemption was provided for the current study by the University of Maryland IRB board. This study's sample consisted of a subgroup of physicians who had managed care practices where at least 10 percent of their patients received Medicaid, defined as "Medicaid practice settings."

Analysis Procedures

The data was split based on the proportion of minority patients, African American and Latino, served by managed care Medicaid providers. That is, we defined those settings where at least 50 percent of the caseload was African American or Latino as having a "high" proportion of minority patients. In contrast, those settings where less than 50 percent of the caseload was African American or Latino were defined as having a "low" proportion of minority patients. We used chi-square tests to conduct group comparisons on categorical measures. Analysis of Variance (ANOVA) was used to conduct similar comparisons on interval measures. The level of statistical significance was set at .05 for all group comparisons.

Results

In Medicaid practices with a high proportion of minority patients, physicians were significantly more likely to be female, African American, and earn a 1999 practice income that was equal to or less than $150,000, when compared to practices in which physicians saw a low proportion of minority patients (Table 1). Furthermore, physicians who provided care to a high proportion of minority patients were significantly more likely to believe that managed care had adversely affected patients' quality of care, reduced patients' access to specialists, and to express that their caseload had a negative impact on ability to tailor treatment to meet the cultural needs of the patients.

Table 2 shows that physicians who had a high case load of minority patients were significantly less likely to report being neither satisfied not dissatisfied with their ability to make decisions independently compared to physicians with a low caseload. Physicians

with a high case load of minority patients were significantly less likely to report a decrease in the number of managed care contracts they participated in and more likely to report the number of managed care contracts remained the same compared to physicians with a low caseload. Additionally, physicians with a high case load of minority patients were significantly less likely to report an increase in the average number of patients they saw in a typical day or in the average number of hours worked in a typical week as compared to physicians with a low caseload.

Compared to physicians with a low case load of minority clients, physicians with a high case load had lower average scores on input into making decisions and ability to initiate changes in managing their practice. However, physicians with a high case load of minority clients did not differ significantly from physicians with a low case load of minority clients on reports about setting the pace of their own work.

Table 1. Selected Medicaid Managed Care Physician Characteristics by Low and High Physician Caseload of African American and Latino Patients

	Low	High
Overall Percent	71.4%	28.6%
Gender[a]		
Female	22.4%	30.6%
Male	77.6%	69.4%
Race/ethnicity[b]		
Hispanic	3.0%	3.6%
White	74.1%	67.7%
African American	4.2%	16.8%
Asian/Pacific islander	18.7%	11.9%
American Indian/Eskimo/Aleut	.1%	.0%
1999 Practice Income (in thousands)[c]		
Less than 100K	20.6%	26.8%
100K-150	35.3%	42.2%
151K-200	17.0%	19.0%
201K-250	12.8%	7.8%
251K+	14.4%	4.3%
Had adversely affected quality of care[d]		
Disagree	10.2%	6.4%
Neither agree/disagree	13.0%	10.4%
Agree	76.8%	83.1%
Reduced patients access to specialists[e]		
Disagree	10.8%	7.4%
Neither agree/disagree	6.1%	4.1%
Agree	83.2%	88.4%
Tailor treatment to meet cultural needs of patients[f]		
Negative	48.9%	59.5%
Neither positive/negative	47.0%	37.3%
Positive	4.1%	3.3%
N	875	350

Note1: [a] chi-square=15.4,df=1,p<.001;
[b] chi-square=102.9,df=4, p<.001;
[c] chi-square=11.3,df=2, p<.01;
[d] chi-square=21.4,df=2, p<.001;
[e] chi-square=9.2,df=2, p<.01;
[f] chi-square=18.7,df=2, p<.001

Note2: Percentages may not equal 100% due to rounding error.
Source: Center for Health Program Development and Management Maryland Study on Physician Experience with Managed Care.

Table 2. Medicaid Managed Care Physician Self Assessment of Medical Practice by Low and High Physician Caseload of African American and Latino Patients

	Low	High
Overall Percent	71.4%	28.6%
Satisfaction with ability to make decisions independently[a]		
Dissatisfied	44.1%	46.4%
Neither satisfied/dissatisfied	11.9%	5.1%
Satisfied	44.1%	48.4%
Number of managed care contracts participate in[b]		
Decreased	15.5%	5.0%
Remain the same	24.9%	36.6%
Increased	59.5%	58.4%
Average number of patients seen each day[c]		
Decreased	4.8%	4.5%
Remained the same	35.4%	44.9%
Increased	59.8%	50.6%
Overall percent	71.4%	28.6%
Average number of hours worked each week[d]		
Decreased	5.9%	9.8%
Remain the same	29.7%	38.3%
Increased	64.4%	51.9%
Mean level of practice management in making decisions:		
Input into decisions[e]	5.6	5.0
Able to initiate changes[f]	5.4	5.2
Can set the pace of own work	4.8	4.9
Can alter my practice[g]	3.9	4.4
N	875	350

Note1: [a] chi-square=22.0,df=2, p<.001;
[b] chi-square=57.4,df=2, p<.001;
[c] chi-square=29.4,df=2, p<.001;
[d] chi-square=16.6,df=2, p<.001;
[e] one way ANOVA, F statistic=41.4, p<.001;
[f] one way ANOVA, F statistic=5.6, p<.02;
[g] one way ANOVA, F statistic=33.0, p<.001.

Note2: Percentages may not equal 100% due to rounding error.
Source: Center for Health Program Development and Management, Maryland Study on Physician Experience with Managed Care.

Discussion

This study found statistically significant differences between physicians providing care in settings with a low caseload of African American and Latino patients as compared to physicians providing care in settings with a high caseload of these patients. In sum, physicians practicing in Medicaid managed care settings with a high caseload of African American and Latino patients are more likely to earn less than other physicians, less likely to have input into making decisions, less likely to believe they can initiate changes but more likely to believe they can alter their practice. They were also more likely to believe that Medicaid managed care had a negative impact on their ability to tailor treatment to meet the cultural needs of their patients.

In this regard, this study's findings are consistent with those in similar studies, which have found that physicians encounter barriers when participating in Medicaid managed care (Bindman, Yoon, & Grumbach, 2003; Greene, Blustein, & Remler, 2005). In a statewide study of physicians who practiced in the California Medicaid (Medi-Cal) managed program between 1996 and 2001, Bindman, Yoon and Grumbach (2003) found that increasing physicians fees did not increase their participation in the managed care program. They concluded that this result may be attributed to historically negative attitudes towards the Medicaid program. Even so, they noted that physician characteristics (race/ethnicity and practice in rural areas) may influence their decision to participate in the Medicaid program. In a separate study in the state of Oregon over the same period, Greene, Blustein and Remler (2005) found no increase in the rate of physician participation in Medicaid managed plans. Like Bindman and colleagues, these researchers noted that historical issues relating to the Medicaid program played a significant role in the lack of increase in physician participation in the Medicaid managed care program. They also found that program requirements such as board certification, providing 24 hour coverage, or the refusal of providers to contract with managed care organizations contributed to the lack of participation in Medicaid managed care. Thus, the creation of Medicaid managed care programs did not resolve some of the

historical barriers to participating in the Medicaid program, and in some cases may have created a few more hurdles. At the same time, this study and other studies suggest that African American physicians may be committed to providing care to the poor irrespective of the administrative or fiscal barriers created by the program.

Implications

This study suggests that more supports are needed both in the development of the Medicaid managed care initiative and in the nation's commitment to training African American physicians. With regard to the first issue, there is a need to address the historical stigma towards the Medicaid program. It seems that as long as providers encounter differential fiscal and administrative barriers in providing care to Medicaid patients there may be a disincentive for participating in Medicaid managed care. As regards the second issue, since it appears that African American physicians continue to provide care to Medicaid patients even as they encounter barriers created by the program, more resources need to be provided to support the training of African American physicians. Given the current patterns in the treatment of the indigent, it is expected that such a policy could contribute to improving barriers to care for Medicaid patients.

Limitations

While this study was able to shed some light on the challenges from the provider's point of view, it does not determine whether these barriers led to curtailing the number of patients in the practice or to physicians relocating. The findings from this study must be considered suggestive only, since the sample consists of practices only in the state of Maryland. Future research should focus on these issues in other states to develop a regional or national profile of the challenges physicians face in caring for the indigent.

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