Studying Access to Care in Managed Care Environments

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Large-scale enrollment of the U.S. population in managed care systems, combined with mounting public and media anti-managed care sentiment, has put concerns about access to care and quality of care at the forefront of public debate. Concerns about the profit and cost-cutting motives of managed care organizations abound, and are combined with increasingly frequent anecdotes and projections of decreased access to care. The debate is emotional and highly visible, yet data are scant. Prior research on access to care can only partially illuminate the issues at hand. As evidenced by this conference and the resulting papers, a new generation of research is needed to address questions and concerns about managed care and to shed light on mechanisms for improving the evolving managed health care system. This article outlines research themes related to access to care. Enumeration of critical issues related to access to care in "managed care" is complicated by a number of definitional issues, including access to "what" (e.g., any care vs. a certain type of care), access "when" (at point of entry to the health care system, or after initial contact has been made), access "by whom" (individuals vs. certain populations or communities), and by the definitions of "managed care" and "access." The Institute of Medicine defines access to care as "the timely use of personal health services to achieve the best possible health outcomes" (Institute of Medicine 1993). This article extends that definition to encompass populations as well as individuals. It discusses both "primary access" or entry into the health care system, and "secondary access" or care once the health care system has been entered. Because concerns about access to care relate largely to fears that reduced access will result in poorer outcomes, I address attributes of access that relate directly to quality care and outcomes.

Managed care, as other articles in this series describe it, merely links the financing of care and the delivery system. It is not monolithic in structure or function—either across plans or communities—and each of the areas outlined here is likely to be affected by the factors that vary across them, such as the organization, governance, and financial characteristics of the managed care system, and the organization and values of the purchasing communities in which the plans exist. While outlining key issues related to access, it must be remembered that each of them is critically affected by these environmental and organizational issues. In that context, the areas discussed relate to access to primary care, access for special populations, effects of managed care on access for communities, mechanisms by which managed care organizations increase access for some populations, and the development of additional mechanisms to evaluate access to care at a community level.

Primary Care

Because most of the U.S. population has some form of health care insurance, we first consider access to primary care for individuals enrolled in a managed care plan. Salient issues include those typically labeled as barriers to access such as difficulty or delay in getting an appointment, office wait, and availability of the provider by telephone. Because of the diverse organizational arrangements of managed care systems and the individual practices within them, these issues may best be addressed by examining the organizational characteristics that best promote access to care.

In addition to merely gaining access to the system, there are several features of health care organizations that may function as barriers to an individual who has entered the health care system. These include health plan practices that either enhance or impede continuity of care or access to preferred provider type and features that affect the amount of time providers spend with patients. An additional feature with major implications for access to care is the "cultural competence" of the organization.

Continuity. Once an individual has made "first contact" with a primary care provider, continuity of care becomes an essential ingredient of primary care (Starfield 1992; Institute of Medicine 1996; Bindman, Grumbach, Osmond, et al. 1996). In the context of managed care, the definition of the term is changing—from continuity of care with an individual provider to continuity with a health system or a managed care organization. Because workloads of primary physicians are such that they are often not available when their patients need to see them, many systems increasingly rely on the combination of urgent care facilities, nurse triage protocols, and electronic medical records to provide "continuity of care." Under what circumstances, and for whom, is access to a continuity relationship with a given individual important? Clearly,

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for some sorts of care, such as care of occasional acute, self-limited illness or trauma, continuity may be less important than getting care in a timely fashion. But when the patient-physician relationship is important, either because of associated psychosocial concerns, adherence to treatment plans, or the need for monitoring of a chronic problem, access to recurrent care with an individual is critical (Starfield 1992; Institute of Medicine 1996; Bindman, Grumbach, Osmond, et al. 1996; Lambrew, DeFriese, Carey, et al. 1996; O'Malley and Forrest 1996; Stewart, Grumbach, Osmond, et al. 1997; Weyrauch 1996).

An example of a problematic arrangement, but one that meets some definitions of continuity, is a child with recurrent ear infections "able to get care when needed." She has repeatedly been seen in the health plan's urgent care clinic because her primary physician does not have available appointments. Twelve months later, she is hearing impaired because repeated treatment failures have not been recognized. She has continuity with the system, but not with a provider. Further work is needed to determine how much patients value continuity of provider vs. health system, and for which kinds of patients and problems continuity affects health outcome. Defining organizational and other characteristics of care systems that result in different models of continuity and measuring their outcomes is important.

Time. Another issue related to "secondary" access in primary care settings is visit time. Time spent with the patient is not only a key element in measures of patient satisfaction, but may relate to adequacy of explanation, counseling, and adherence to treatment plans. In many managed care settings, the perceived need to increase productivity is accomplished by shortening visit time. In some systems, providers report that they often do not have adequate time to spend with patients or to work through a complicated problem (Borowsky et al. 1996). This type of reduced access not only can jeopardize the doctor-patient relationship but can result in emergent visits, clinical errors, inadequate patient education, or lowered patient satisfaction. The issue here is not to contrast the adequacy of visit time in managed and non-managed care systems, but again to determine which plan structures, organizational factors, and financial incentives produce encounters satisfactory to both patient and provider from a time perspective.

Provider Type. A third issue in primary care is access to a provider of the gender and specialty type (and often ethnicity) the individual wants to see. For example, over half of women prefer to see an ob/gyn for Pap smears and mammograms, and either a family physician or an internist for the rest of their care (Pemberton et al. 1997). Many also prefer to see women physicians, a preference largely independent of provider type (Lurie, Margolis, McGovern, et al. 1997). These preferences ultimately affect preventive procedure use, considered a key measure of access with regard to preventive care (Institute of Medicine 1993). When a woman does not see a provider of her preferred gender (and as a result needs to see a second provider for routine Pap smear and breast exam), screening rates fall (Lurie, Margolis, McGovern, et al. 1997). Similar issues may relate to race/ethnicity. For example, African American patients report receiving more counseling and preventive care and greater satisfaction when seeing African American physicians (Komaromy 1996). However, some managed care plans may not include minority physicians in their provider panels because of concerns about adverse patient selection (Rosenbaum et al. 1997). Thus, monitoring access to probe these aspects of provider choice will be important.

Cultural Competence. Other structural aspects of the managed care system, such as staff and providers who possess the cultural competence to care for specific populations, are also important. While some investigators have already begun to define characteristics of organizations and providers that contribute to cultural competence (Lavizzo-Mourey and Mackenzie 1996), further work is needed to define and measure cultural competence.

Special Populations

Special populations have long been a concern of researchers and policymakers, because they often have unusual or more intensive needs which are difficult to accommodate when considering "population health" from the perspective of a working, enrolled, managed care population. Difficulties often arise because of the need to provide links with other services considered to be non-medical. They are also more vulnerable to adverse outcomes, providing "early warning signs" regarding problems that may occur in the general population (Aday 1993), such as increased morbidity or mortality from certain diseases (e.g., measles, diabetes, hypertension) or systems of care. Other articles in this series will focus on chronic (Wagner 1997) and long-term (Binstock 1997) care. In addition to the growing focus on low-income populations resulting from enrollment of Medicaid beneficiaries in managed care plans, this article focuses on three additional special populations representing the diversity of special needs populations and their related considerations. Other special populations with traditional access problems include other low-income people, homeless individuals, disabled, and substance abusing populations. A starting point for research in this area is the determination of what kinds of managed care providers possess the expertise, desire, or ability to care for special populations when compared to the array of community health centers and providers that exist for this purpose. Research is needed to determine whether it is most effective for managed care organizations to contract with (and work with) community health centers for this purpose or to develop expertise themselves.

Low-income and Medicaid enrollees. Low-income and medically indigent populations have traditionally been a focus of research and concern related to managed care. These populations often report worse access to care and have poorer health outcomes than their more advantaged counterparts. There is no compelling reason to believe that this will change under a managed care arrangement, although, in theory, incentives that create a special focus on prevention, either through Medicaid HEDIS or through health plan desires to keep a population healthy could result in improved access and health outcomes for these populations. The corollary concern is also apparent: because this population often has difficulty negotiating the health care system, increased organizational roadblocks may make access to care more difficult. This could be related both to "transitional issues" as individuals shift into managed care, as well as to longer-term issues related to the organization and culture of the managed care system and its approach to this population. An additional concern is that in heavily competitive areas in which the potential for managed care companies to generate profit for shareholders drops, discontinuing a Medicaid contract because it is not profitable—and the resultant confusion—may have major implications for access to care for the populations of concern. The research agenda thus must address both transitional and long-term issues as well as those related to a dynamic profit-driven marketplace. In doing so, we should be mindful that commonly used measures of "access," as measured by satisfaction with access to care, may not be as meaningful for this population. Individuals often report high levels of satisfaction with care when, in fact, other measures, such as presence of a usual source of care or use of emergency departments for care would suggest that access to care is indeed a problem.

Individuals Needing Mental Health Care. Recent work relating to individuals with schizophrenia has suggested that in some managed care systems patients may fare less well than those who remain in fee-for-service care (Manning, Liu, Stoner, et al. 1996). However, relatively little research has focused on access to mental health care for individuals with sub-acute mental health problems, much of which occurs in "carve out" mental health programs. For example, capitating mental health care may lead to substantially reduced access to services for individuals with common mental health problems, such as anxiety and depression; individuals with crisis problems take priority.

There are, as yet, no data regarding whether managed care systems provide better or worse access to mental health care for such mental health problems. Focus groups and surveys of primary care providers in three Minnesota HMOs suggest major problems with the availability of mental health care for their patients who are not acutely psychotic or suicidal (Borowsky et al. 1996). Additional work is necessary to determine what structures and organizations are able to provide access to mental health care that leads to equivalent outcomes. This also includes examining whether individuals receive an adequate amount of care (vs. any care) and whether the type of provider is appropriate for treating the mental health problem. For example, evidence suggests that co-management of depressed patients by a primary care provider and a psychiatrist is associated with better outcomes (Katon, Von Korff, Lin, et al. 1995; Wells, Burnam, Rogers, et al. 1992).

Adolescents. Another special population for whom access to care research requires greater focus is adolescents. Although most adolescents are generally healthy, those with common problems often require confidential services in order to attend to those problems, such as mental health/substance abuse, or reproductive care. Many teens seek care through teen clinics or Planned Parenthood–type clinics, many of which are financially stressed because of difficulty securing managed care contracts and, at the same time, being able to maintain client confidentiality. Managed care systems, which are often (appropriately) intent on documenting encounters and receipt of preventive services, may find that these data practices are unacceptable to adolescents. Those seeking to provide access for this population may need to alter data collection and reporting procedures, or may need to support nontraditional sites of care, such as school-based or teen clinics. Regarding mental health, surveys of youth (Brandenburg, Friedman, and Silver 1990; Costello 1989; Costello et al. 1993; Padgett, Patrick, Burns, et al. 1993) suggest that depression and suicidal ideation are common; yet there is rarely evidence of mental health service use for this population in managed care plans. The nature of access required by adolescents and way in which health plans choose to meet those needs should be the subject of further study.

Children with Special Needs. Finally, the nature of access to care for children with special needs is of interest because it involves not only direct medical care provided by physicians in a managed care setting, but linkages, too, between managed care organizations and overlapping systems of public health, social service agencies, and school systems (Ireys, Grason, and Guyer 1996; Newacheck, Stein, Walker, et al. 1996).

Effects of Managed Care on Access to Care for Communities

Just as access to care can be measured on an individual level, it can and should be measured on a community level. As providers become more financially squeezed by the time and economic pressures they experience with managed care, they may be less willing to provide care to the uninsured or to find resources for referral and diagnostic services (Komaromy, Lurie, and Bindman 1995). Does greater managed care penetration in a geographic area enhance or impede the ability of uninsured and underinsured individuals to receive care? Clearly, decreasing access to care for the uninsured would be an undesirable effect of increased managed care penetration in a community.

An issue related to access at a community level is access to emergency medical services (Picken, Zucker, Griffith, et al. 1996). In some areas, doctors in safety net hospitals report seeing increased numbers of MCO patients with chest pain who, after being told that their problem can wait until office hours, present in the ER because they feel they "won't be turned away." Others report delays in patient-initiated care seeking for life-threatening conditions such as myocardial infarction. The magnitude of this problem can represent cost-shifting from HMOs to community safety net providers and may be associated with differences in outcomes.

Mechanisms for Increasing Access

MCOs are accountable for the health of their enrollees and, arguably, have shared responsibility for the communities in which they have market share. Thus, a fourth priority area for research is identifying and testing innovative ways for MCOs to expand access for individuals or communities. Showstack, Lurie, Leatherman, et al. (1996) identified attributes of socially responsible managed care organizations, including enrollment of a broadly representative sample of the community and contributing to the health of the community. The large-scale enrollment of Medicaid managed care provides a host of new opportunities for managed care organizations to reach this traditionally underserved, high-risk population. In the spirit of contributing to the health of the community (and perhaps in the hope of ultimately increasing market share), some health systems have "enrolled" a finite number of uninsured individuals in their communities. Whether these types of activities become strategies related to expanding access or to improving the health of a community deserves watching.

One additional way in which managed care organizations have begun to experiment with new delivery mechanisms that increase access for children is via the public school system. In geographic areas with relatively few managed care plans, virtually all children enrolled in public schools may be enrolled in a managed care plan. Managed care plans may be able to increase access to care and realize additional benefits in terms of health status and improved utilization patterns by creative arrangements with school systems.

These can range from partnerships around case management functions to locating some clinical services on-site in schools. While school clinics are common at the high school level, they are less common in elementary schools. Two experiments that deserve watching are one in Minneapolis in which health plans have pooled resources to provide on-site services at an inner city school in which over three-quarters of the children are enrolled in a managed care plan through Medicaid (*Challenge* 1996), and that in Denver in which Kaiser is providing care to uninsured children through school-based clinics (Keller 1996).

Health plan data systems can also be harnessed to expand access to care. For example, plans can identify people who do not use health care services, are not up-to-date with preventive care, or have not refilled chronic medications, to determine whether their access is adequate and how it can be improved.

It is well known that most illness that plagues U.S. citizens is a result of lifestyle and environmental factors (McGinnis and Foege 1993; Adler, Boyce, Chesney, et al. 1993). To that end, interventions aimed at a community, rather than at specific individuals, are likely to enhance the health of that community in the long run. Of course, because of repeated cycles of enrollment and disenrollment, having a single managed care organization focusing prevention activities on current enrollees is not a strategy that will pay off even in terms of creating healthier enrollees for the future. However, strategies that target communities may have such a payoff, and it may be in the best interests of MCOs to develop them either individually or collectively. Such activities might expand access to preventive services or target lifestyle factors for entire communities. As examples, plans may try to work together to achieve universal hepatitis B immunization for adolescents (not just their enrollees) by working with school systems, or they might target smoking and youth access to tobacco by joint initiatives at a community level.

However, we currently know little about the characteristics of markets and of managed care organizations that undertake activities aimed at expanding access and providing "community good." Are not-for-profit plans more likely to engage in such activities than for-profit plans? What factors create collaboration between plans for the benefit of the community? These are some additional questions about increasing access to care that require examination.

Developing Additional Methods to Measure Access

Current methods for measuring access to care enable us to measure access to care for individuals: to measure travel time, waiting time, presence of a usual source and usual provider when needed, and delays in care seeking. We do less well at measuring factors such as the cultural competence of an organization—a clear prerequisite for access to care for many populations—or measuring access to care on a community or population level.

Whether managed care organizations expand or inhibit access for communities will need to be determined. To do so will require additional methods for monitoring access to care on a community level. While examination of admissions for ambulatory-sensitive conditions on a geographic basis has brought us closer to community-level measurement (Bindman, Grumbach, Osmond, et al. 1995), nearly all studies of access rely on a clinical encounter or a large random sample national study to identify a population. We still lack ways to measure changes in morbidity that result from changes in access, whether expansion or contraction. This is a salient concern for enrollees of managed care organizations, as well as for communities experiencing significant enrollment of individuals in managed care organizations.

Finally, it must be said that in future studies on access to care in managed care environments, research design choices are critical. While in some cases comparisons should be made with non-managed care systems, it is increasingly important to compare different types of managed care organizations and communities. The point of all of this work on access is, after all, not to bash managed care as a delivery mechanism, but to sort out which system characteristics—in terms of organizations, market area characteristics, financial characteristics, for-profit status, and so forth—seem to matter, not only for maintaining access, but for expanding it.

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