ACHI
Arkansas Center for Health Improvement

ISSUE BRIEF

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

Who Pays for Primary Care in Arkansas? • May 2013

Does Arkansas have enough primary care providers for our citizens in all parts of the state now? Will we have enough to meet future demand? What are the dominate payer sources for health care coverage in Arkansas? Will physicians restrict access by payer source or accept only privately insured patients, particularly in rural areas, to the detriment of patients with public payer sources?

Most primary care physicians in the state see patients who receive health care coverage from one of three payer sources—Medicaid, Medicare, and commercial insurance. For children under the age of 19, the largest payer is by far Medicaid. Adults aged 19–64 are predominantly covered by commercial insurance and adults 65+ are usually covered by Medicare. Physicians in rural areas are more reliant on patients with public payer sources than on patients with commercial insurance. Given this, it does not appear that patients with public payer sources of health care will experience barriers to accessing health care by physicians selectively taking private insurance in rural areas; however, this will depend on rural physician response to greater numbers of individuals with private paying sources due to expanded coverage.

INTRODUCTION

Physician maldistribution is an issue in rural Arkansas as both primary care physicians and specialists tend to concentrate in urban areas. As a result, many portions of the state lack the capacity to absorb the additional primary care demand that is going to occur with expansion of coverage through Medicaid premium assistance and the implementation of the Arkansas insurance exchange. The geographical maldistribution of physicians also results in added financial barriers to patients who must travel to access health care.

Existing workforce assets in physician extenders—advanced practice nurses (APNs) and physician assistants (PAs)—can ameliorate the shortage of primary care clinicians in the state. However, APNs and PAs currently follow similar patterns of practice as physicians in that they also tend to locate in urban areas. Even where access is unaffected by geographical or financial concerns, there may still be barriers to accessing health care depending on whether an individual has a public or private payer source.

CONTEXT

In ruling most of the Patient Protection and Affordable Care Act constitutional, the United States Supreme Court left the expansion of Medicaid as provided in the act optional for states, which has made the topic of Medicaid expansion politically polarizing for a number of reasons. Reasons for opposition to Medicaid expansion vary widely but include opposition to expansion of entitlement programs, a growing federal deficit, and (most pertinent to access) the potential lower payment differentials between public and private insurance that could harm citizens' access to care if physicians selectively choose patients with higher-reimbursing private insurance.

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Medicaid typically pays physicians 56 percent of the amount that private insurers pay.[1] Given these low reimbursement rates, more and more doctors are refusing to accept Medicaid nationwide.[2] However, almost 91 percent of physicians in Arkansas are estimated to have accepted new Medicaid patients in 2011, and, in 2008, more than 90 percent of physicians nationwide continued to accept Medicare patients.[2,3]

An ACHI survey of physicians showed similar results: 90 percent of the physicians who responded reported accepting public insurance. With this information in hand, ACHI then looked at claims data to corroborate these self-reported statistics.

METHODS

To evaluate the extent to which providers do not participate in Medicaid or Medicare, ACHI examined participation through paid claims for providers of children's care (for which Medicaid is a primary payer) and adult care (for which Medicare is a primary payer). Differences in a physician's patient panel mix in rural counties (more often counties with inadequate supply) were compared with urban counties (more often those with an adequate or excess capacity of providers).[4]

Medicaid benefits are largely limited to children, pregnant women, the disabled, and seniors requiring long-term support. Medicare, conversely, offers full benefits to most individuals once they reach 65 years of age. Commercial carriers offer full benefits to most individuals from birth through age 65. The assessment was limited to those services provided by primary care physicians who billed Medicaid, Medicare, or the two largest commercial carriers in the state.

Using a master provider file, patient profiles from each identified provider within the state were collected from Medicaid, Arkansas BlueCross BlueShield, or QualChoice of Arkansas, or were generated from Medicare data housed by the Arkansas Health Data Initiative. Information on the aggregate number of patients served and patient visits was stratified by age into children (0–18 years of age) and adults (19 years of age and older). From each payer source, this information was then aggregated and analyzed to generate for each provider the proportion of patients and number of visits provided by each major payer source—Medicaid, Medicare, or private insurance.

RESULTS

County-level Payer Mix

Data from three counties—Desha, Stone, and Saline—were selected to show examples of physician payer mix for care provided to both children and adults in 2009.

The number of observations (e.g., physicians) within each county reflects the larger number in Saline County (39 physicians) compared with Desha (6 physicians) or Stone (6 physicians)

1 Moffit RE, "Obamacare: Impact on Doctors," Heritage Foundation WebMemo No. 2895, May 11, 2010, http://www.heritage.org/research/reports/2010/05/obamacare-impact-on-doctors.
2 National Ambulatory Medical Care Survey Electronic Medical Records Supplement, 2011, cited in Decker S. "In 2011, Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help," *Health Affairs* 2012;31(8):1673–1679.
3 Bishop TF, Federman AD, Keyhani S. "Declines in Physician Acceptance of Medicare and Private Coverage." *Arch Intern Med.* 2011;171(12):1117-1119.
4 For a more detailed discussion of the primary care physician supply in Arkansas, please see the issue brief titled "Supply and Demand of Primary Care Physicians," released in April 2013 by the Arkansas Center for Health Improvement. Available at www.achi.net.

Counties. In these three selected counties, physicians do not appear to restrict patient panels to privately insured individuals. Medicaid appears to be a dominant payer in each physician's panel for pediatric patients with all of the physicians in Stone and Desha Counties receiving Medicaid payments for patients' care. The majority of physicians in Saline County accepted Medicaid, but there were some physicians who did not have any Medicaid claims. For adult patients, most physicians have a more balanced profile of commercial and Medicare patients with a larger proportion of commercial coverage in Saline County, which has higher private insurance rates.

On a county level, these examples show that the relative volume of Medicaid visits for physicians in rural counties is higher than the volume of Medicaid patients for similar physicians in more metropolitan counties, irrespective of patient age. For example, the majority of Saline County physicians in this analysis had fewer than 500 visits from Medicaid patients of all ages, while the overwhelming majority of Desha County physicians had more than 500 visits from Medicaid patients. This suggests that physicians in rural areas such as Desha County are more reliant on Medicaid as a payer source when compared with more metropolitan counties, where physicians may have the flexibility to limit the number of patients from public payer sources.

Table 1 presents total numbers of patients and visits for both children and adults by payer source for the three example counties. In both rural counties (Desha and Stone), around 4 out of 5 children (0–18 years) were covered by Medicaid (84 percent in Desha, 79 percent in Stone) and Medicaid paid for the vast majority of visits (96 percent in Desha, 95 percent in Stone). For adults in these two counties, almost half of patients were covered by Medicaid and Medicare (45 percent in Desha and 46 percent in Stone) with public programs paying for the majority of visits—private payers covered only 15 percent of adult visits in Desha County and 8 percent of adult visits in Stone County.

In the more densely populated county of Saline, among children, Medicaid was the primary insurance source for just over half of the children (55 percent) yet covered almost 4 out of 5 visits (79 percent). Importantly, however, visits for children in Saline County were four to five times more frequently paid for with private coverage than in the rural counties—21 percent versus 4 to 5 percent. For adults in Saline County, the majority were covered by private payers (65 percent) with Medicare covering just under one-third (31 percent). However, the total number of visits were predominantly paid for by Medicare (66 percent), which covers those older than 65 years of age.

Table 1: Comparison of Provider Payer Mix for Selected Counties in 2010

County	Type/Age	Total	Medicaid	Medicare	Private
Desha	**(6 providers)**				
	Patients 0–18 years	4,096	84%	0%	16%
	Visits for Patients 0–18	9,388	96%	0%	4%
	Patients 19+ years	7,260	20%	25%	55%
	Visits for Patients 19+	13,312	44%	41%	15%
Stone	**(6 providers)**				
	Patients 0–18 years	2,243	79%	0%	21%
	Visits for Patients 0–18	5,505	95%	0%	5%
	Patients 19+ years	6,567	7%	39%	54%
	Visits for Patients 19+	18,172	15%	77%	8%

County	Type/Age	Total	Medicaid	Medicare	Private
Saline	**(39 providers)**				
	Patients 0–18 years	29,629	55%	0%	45%
	Visits for Patients 0–18	45,112	79%	0%	21%
	Patients 19+ years	45,096	4%	31%	65%
	Visits for Patients 19+	70,309	10%	66%	24%

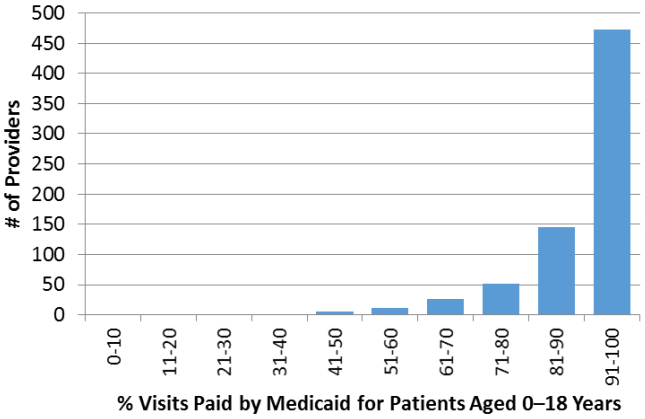
Statewide Physician Payer Mix

Similar analyses were conducted for a statewide assessment. From the 1,782 primary care physicians[5] listed in the dataset, 1,564 physicians each had a minimum of 500 visits; 718 physicians had at least 500 visits from children (ages 0–18 years) and 1,257 physicians had at least 500 visits from adults. These 1,564 physicians were included in the statewide analyses. The minimum visit was set at 500, representing an average of ~10 visits per week, to eliminate providers who provided minimal contributions to the workforce. Examining the 1,564 primary care physicians statewide, most primary care physicians serve both children and adults with a subset of pediatricians serving only children and similarly some family physicians and internists serving only adults.

Children

For children in Arkansas, Medicaid covers 60 percent of the population (844,365 individuals).[6] For the 718 providers with at least 500 visits by children in the year, 8 (1 percent) have less than half of their child patient visits paid for by ARKids and 210 physicians (29 percent) had 50–90 percent of their child patient visits paid by ARKids. Conversely, the majority (approximately 460 providers, 70 percent) had more than 90 percent of their payments for child visits paid by ARKids (Graphic 1). This suggests that for children's care the ability to restrict to private insurance only is limited.

Graphic 1: Number of Providers by Percent of Visits Paid by Medicaid (patients aged 0–18 years; 718 providers)



Adults

For adults, Medicare covers most individuals over age 65 (Medicaid beneficiary population = 552,375 in 2012).[7] Those under age 65 who are insured are predominantly commercially covered. Importantly, 25 percent of Arkansans 19–64 years are not insured; therefore, when seen by providers, they were not reflected in these distributions because they generated no claim.

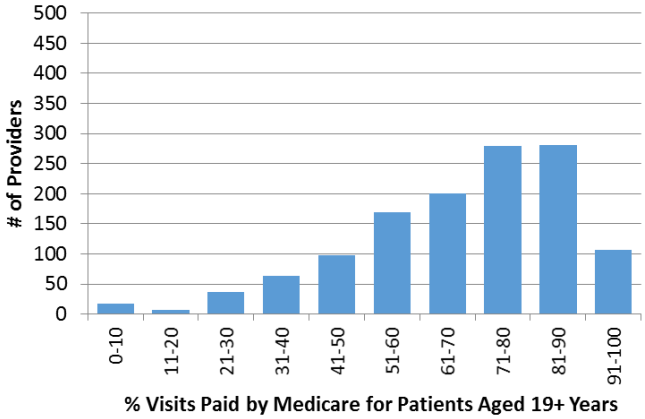
5 Primary care physicians are defined as internal medicine, general/family medicine, geriatrics, and pediatrics for purposes of this analysis. Obstetricians/gynecologists have been excluded for purposes of this analysis.

6 Arkansas Medicaid Program Overview 2012, Arkansas Department of Human Services. Web 21 Feb 2013 at https://www.medicaid.state.ar.us/Download/general/MOBSFY2012.pdf.

7 The Henry J. Kaiser Family Foundation. *State Health Facts: Total Number of Medicare Beneficiaries*. 2012. Accessed at: http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/?state=AR on May 20, 2013.

Because of the higher disease burden and clinical needs, visits by Medicare beneficiaries far exceed those of their commercial counterparts. For the 1,257 providers with at least 500 visits by adults in the year, only 1 percent (17 providers) have fewer than 10 percent of their adult patient visits paid for by Medicare; 17 percent (213) have at least half of their adults visits paid by Medicare. Conversely, 45 percent (567) of these physicians have more than three-fourths of adult patient visits paid by Medicare. Unlike children's care, more providers may restrict their practice to predominantly private patients, although the majority of physicians continue to serve both private and Medicare beneficiaries.

Graphic 2: Number of Providers by Percent of Visits Paid by Medicare (patients aged 19+ years; 1,257 providers)



CONCLUSION

The vast majority of physicians in Arkansas accept both public and private sources of insurance, with physicians in rural areas having greater numbers of patients with public insurance. Physicians in urban areas have more of an ability to restrict their patient panels toward commercial insurance, but even so, most still accept publicly insured patients. The ability of physicians to restrict care to privately insured patients, especially in rural counties, is relatively limited and therefore patients with public payer sources should not experience financial barriers to accessing care.

Physician shortages in the short term are expected to be exacerbated with expanded coverage through the adoption of the "private option" and the implementation of the exchange. This shortage will primarily hit rural areas, which are already experiencing shortages. Telemedicine, the use of APNs and PAs as clinician extenders in primary care, and the transportation of patients to physicians and vice versa can help improve the shortage of primary care clinicians as well as the issue of maldistribution of clinicians.