Contract No.: 500-01-0025(01)
MPR Reference No.: 8923-520

MATHEMATICA
Policy Research, Inc.

Results from the 2003 and 2004 Targeted Beneficiary Surveys on Access to Physician Services Among Medicare Beneficiaries

Final Report

January 20, 2005

Timothy Lake
Marsha Gold
Anne Ciemnecki
Jason Markesich
Nuria Diaz-Tena
So Sasigant Limpa-Amara

Submitted to:

Centers for Medicare & Medicaid Services
2-21-15 Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Project Officer:
Renee Mentnech

Submitted by:

Mathematica Policy Research, Inc.
50 Church Street, 4th Floor
Cambridge, MA 02138
Telephone: (617) 491-7900
Facsimile: (617) 491-8044

Project Director:
Anne Ciemnecki

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

ACKNOWLEDGMENTS

We would like to acknowledge numerous people who made contributions to this report and to the targeted survey of Medicare beneficiaries described herein. This survey project would not have been possible without the leadership of Renee Mentnech, the project officer at CMS, who identified the need for the survey, developed the overall design of the study, and guided us in key design decisions throughout the project. Mary Kapp at CMS also provided excellent advice and guidance for all aspects of the project. In addition, the study benefited from the work of numerous CMS staff in ORDI, CBC, OIS, and the regional offices at CMS who are involved in monitoring beneficiaries' access to physician services, and who assisted in the selection of the geographic areas targeted in this report.

At Mathematica, we would like to thank Randy Brown for his review and comments on both the study design and the report. Barbara Carlson and Dan Kasprzyk also provided review of the sampling design and weighting methodology. The survey was conducted by telephone interviewers with oversight by Thomas Barton and a team of supervisors. Anne Hower led programming efforts to develop the survey analytic file. Ben Shiller performed programming for analysis of the survey results. Roy Grisham edited the report, and Margaret Hallisey performed the word processing and production of the report. Finally, we would like to thank the many Medicare beneficiaries who contributed both their time and perceptions of access to care to this study.

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

CONTENTS

CONTENTS *(continued)*

Chapter **Page**

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

TABLES

TABLES *(continued)*

FIGURES

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

EXECUTIVE SUMMARY

Reductions in the fee rates paid to physicians by Medicare in 2002 and early 2003 raised concerns that beneficiaries in some market areas may have difficulty obtaining the care they need in a timely manner. A combination of factors caused the legislatively specified formula, which sets the payment rates for physicians' services, to produce negative updates for 2002 and 2003.[1] In 2002, physician payments for Medicare services were cut by 5.4 percent. In early 2003, payments were cut again by 4.4 percent but were subsequently adjusted so that they were increased by 1.6 percent over 2002 rates starting March 1, 2003. Since then, payments have been increased by 1.5 percent in 2004, and the same increase is planned for 2005.

This report is the second of two reports from a study commissioned by the Centers for Medicare & Medicaid Services (CMS) and conducted by Mathematica Policy Research, Inc. (MPR) to provide rapid feedback on whether reductions in the payment rates to physicians in 2002 and early 2003 had a negative effect on access to care for Medicare beneficiaries (CMS 2002; CMS 2003). The reports are based on surveys of Medicare fee-for-service (FFS) beneficiaries in 11 targeted markets who were thought likely to be experiencing high rates of access problems.

In MPR's first report, based on a 2003 survey, we found relatively low rates of access problems in the targeted markets (Lake et al. 2003). Only a small percentage of beneficiaries had problems that could be attributed to reasons tied to physicians' willingness to accept Medicare patients. However, the extent of problems varied by market and were more common for "transitioning" beneficiaries who had recently moved or made changes in their Medicare coverage arrangements. Higher rates of problems also were reported for beneficiaries with other vulnerable characteristics (for example, low income, poor health, disability, and lack of Medicare supplemental coverage).

This report presents results from a survey of the same communities in 2004 and assesses whether the situation has changed since 2003. Because we found little change between 2003 and 2004 (as highlighted in more detail below), and used the same survey methods in both years, we took advantage of the ability to pool two years of data to provide a more detailed analysis of the characteristics of beneficiaries more likely to experience problems.

METHODS

This study first identified a set of geographic areas likely to have problems with declining willingness of physicians to accept Medicare patients. Within these areas, we interviewed Medicare beneficiaries about their access problems, during two rounds of surveys in 2003 and

[1] The payment formula was enacted in the Balanced Budget Act of 1997 and refined in the Balanced Budget Refinement Act of 1999.

2004. In each year, we targeted a portion of beneficiaries who might have been especially vulnerable if physicians were, in fact, not accepting Medicare beneficiaries or limiting their Medicare practices. In the first-round survey, telephone interviews were conducted between April and June 2003. In the second-round survey, interviews were conducted during the identical months in the following year, 2004. The same methods for identifying the samples and same survey instrument were used in each year. Interviews generally lasted 10 to 15 minutes. A small portion of the beneficiaries in each sample responded by mail, when they preferred not to respond by telephone.

With a budget for 3,300 telephone interviews in each round, we aimed to interview about 300 beneficiaries in each of 11 purposely chosen markets each year. This approach attempted to strike a balance between the competing goals of geographic diversity (that is, selecting a reasonably large number of diverse sites) and adequate site-level statistical precision of our survey estimates (obtaining sample sizes per site large enough for reliable estimates of the proportion having access problems). We also oversampled transitioning beneficiaries who recently became eligible for Medicare, left a Medicare managed care plan, or moved into the local area. These beneficiaries were thought to be more likely to seek a new provider, and hence more likely to experience a problem accessing care. Our goal was to have these beneficiaries represent half the total sample (about 150 beneficiaries per site, or 1,650 beneficiaries across the 11 sites in each year) in order to have more sample members likely to have access problems and therefore more information on the reasons for these problems. To compensate for this design, the data were weighted so that results represent the overall Medicare FFS population in a local area.

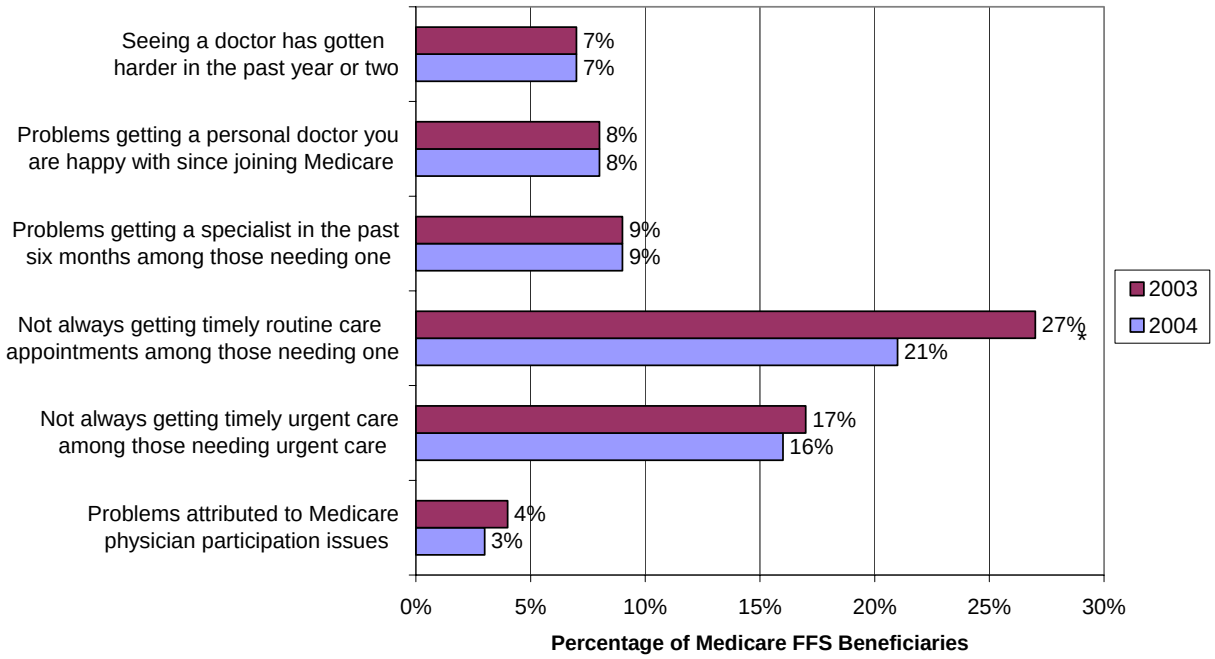
TRENDS IN ACCESS PROBLEMS, 2003 TO 2004

Rates of access problems generally did not change from 2003 to 2004. The proportion of beneficiaries experiencing major physician access problems remained small in both years. While the proportion of beneficiaries reporting access problems for particular areas of care ranged from 8 to 21 percent, the proportion with serious problems or problems attributed to physicians not accepting Medicare patients or limiting their Medicare practices was low (about 4 percent) and stable (see Figure 1).

Of the key access outcomes measured, the only significant change from 2003 to 2004 was an increase in the proportion of beneficiaries who were always able to get timely routine care appointments when needing one. However, the change from 2003 to 2004 reflects a shift from "usually getting routine care appointments as soon as needed" to "always getting routine care appointments as soon as needed," suggesting an improvement among those with minimal problems to begin with.

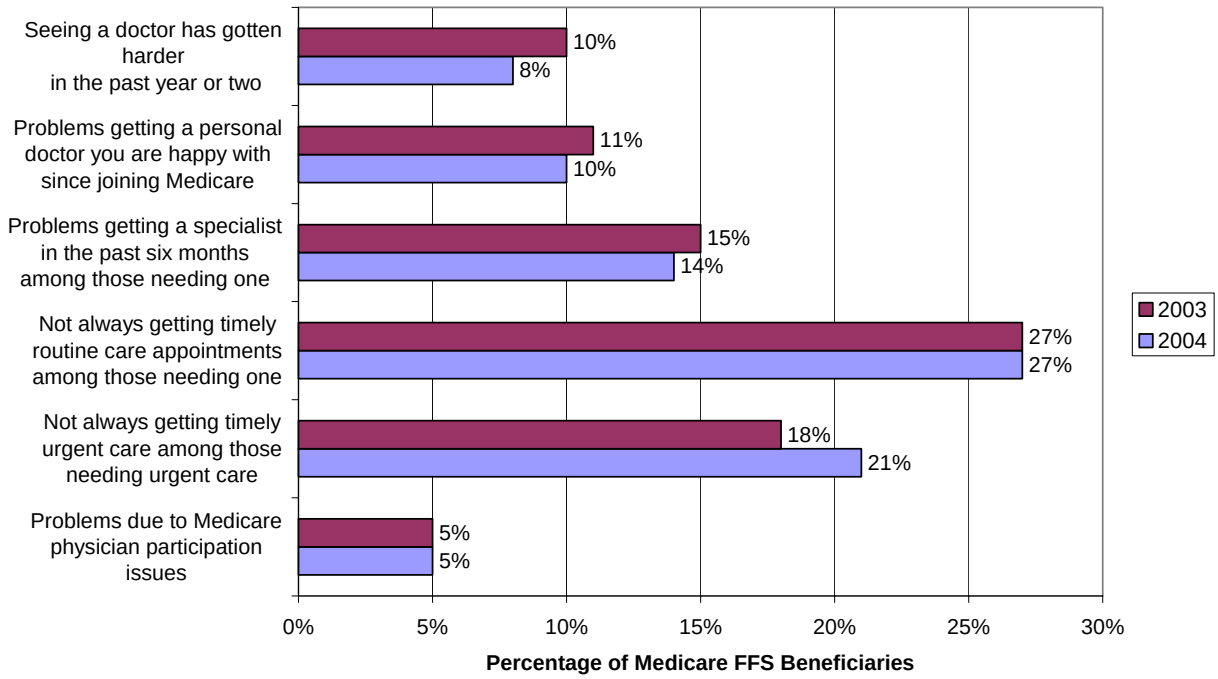
As Figure 2 shows, transitioning beneficiaries also experienced little change in rates of problems. The only exception was a 3-point increase in the percentage of beneficiaries who did not always receive timely urgent care in the past six months, among those needing it. However, the sample size (those needing urgent care) for this measure was relatively small, so that the change is not statistically significant. Although beneficiaries in general were less likely to

FIGURE 1: 2003-2004 Trends in Physician Access Measures (All Beneficiaries)



* Difference between 2003 and 2004 is statistically significant, $p < 0.05$. All other differences were not statistically significant

Figure 2: 2003-2004 Trends in Physician Access Measures (Transitioning Beneficiaries Only)



NOTE: None of the 2003-2004 differences was statistically significant at the $p < 0.05$

report problems getting routine care appointments in 2004 than in 2003, we did not find this trend for transitioning beneficiaries.

We also found few significant trends over time for other beneficiary subgroups, including disabled beneficiaries, those in poor or fair health, those with no Medicare supplemental coverage, those with lower incomes, and those in different racial or ethnic groups. In addition, we observed few significant changes in access problems within specific geographic sites (data not shown).

EFFECTS OF BENEFICIARY CHARACTERISTICS ON ACCESS PROBLEMS

Given the general lack of change over time, and the findings from our first report of higher rates of problems among certain vulnerable populations, we pooled the 2003 and 2004 survey data sets to examine subgroup differences more closely, and with more statistical precision given a larger sample size (more than 6,500 beneficiaries).

We first conducted descriptive comparisons of rates of access problems among different beneficiary subgroups, focusing on measures of any problems and those that may have been related to Medicare physician payment policy. These included the proportion of beneficiaries (1) who had any problems (for any reason), (2) who had problems attributed to physicians' willingness to accept Medicare (for example, the doctor is taking no new Medicare patients), and (3) who had problems due either physicians' willingness to take Medicare patients or other physician availability issues.

As Table 1 shows, beneficiaries with vulnerable characteristics— including transitioning status, disability, poor/fair health status, low income, and no Medicare supplemental coverage— had significantly higher rates of problems. We also found that rates of problems were especially high for beneficiaries with certain combinations of vulnerable characteristics. For example, beneficiaries who were in transition and in poor or fair health had rates of problems related to Medicare physicians' willingness to accept Medicare that were nearly three times as high as the rates for all beneficiaries (9.2 percent versus 3.7 percent). Our analysis focused on a limited number of combinations, and some of these were not associated with markedly higher rates of problems. For example, disabled beneficiaries without supplemental coverage did not have higher rates of problems than other disabled beneficiaries, although both rates were high.

We then conducted a multivariate analysis to test the independent effects of beneficiary characteristics on the likelihood of problems, controlling for other measured factors. We specified a set of logistic regressions in which the dependent variable was the probability of reporting a problem, and the independent variables were selected beneficiary characteristics and a set of 11 dummy control variables for geographic site location (not shown). Regression models were specified for all beneficiaries, and for three subgroups of interest, including transitioning beneficiaries, beneficiaries without supplemental coverage, and disabled beneficiaries.

TABLE 1
ACCESS PROBLEMS ASSOCIATED WITH PHYSICIANS' WILLINGNESS TO ACCEPT MEDICARE PATIENTS, BY SELECTED BENEFICIARY CHARACTERISTICS, 2003-2004 POOLED DATA

	Percentage of Medicare FFS Beneficiaries With:		
	At Least One Access Problem (Any Reason)[a]	At Least One Access Problem Due to Physician Willingness to Accept Medicare	At Least One Access Problem Due to Physician Willingness to Accept Medicare or Other Physician Availability Issues[b]
All Beneficiaries	24.8	3.7	8.9
Characteristics			
Transitioning Status			
Transitioning beneficiaries	28.7[c]	5.4[c]	12.1[c]
Continuous beneficiaries	24.5	3.5	8.6
Age			
Under age 65 (disabled)	50.9[c]	9.9[c]	24.4[c]
65-69	23.9	4.0	10.0
70-74	21.7	3.3	7.0
75-79	23.6	3.5	7.4
80-84	23.4	1.3	5.5
85+	18.1	2.0	4.9
Health Status			
Fair or poor	37.8[c]	5.0[c]	14.0[c]
Excellent, very good, or good	20.4	3.2	7.1
Annual Income			
Less than $10,000	31.1[c]	5.4[c]	12.6[c]
$10,000-$25,000	31.5	3.2	9.6
More than $25,000	21.7	3.8	8.1
Medicare Supplemental coverage			
No	32.1[c]	6.2[c]	14.3[c]
Yes	23.5	3.2	7.9
Combination of Characteristics			
Transitioning beneficiaries who are:			
Disabled (age < 65)	43.6[c]	8.3[c]	17.6[c]
In poor or fair health	46.2[c]	9.2	20.4[c]
Low income (< $10,000)	40.7[c]	6.7[c]	17.3[c]
Beneficiaries with no supplemental coverage who are			
Transitioning	27.2[c]	5.3[c]	11.6[c]
Disabled (age < 65)	45.7[c]	8.7[c]	25.2[c]
Poor or fair health	34.9[c]	3.9[c]	11.9[c]
Low household income (< $10,000)	29.4[c]	4.9	10.4[c]

Source: 2003 and 2004 targeted surveys of Medicare FFS beneficiaries conducted by MPR for CMS.

[a]Includes one or more problems with finding a personal doctor or specialists, untreated medical conditions, delays in receiving care, and poor or fair ratings of the availability of primary care doctors or specialists.

[b] Other physician availability issues include response categories such as "doctors not taking any new patients" or "found doctor, but appointments hard to get", indicating limited physician availability that is not specific to Medicare. However, these responses may represent some cases in which a beneficiary is unaware of a doctor's decision to limit participation in Medicare.

[c]The difference between estimated proportions for the subgroups is statistically significant, with $p<0.05$. For beneficiaries with combinations of characteristics, the comparison was between beneficiaries with the particular combination of characteristics (e.g. transitioning and disabled) and all other beneficiaries who do not have this combination of characteristics.

As Table 2 shows, only some of the vulnerable characteristics we measured had an independent effect on access to care, when controlling for other factors in regression analysis. Disability (under age 65), and poor or fair health status independently increased the likelihood of access problems.[2] Another notable finding was that women had a significantly higher predicted rate of problems (nearly 5 percentage points) than men, when controlling for other measured factors in the model (results not shown).

When controlling for other factors in our regression analysis, transitioning status did not have a significant independent effect on the probability of access problems, in contrast to observed differences (Table 2). However, when we analyzed the effects of beneficiary characteristics for transitioning beneficiaries themselves, we found that poor/fair health status and low income had relatively large effects for this group, compared to all beneficiaries. This may indicate that although transitioning status itself did not contribute to access problems, transitioning beneficiaries may nonetheless have been more vulnerable to certain circumstances. On the other hand, transitioning beneficiaries showed smaller effects of being under age 65 disabled, perhaps because transitioning status is associated with a lower level of disability and better ability to navigate the health care system.

GEOGRAPHIC VARIATION IN RATES OF ACCESS PROBLEMS

Rates of access problems, adjusted for population differences, varied significantly across the 11 geographic areas targeted in this study in 2003-2004 (Table 3).[3] The proportion of beneficiaries with any problems ranged from 20 percent to nearly 35 percent, and the proportion of beneficiaries with a problem due to Medicare physicians' willingness to accept Medicare ranged from 1 percent to 14 percent.

Alaska and Denver, Colorado stood out as having consistently high rates of problems on multiple measures. Ft. Worth also had a relatively high percentage of beneficiaries reporting at least one problem, although this result was driven primarily by a high percentage of beneficiaries who had a problem getting a personal doctor they were happy with since joining Medicare (data not shown).

[2] Disabled (under age 65) beneficiaries were in the omitted reference group for the regressions. As Table 2 shows, beneficiaries of all age groups 65 years or older were predicted to have lower rates of problems than disabled beneficiaries.

[3] Regression adjusted rates are estimates of what rates of problems would have been if each site had average population characteristics for all 11 sites.

TABLE 2

EFFECTS OF SUBGROUP CHARACTERISTICS ON THE PROBABILITY OF ANY ACCESS PROBLEMS, 2003-2004 POOLED DATA

	All Beneficiaries		Transitioning Beneficiaries	
	Observed Difference	Regression-Adjusted Difference[a]	Observed Difference	Regression-Adjusted Difference[a]
Transitioning (vs. Non-Transitioning)	4.2*	0.7	n.a.	n.a
Age				
< 65 disabled (reference) [b]				
65-69	-27.0*	-16.2*	-17.5*	-6.7*
70-74	-29.2*	-19.1*	-11.6*	-2.4
75-79	-27.3*	-17.5*	-15.7*	-4.9
80-84	-27.5*	-19.6*	-17.5*	-6.9
85+	-32.8*	-23.9*	-11.1*	-0.4
Poor or Fair Health (vs. Excellent, Very Good, or Good Health)	17.4*	13.4*	24.0*	19.1**
No Supplemental Coverage (vs. Supplemental Coverage)	8.6*	1.1	7.0*	-0.4
Income				
<$10,000[b]				
$10,000-$25,000	0.4	2.8	-7.0*	-6.0
>$25,000	-9.4*	-4.7	-16.7*	-10.5*

[a]The regression adjusted differences reflect the estimated change in the percentage of beneficiaries with access problems given this characteristic (vs. not), with mean characteristics for all other variables in the regression model.

NOTE: A set of dummy variables indicating the 11 targeted geographic sites (not shown here) were also included in the regressions to control for differences in geographic location.

*Difference is statistically significantly different than zero, $p < 0.05$.
**Difference is statistically significantly different than zero, $p < 0.01$

These regression-adjusted rates were not substantially different from observed rates of access problems in specific sites, indicating that population differences played a small role in the observed geographic variation in the extent of access problems.

LIMITATIONS

Several limitations to this study should be noted. First, since we chose markets thought to represent areas with a high level of access problems, the results presented here are not nationally representative. Instead, we tried to confirm and enumerate the extent of access problems in these areas, then explore the reasons for the problems. Second, all the results are based on beneficiaries' perceptions of access issues and the reasons for the problems they experienced. We were not able to identify the true causes of problems or to determine whether specific

TABLE 3

ACCESS PROBLEMS ASSOCIATED WITH PHYSICIANS' WILLINGNESS TO ACCEPT MEDICARE PATIENTS , BY GEOGRAPHIC AREA, 2003-2004 POOLED DATA

	Regression- Adjusted Percentage of Medicare FFS Beneficiaries With:		
	At Least One Access Problem (Any Reason)[a]	At Least One Access Problem Due to Physicians' Willingness to Accept Medicare	At Least One Access Problem Due to Physicians' Willingness to Accept Medicare or Other Physician Availability Issues[b]
All Beneficiaries	24.8	3.7	8.9
Geographic area			
Alaska (state)	34.8 [c]	14.2 [c]	20.9 [c]
Phoenix, AZ	25.4	4.1	8.2
San Diego, CA	27.1	3.3	9.7
San Francisco, CA	20.6	1.2	5.5
Denver, CO	27.1	11.1	15.9
Tampa, FL	21.0	2.6	5.7
Springfield, MO	20.1	3.0	8.8
Las Vegas, NV	26.2	2.0	7.1
Brooklyn, NY	23.2	1.5	5.3
Ft. Worth, TX	25.2	11.0	15.5
Seattle, WA	22.3	5.9	10.3

Source: 2003 and 2004 targeted surveys of Medicare FFS beneficiaries conducted by MPR for CMS.

NOTE: Regression adjusted rates are estimates of what the proportion of Medicare beneficiaries with access problems would be if each site had average beneficiary characteristics across all 11 sites.

[a]Includes one or more problems with finding a personal doctor or specialists, untreated medical conditions, delays in receiving care, and poor or fair ratings of the availability of primary care doctors or specialists.

[b] Other physician availability issues include response categories such as "doctors not taking any new patients" or "found doctor, but appointments hard to get", indicating limited physician availability that is not specific to Medicare. However, these responses may represent some cases in which a beneficiary is unaware of a doctor's decision to limit participation in Medicare.

[c]Chi Squared test showing overall differences of site estimates is statistically significant, with $p < 0.05$

problems reported actually had significant consequences for beneficiaries. For example, some beneficiaries with access difficulties may have been unaware of physician supply or Medicare physician participation issues, while others may have mistakenly attributed their difficulties to these issues; thus, these results may either understate or overstate the actual extent of the problem. Although the validity and reliability of answers to these questions have not been tested, beneficiaries nonetheless offer an important perspective on reasons for problems not provided by other sources of information.

Finally, we cannot say conclusively whether increases in payment set for most of 2003 and 2004, and those planned for 2005, have offset any potentially negative effects of cuts in 2002 and early 2003. This study was not designed to measure directly the effect of Medicare physician payment changes on physician access to care. Payment changes over the past few years were made nationwide; thus, we cannot estimate directly what would have happened in absence of these changes by observing a group of beneficiaries not exposed to these changes. Nonetheless, the results from this study indicate that there has been no major deterioration in beneficiaries' perceptions of access to care in the 11 targeted markets thought to have problems, over a one-year period following the recent cuts in Medicare fees.

CONCLUSIONS

The results from this study are generally reassuring. We attempted to target areas with severe access problems; yet we found the proportion of beneficiaries who reported problems to be small. We also found little indication that problems have worsened in these areas in the past year or so. Rates of access problems reported by all beneficiaries, and among vulnerable subgroups, remained stable from 2003 to 2004. In both years, a small percentage of beneficiaries said that seeing a doctor had become more difficult in the past year or two, while a large percentage reported no change.

Nevertheless, some of our findings are grounds for concern. In 2003, we found that rates of access problems were higher (though still moderate in size) in a few market areas and among beneficiaries with certain characteristics, such as those who had made recent transitions in location or health coverage and thus were more likely to be looking for a new physician. Further, some beneficiaries with problems cited reasons that are associated with physicians not accepting Medicare patients or limiting their Medicare practices.

The situation for vulnerable subgroups did not change dramatically in 2004. Access has not grown worse for these groups, but it has not improved, either. An analysis of 2003 and 2004 pooled data reveals that beneficiary characteristics have independent effects on access problems. In particular, beneficiaries who were disabled or who were in relatively poor health were significantly more likely to report access problems, when controlling for other factors. Among transitioning beneficiaries, the effect of health status was especially large. Lower income also increased the likelihood of access problems among transitioning beneficiaries. Beneficiaries with these vulnerable characteristics will be important to track over time because they may feel the greatest impact if access barriers increase in the future.

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

I. INTRODUCTION

A. OVERVIEW

This report is the second of two reports from a study commissioned by the Centers for Medicare & Medicaid Services (CMS) and conducted by Mathematica Policy Research, Inc. (MPR) to provide rapid feedback on whether reductions in the payment rates to physicians in 2002 and early 2003 had a negative effect on access to care for Medicare beneficiaries (CMS 2002; CMS 2003). The reports are based on surveys of Medicare fee-for-service (FFS) beneficiaries in 11 targeted markets that were thought likely to be experiencing high rates of access problems.

In MPR's first report, based on a 2003 survey, we found relatively low rates of access programs in the targeted markets (Lake et al. 2003). Only a small percentage of beneficiaries had problems attributed to reasons that appeared tied to reduced Medicare fees. However, the extent of problems varied by market and were more common for beneficiaries who had recently moved, joined Medicare, or disenrolled from a Medicare managed care plan. Higher rates of problems also were reported for beneficiaries with other vulnerable characteristics (for example, low income, poor health, disability, and lack of Medicare supplemental coverage).

This report presents results from a survey of the same communities in 2004, to assess whether the situation had changed since 2003. Because we found that there was little change between 2003 and 2004, and we used the same survey methods in both years, we took advantage of the ability to pool two years of data to provide a more detailed analysis of the characteristics of beneficiaries more likely to experience problems.

B. POLICY CONTEXT AND RECENT RESEARCH

A combination of factors caused the legislatively specified formula, which sets Medicare payment rates for physicians' services to produce negative updatesin 2002 and 2003.[1] In 2002, physician payments for Medicare services were cut by 5.4 percent. In early 2003, payments were cut again by 4.4 percent, but were then increased by 1.6 percent starting March 1, 2003.

The payment provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) averted further formula-driven cuts for these years. In 2004, payments were increased again by 1.5 percent—as legislated in the MMA—and payments are mandated to be raised by the same amount in 2005 (CMS 2004). However, without further congressional action, reductions are planned to begin again in 2006, and the underlying payment update formula now in place remains controversial.[2]

In our review of previous research conducted since major payment reforms were first implemented in 1992 (Lake et al. 2003), we concluded that most beneficiaries have not had problems accessing physician services. More recent evidence made available since our first report showed little dramatic change in this overall access picture. A telephone survey of about 1,000 Medicare beneficiaries nationwide conducted by Project Hope for MedPAC in fall 2003 indicated relatively few access problems reported. For example, only 7 percent of beneficiaries seeking a new physician reported a problem finding one, with a similar proportion of those seeking a specialist reporting problems (MedPAC 2004). MedPAC also conducted an analysis of national Medicare fee-for-service CAHPS data from 2000 to 2002, and found consistently low

[1]The payment formula, based on the Sustainable Growth Rate (SGR), was enacted in the Balanced Budget Act of 1997 and refined in the Balanced Budget Refinement Act of 1999.

[2]Under current law, because the SGR will take into account payment updates in 2003, 2004, and 2005 (which averted cuts those years), without additional congressional action, future cuts will be set to offset the recent increases (Holtz-Eakin 2004).

rates of reported problems during this period. However, the percentage reporting they are able to schedule timely routine care appointments dropped from 93 percent to 90 percent over the two-year period.[3] The Community Tracking Study recently found some improvement in access to care for all Americans, with particular gains for vulnerable populations, including the uninsured and those with low incomes, from 2001 to 2003 (Strunk and Cunningham 2004). In particular, respondents were more likely in 2001 than in 2003 to indicate they "didn't get the medical care they needed" and "put off or postponed care they thought they needed." Medicare beneficiaries were not examined separately in this analysis.

A Project Hope survey of physicians sponsored by MedPAC in 2002 indicated that "among physicians accepting any new patients, 96 percent were accepting some or all new Medicare patients," and that Medicare patients were more likely to be accepted than all other patients, except privately insured FFS or PPO patients. The growth in number of physicians that billed Medicare for any services has exceeded the growth in the number of beneficiaries from 1995 to 2002, while overall Medicare physician participation (the agreement of physicians to accept assignment for all Medicare patients) grew from 80 percent in 1997 to 91 percent in 2002 (MedPAC 2004).

C. ORGANIZATION OF THIS REPORT

In the remainder of this report, we discuss this study in more detail. In Chapter II of the report, we review the methods for the study. In Chapter III, we present results on the extent of change in access problems from 2003 to 2004. In Chapter IV, we present results from a more

[3]Changes in the wording of the definition of "routine" care in the 2000 and 2002 CAHPS-FFS survey instrument may explain some of this change.

detailed analysis of the relationship between beneficiary characteristics and access problems. And in Chapter V, we discuss our conclusions from the study.

II. METHODS

In this chapter, we discuss our survey design and approach to analyzing and reporting the results from the 2003 and 2004 target beneficiary surveys. We start by describing how we selected the targeted sites, then discuss how we chose beneficiary samples within each site. Next, we give an overview of the survey instrument design and summarize how we conducted the survey. Finally, we discuss our methods for analyzing and reporting the survey results.

In short, the study first identified a set of geographic areas likely to have problems with Medicare beneficiaries' access to care. In each of these areas, we interviewed Medicare beneficiaries about their access problems during two rounds of surveys conducted in 2003 and 2004. In each year, we targeted a portion of beneficiaries who might have been especially vulnerable if physicians were, in fact, not accepting Medicare beneficiaries or limiting their Medicare practices. In the first-round survey, telephone interviews were conducted between April and June 2003. In the second round, survey, interviews were conducted during the identical months in the following year, 2004. The same methods for identifying the samples and same survey instrument were used in each year (Lake et al. 2003). Interviews generally lasted 10 to 15 minutes. A small portion of the beneficiaries in each sample responded by mail, when they preferred not to respond by telephone.

With a budget for 3,300 telephone interviews in each round, we aimed to interview about 300 beneficiaries in each of 11 purposely chosen markets each year. This approach attempted to strike a balance between the competing goals of geographic diversity (that is, selecting a reasonably large number of diverse sites) and adequate site-level statistical precision of our survey estimates (obtaining large enough sample sizes per site for reliable estimates of the proportion having access problems). We oversampled transitioning beneficiaries who recently

became eligible for Medicare, left a Medicare managed care plan, or moved into the local area. Our goal was to have these beneficiaries represent half the total sample (about 150 beneficiaries per site, or 1,650 beneficiaries across the 11 sites in each year) in order to have more sample members likely to be seeking a new provider and potentially having access problems, and therefore, being able to provide information on the reasons for problems. To compensate for this design, the data were weighted so that results represent the overall Medicare fee-for-service (FFS) population in a local area. The rest of this chapter provides details of the study design.

A. RESEARCH QUESTIONS AND STUDY FRAMEWORK

The main goal of this study is to assess the extent of access problems for Medicare beneficiaries in a chosen set of local markets after cuts in Medicare physician payment rates were implemented. The study focuses on markets perceived as more likely to have existing access problems and addresses the following key questions:

- What proportion of Medicare beneficiaries reported different types of access problems in selected local markets? Did rates of access problems change significantly from 2003 to 2004?
- Did the extent of access problems vary across selected markets? Were there major changes in the rate of problems in specific local markets from 2003 to 2004?
- What beneficiary characteristics were associated with problems with access to physician services? Have specific beneficiary subgroups experienced changes in the extent of problems from 2003 to 2004?
- What proportion of Medicare beneficiaries attributed access problems to physicians limiting their Medicare practices or no longer treating or accepting Medicare patients? Has this proportion changed from 2003 to 2004?

Our framework for designing the study recognizes the multidimensional nature of access to health care services in Medicare, including enabling, predisposing, and need factors (Aday and Anderson 1975). We used this framework to help identify the particular markets, subgroups, and types of access problems most likely to be affected by changes in Medicare payments to

physicians. Given the urgent nature of potentially growing access problems, the study was also designed to provide timely information to CMS. A major challenge was to target our study effectively so that it could detect emerging access problems related to physicians' responses to changes in Medicare reimbursement, even though such problems may be rare for most beneficiaries living throughout the country.

This framework guided both our survey design and our analysis of the results from the surveys. In particular, we wanted to identify markets that already had access problems and emerging signs of problems with physician willingness to treat Medicare patients, which we expected would make them most vulnerable to subsequent payment cuts. Within markets, we also wanted to identify beneficiaries likely to be more vulnerable to changes in physician willingness to treat Medicare patients. We hypothesized that those in "transition" might be more likely to experience problems since they were more likely to be seeking out a new provider. Operationally, we defined this group as beneficiaries newly eligible for Medicare, new to the geographic market, or new to Medicare FFS (having disenrolled from a Medicare managed care plan); we oversampled the transitioning beneficiaries so that there would be a sufficient number to study. Across sites, we also looked at subgroups that historically have had more problems accessing care—such as those with lower incomes, poorer health status—under the assumption that they too might be most vulnerable to changes in physicians' willingness to treat Medicare beneficiaries. We examined some groups with combinations of these characteristics that might make them especially vulnerable.

Finally, we aimed to analyze whether access problems varied among individual market areas targeted in the survey, after payment cuts were implemented. For example, we expected that such market factors as overall physician supply, organization of the local delivery systems, and

the extent of managed care would likely play a role in access problems and may interact with the effects of payment cuts.

B. SELECTION OF GEOGRAPHIC SITES

The first step in our sampling approach was to choose the 11 geographic areas to survey. We used a purposive sampling approach—as opposed to random sampling—to select the markets that were most likely to have substantial or growing Medicare physician access problems in light of changes in physician payment policy. We wanted to identify areas where problems were anticipated and for which a survey can confirm or refute anecdotal reports that the Medicare payment restrictions were contributing to access problems.[1] If few problems were found in these sites, problems were likely to be minimal elsewhere.

Our approach to selecting areas was driven by analysis of empirical data, with a preference for indicators that would provide quantitative evidence that access to physicians by Medicare beneficiaries was, or could be, becoming a problem. Our approach was constrained by the limited data available to support selection of local areas. The only directly relevant indicators universally available across the country come from the Medicare FFS Consumer Assessment of Health Plans Survey (CAHPS-FFS). The most recent CAHPS-FFS data available at the time of selection were from the 2001 survey, before the recent Medicare fee reductions. We relied on four measures from CAHPS-FFS for selection:

1. Percentage of Medicare beneficiaries who had a problem (small or big) finding a personal doctor they were happy with since joining Medicare
2. Percentage of Medicare beneficiaries who in the past six months had a problem (small or big) seeing a specialist, among those needing one

[1] We describe our approach for selection of the surveyed areas in detail in Lake et al. (2003) and in Gold et al. (2002).

3. Percentage of Medicare beneficiaries who never, sometimes, or usually (versus always) got a timely appointment for routine care, among those seeking appointments in the past six months[2]

4. Percentage of Medicare beneficiaries who never, sometimes, or usually (versus always) got timely urgent care, among those needing urgent care in the past six months

The core unit for our selection data analysis was the CAHPS-FFS "geo unit." The 276 geo units are mutually exclusive and totally exhaustive of the nation. Geo units do not cross states, so they are consistent with CMS's state-based monitoring efforts on physician access. Geo units consist of sparsely populated states, major metropolitan areas, large urban counties, and large rural areas within states.[3] Geo units below the state level are formally identified by a code number and referenced by their largest county. Many geo units, including the 11 sites selected for this study, cover all or most counties in a major metropolitan area (or entire state) and can be informally identified through the name of their most prominent city.

We combined the CAHPS measures described above with state-level information taken from CMS monitoring activities, including environmental scanning reports by CMS regional offices and telephone calls to 1-800 Medicare and Medicare carriers in 2002. Areas designated as eligible for site selection generally met two criteria:

1. They had high rates of access problems reported on the 2001 CAHPS measures. In particular, they were in at least the top 10 percent of areas nationwide on one of two measures: the percentage of beneficiaries with problems finding a personal doctor

[2] We split this item, and the next item, in terms of "always" versus other responses to parallel definitions used in the previous two items. The goal was to distinguish areas based on the proportion of beneficiaries with any problems versus no problems.

[3] The geo units include seven states, a few single counties, and two partial county areas (northern and southern Los Angeles County). The remaining units are metropolitan areas or multi-county rural areas within states. For this project, we combined the geo codes for Harris and Montgomery counties in Texas to correct for design problems in the 2000 and 2001 CAHPS surveys.

since joining Medicare and the percentage of those needing a specialist who had problems seeing one in the past six months.

2. They were located in states where CMS monitoring efforts in 2002 indicated emerging physician access issues related to Medicare payment or physicians willingness to accept Medicare. CMS monitoring included state-level reports on problems reported to the regional offices by providers, associations, interest groups or others that were related to Medicare beneficiary access and declining physician participation in Medicare. This included state-level rates of telephone calls from beneficiaries about access problems to 1-800 Medicare and local Medicare carriers.

The metropolitan areas/state (largest county) associated with the geographic areas selected through this analysis were follows: the state of Alaska, Phoenix (Maricopa), AZ; San Diego (San Diego), CA; San Francisco (San Francisco), CA; Denver (Denver), CO; Tampa (Hillsborough), FL; Springfield (Greene), MO; Las Vegas (Clark), NV; Brooklyn (Kings), NY; Ft. Worth (Tarrant), TX; and Seattle (King), WA.

C. BENEFICIARY SAMPLE DESIGN

In this section, we describe our sampling approach for the 2004 survey. The sampling design for the 2003 survey—described earlier in Lake et al. (2003) is, by design, identical to the 2004 approach described here.[4] Response rates were also very similar. In each selected site, the target population for this study consisted of Medicare FFS beneficiaries who had Part B coverage and Medicare as their primary payer and were living in one of the 11 selected areas during the sample selection period. We excluded beneficiaries dually eligible for Medicaid, because their access problems are likely to reflect state Medicaid policies, as well as Medicare policy. Based on a screening procedure, we excluded people enrolled in a hospice and people in institutions because we expected their access issues would be different. We selected the sample using the

[4] Response rates and exact sample sizes varied between the two rounds of survey, as we discuss later; but the differences were not substantial.

Medicare Enrollment Database (EDB), the master Medicare beneficiary enrollment file maintained by CMS. Appendix A provides additional details on our sampling approach.

We stratified the sampling frame into two explicit strata: (1) the transitioning FFS Medicare beneficiaries in January 2004 who were newly eligible for Medicare, recently disenrolled from a Medicare managed care plan, or at the same market area for less than six months; and (2) other Medicare beneficiaries who were in FFS in January 2004 and have been in FFS and at the same location for more than six months. Because the transitioning stratum comprised beneficiaries who may have been more likely to be seeking new providers, we thought they might have been more sensitive to any effects of the changes in the fee schedule on physicians' decisions not to accept Medicare patients or limit their Medicare practices. We oversampled beneficiaries in transition to obtain an equal number of completed interviews with transitioning and other Medicare beneficiaries. While this oversampling resulted in a loss of precision for the aggregate estimates, it did provide more accurate estimates for this especially vulnerable group. Because the incidence of access problems was expected to be higher for the transitioning stratum, this oversampling also yielded more observations on beneficiaries' perceived reasons for any access problems.[5] This transitioning stratum consisted of three subgroups:[6]

[5] We estimated in this study that for the combined estimates of transitioning and other beneficiaries, the design effect, on average, would be about 1.70. The design effect reflects the relative increase in the sampling variance that results from the selected sampling plan compared to a simple random proportionally allocated sampling process. Dividing the sample size by the design effect yields an estimate of the effective sample size (for example 300 divided by 1.70 equals an effective sample of 176) that can be used to prepare confidence intervals for the estimates using standard normal distribution theory.

[6] If beneficiaries met multiple criteria, they were placed in the first applicable group as listed above.

1. ***Newly Entitled to Medicare.*** We defined the "newly entitled to Medicare" as those beneficiaries whose most recent span of enrollment to the traditional Part B Medicare program began after July 1, 2003.
2. ***New Movers.*** We identified the "new movers" as those beneficiaries who moved into one of the 11 sites between July 1, 2003, and January 1, 2004 (excluding those newly entitled to Medicare). Appendix A provides additional information about the movers in Alaska.
3. ***Switchers.*** We define "switchers" as beneficiaries who switched from Medicare managed care to Medicare FFS between July 1, 2003, and January 1, 2004, and were enrolled in FFS at the end of January 2004 (excluding new movers and those newly entitled to Medicare.

We used a sequential sampling method (Chromy 1979) to select the beneficiaries from each of the two explicit strata. With this approach, we sorted beneficiaries in each of these two strata by gender and age (younger than age 65, ages 65 to 74, ages 75 to 84, and age 85 and older). The combined sequential sampling and sorting method produces an implicit stratification process that helped ensure the samples we selected were representative on these characteristics. We selected, but did not immediately release for interviewing, an preliminary sample of 300 beneficiaries from the transitioning stratum and 300 beneficiaries from the other strata in each of the 11 selected sites, or a total of 600 beneficiaries per site. We then divided the entire preliminary sample into 30 waves containing 20 beneficiaries each (10 from the transitioning strata, and 10 from the other strata). The wave-based design allowed us to release a set of sample waves to achieve a target of 300 beneficiaries per site based on predicted response rates in each site. Additional waves were then released as needed if and when lower response rate was being achieved in particular sites. We released the waves in a sequential order to ensure that each case received the same recruiting effort.

As Table II.1 shows, the overall response rate across the 11 sites was 73.5 percent in 2004, with a total number of complete cases of 3,287—just below our target of 3,300—a response rate

very similar to that of the 2003 survey.[7] The lowest-weighted response rates for 2004 were found in the Brooklyn, San Francisco, and Las Vegas areas, with rates of 62 to 69 percent. These sites had the lowest response rates in 2003 (of 63 to 65 percent). The highest weighted response rate was in Alaska, with a response rate over 84 percent. In 2003, Alaska had a high response rate as well (of 80 percent). Seattle had a response rate of 81 percent in 2003, but in 2004 the response rate dropped to 74 percent.

TABLE II.1

CALCULATION OF RESPONSE RATES BY 11 SELECTED GEOGRAPHIC SITES FOR THE TARGETED BENEFICIARY SURVEY, 2004

	Sample Released	Sample Completes	Population Counts	Weighted Count of Completes and Ineligibles	Weighted Response Rate
Alaska	380	305	28,541	24,190	84.62
Phoenix, AZ	420	292	180,739	132,623	72.86
San Diego, CA	440	302	119,671	89,290	74.04
San Francisco, CA	480	302	63,038	43,380	68.10
Denver, CO	380	295	81,247	64,837	79.46
Tampa, FL	400	299	108,247	81,503	74.36
Springfield, MO	380	306	87,341	72,282	82.42
Las Vegas, NV	460	313	76,329	52,579	68.60
Brooklyn, NY	500	301	98,221	63,003	61.89
Fort Worth, TX	400	287	102,406	76,448	73.89
Seattle, WA	400	285	125,484	94,156	74.22
11 sites	**4,640**	**3,287**	**1,071,742**	**794,291**	**73.47**

Source: 2004 targeted beneficiary survey (TBS) conducted by MPR for CMS.

[7] In the 2003 survey the overall response rate was 73.8. We report weighted response rates here. Weighted and unweighted response rates did not vary substantially.

Table II.2 shows an overall weighted *location* rate (percentage of sample members located) of 87.9 percent and a survey *participation* rate among eligible located cases of 83.6 percent, to yield an overall response rate of 73.5 percent. It also shows the response rates for a subset of the characteristics available from the EDB. We found that response rates were higher for the transitioning beneficiaries, and lower for males, those under age 65 and nonwhites. Response rates were driven largely by differences in the ability to locate and contact these groups (versus the participation rate). Across geographic areas, our success in locating beneficiaries ranged from 80 percent (Las Vegas, NV) to 92 percent (Springfield, MO). The weighted completion rates among those located were in a similar range, from 69 percent in Brooklyn, NY, to 94 percent in Alaska (see Appendix A for more details on response rates). The location rates in 2003 were similar or smaller in all sites than in 2004, except in Phoenix, AZ (88 percent in 2003 and 84 percent in 2004) and San Diego, CA (89 percent in 2003 and 85 percent in 2004). The participation rates were similar in 2004 and in 2003, except in Phoenix, AZ; San Diego, CA; Las Vegas, NV, where the participation rates increased by more than 4 percent points, and in Brooklyn, NY; and Ft. Worth, TX where the participation rates decreased more than 6 percent points.

TABLE II.2

RESPONSE RATES BY BENEFICIARY CHARACTERISTICS
FOR THE TARGETED BENEFICIARY SURVEY, 2004

	Location Rate	Completion Rate	Response Rate
Total	87.9	83.6	73.5
Sampling Stratum			
Transitioning beneficiaries[a]	86.7	86.0	74.5
Other beneficiaries	88.0	83.4	73.4
Gender			
Male	85.9	83.5	71.7
Female	89.5	83.6	74.9
Age			
Younger than 65	71.4	89.2	63.6
65 to 74	89.6	84.0	75.3
75 to 84	88.6	83.1	73.6
85 and older	92.5	79.3	73.3
Race			
White	89.5	84.1	75.2
Nonwhite	76.9	79.8	61.4

Source: 2004 targeted beneficiary survey (TBS) conducted by MPR for CMS.

[a]Includes beneficiaries who became eligible for Medicare FFS, disenrolled from a Medicare HMO, or moved to the area in the past six months

D. DEVELOPMENT OF SURVEY WEIGHTS

We designed survey weights to account for the differential sample selection probabilities and to attempt to eliminate in the survey outcomes any potential biases that might have resulted from survey nonresponse.[8] These weights allowed an unbiased estimation of Medicare beneficiary population totals, as well as means and proportions for the entire sample or subgroups.

[8] See Appendix A for additional detail on development of survey weights.

The survey weights were developed based on four different adjustments. The first adjustment consisted of a base projection weight for each beneficiary in the sample released for interviewing (n = 4,640 across all 11 selected sites) equal to the beneficiary's inverse probability of selection. This weight accounted for differences in the sample selection rates between the two strata (transitioning versus other) and across the 11 sites. The second and third adjustments were for differential nonresponse among sample members; and the fourth was a post-stratification adjustment to align the weighted counts to match those in the study population.

Completion of the survey by beneficiaries is dependent on two basic outcomes: (1) whether we could obtain a phone number for a sampled beneficiary, and (2), once contacted, whether the beneficiary agreed to participate in the study. Based on empirical analysis after the survey, we found the characteristics of the sampled members that influenced the likelihood of these two outcomes were different. For example, we found in Brooklyn that whites were more likely to have a locatable phone number but were less likely to participate than their non-white counterparts.

To account for these differences in nonresponse, we developed two separate adjustments. For the location adjustment, we formed weighting cells by site, stratum, age, race, gender, and movers, with a minimum of 20 located beneficiaries for each cell that had nonlocated beneficiaries. Each cell had as a location adjustment the ratio of the weights of all the beneficiaries in the cell and the weights of the located beneficiaries in the cell. The location adjustment was applied to all located cases to compensate for the nonlocated cases. For the participation adjustment among the located cases, we estimated one weighted logistic regression model to predict participation based on the beneficiary characteristics from the EDB. We computed a propensity score to serve as the weight adjustment for each of the completed cases based on the reciprocal of the case's predicted probability of successful completion. This

adjustment methodology gave participants who had characteristics similar to nonparticipants a larger weight, so that characteristics of the survey nonparticipants were appropriately represented in the final estimates. The use of these methods is widely accepted, and the methods have several beneficial properties (Rosenbaum and Rubin 1984; Kalton and Kasprzyk 1986); namely, they better allow the researcher to incorporate multiple characteristics into the adjustment process. We also note that the combined use of the logistic (exponential) models with the post-stratification process, in effect, have similar mathematical foundations to the generalized weight-raking approach used in the CAHPS surveys. The primary variables used in the adjustments included the beneficiary's age category, gender, disability status, race (white, black, other), whether the beneficiary moved in the last six months and whether they were newly eligible for Medicare or disenrolled from a Medicare managed care plan in the past six months.

Overall, the adjustments for nonresponse and the oversampling of transitioning beneficiaries created a design effect of 2.02 for estimates using the entire sample.[9] The effective total sample size due to the design effects is 1,828, compared with an actual sample size of 3,287 completed interviews. The design effects for the transitioning and the other non-transitioning strata were smaller than the overall effect; thus, the effective sample sizes of these two strata were not much smaller than their actual sample sizes (1,324 versus 1,656 for transitioning beneficiaries, and 1,393 versus 1,631 for other beneficiaries). The design effects discussed here were based on the variation in the survey weights and do not account for differences in the variability of the survey questionnaire items.

[9] As discussed in footnote 6, the design effect due to oversampling of transitioning beneficiaries was 1.70 for one site and 1.97 combining all sites. Adjustments for non-response increased the overall design effect to 2.02.

E. SURVEY INSTRUMENT

We developed the survey instrument to address four Medicare physician access domains in a 15-minute telephone interview (with some completed by mail): (1) recent changes in provider and difficulty finding new provider, (2) ability to get timely appointments for routine care and timely urgent care, (3) unmet health care needs and delays in care, and (4) satisfaction with the ease of obtaining physician services. In addition, we included a brief set of questions about health status, socioeconomic status, demographics, and supplemental insurance coverage. Appendix B contains copies of the computer-assisted telephone interview (CATI) survey version and mail survey version of the instrument. In constructing the survey questionnaire, we relied to a large extent on existing items from the Medicare CAHPS-FFS survey, as well as the Medicare Current Beneficiary Survey and the Community Tracking Survey Household Survey.

We also developed new items asking beneficiaries with access problems why they thought they had experienced difficulties. These items typically followed immediately after items about the existence of access problems and were asked of the beneficiaries who reported problems. These new items were asked as open-ended questions, with interviewer coding of responses in one or more applicable categories. The responses that did not fit precoded categories were typed verbatim.

As part of the development of the 2003 survey, both the CATI instrument and the mail survey instrument were pretested among Medicare beneficiaries outside the areas targeted for the survey. We recruited eight Medicare beneficiaries who resembled the targeted population to complete the pretest interview by telephone. The instrument was tested to ensure that the language, logic, and format were comprehensive. We made revisions as a result of the pretest and completed a final version of the CATI instrument. Next, we drafted the mail questionnaire, which also was pretested among a group of Medicare beneficiaries who resembled the targeted

population. The questionnaires were distributed to a group of seniors visiting a New Jersey senior center. Nine of the mail questionnaires were completed. We made revisions to the mail questionnaire using the information and feedback gathered from the pretest.

The 2004 survey questionnaire was identical to the instrument used in 2003, with one exception. We inserted a question in the section on beneficiary characteristics that asked respondents if they were receiving Medicaid at the time of the interview. This item was not asked in the first round of the TBS, but did appear as item E6 in the second-round survey.

F. SURVEY PROCEDURES

As in the 2003 survey, the 2004 survey used a mixed-mode approach. CATI was combined with self-administered mail followup for those sample members who would not respond by telephone or for whom a telephone number was not available. Telephone interviewing began on April 16, 2004, and continued for 12 weeks. Of the 3,287 completed interviews, 88 percent were completed by telephone, and 12 percent were completed by mail.[10]

Because the field period was intended to be short (less than three months), most of the sample was released to telephone interviewers at the outset. The initial sample release, which assumed a 75 percent response rate and 99 percent eligibility rate, contained 4,400 cases in 11 sites.[11] An additional 240 cases were released across eight sites where a higher-than-expected

[10]We saw an increase in the use of mail survey administration in 2004. Last year, 92 percent of the 3,280 interviews were completed by telephone, while 8 percent were completed by mail. This difference in the percentage of mail-based responses between the two rounds of TBS is statistically significant. We attribute this shift in mode of administration to an increase in the number of individuals who initially refused to complete the survey via telephone.

[11]The initial sample release was as follows: 380 cases in Alaska, 380 in Phoenix, AZ; 400 in San Diego, CA; 440 in San Francisco, CA; 380 in Denver, CO; 380 in Tampa, FL; 380 in Springfield, MO; 440 in Las Vegas, NV; 460 in Brooklyn, NY; 380 in Forth Worth, TX; and 380 in Seattle, WA.

number of sample members refused or were unlocatable.[12] In total, 4,640 cases were released. Three percent (153 cases) were ineligible due to death, institutionalization, or participation in a hospice program. For a sample that was eligible or for whom eligibility was unknown (4,487 cases), 73 percent completed interviews, 8 percent were could not be located, 10 percent refused, and, because of cognitive or language barriers, 2 percent could not be interviewed. For the remaining 7 percent, efforts to reach sample members ended because the field period was over. By this time, an average of 30 calls per case had been made to these sample members. Many had in excess of 50 contact attempts. Table II.3 compares the final disposition rates for both rounds of the survey.

TABLE II.3

FINAL TARGETED BENEFICIARY SURVEY DISPOSITION RATES, BY ROUND

Final Disposition	2004	2003
Completed Interview by Phone	65%	67%
Completed Interview by Mail	8%	6%
Refused	10%	8%
Unlocatable	8%	12%
Physical/Cognitive/Language Barrier	2%	1%
Effort Ended	7%	6%
TOTAL	**100%**	**100%**

[12]This includes 40 cases in Phoenix, AZ, 40 in San Diego, CA; 40 in San Francisco, CA; 20 in Tampa, FL; 20 in Las Vegas, NV; 40 in Brooklyn, NY; 20 in Ft. Worth, TX; and 20 in Seattle, WA.

All members of the sample received an advance letter prior to the first attempt to reach them by telephone. The letter, from CMS, explained the background and purpose of the study, encouraged participation, and offered MPR's toll-free number to call to ask questions on completing the interview. The letter was mailed "Return Service Requested" so that address changes or corrections would be forwarded to MPR.

The EDB file from which the sample was selected does not contain telephone numbers. Thus, before interviewing could begin, MPR forwarded the sample file to a vendor for automatic matching of addresses and telephone numbers. This telematch vendor found telephone numbers 63 percent of the cases, and about 80 percent of these were correct. We also used Social Security Administration (SSA) files that contain telephone numbers and sometimes have a more up-to-date address than the EDB. CMS executed an interagency agreement with SSA to append telephone numbers and address to the TBS sample. MPR used the SSA information when the EDB and telephone look-up data were not sufficient for locating members of the sample. In 2004, SSA information was the ultimate source of telephone numbers for 23% of the beneficiaries in the sample.

MPR's locating staff used alternative strategies to find contact information for those not updated on the telematch file or for advance letters returned without a correct address. The locators explored online national databases and dialed telephone directory assistance when necessary. Locating efforts continued throughout the field period. A total of 2,101 cases (45 percent of the total sample released) needed a locating effort, and locators found telephone numbers for 83 percent (n = 1,741) of those cases.[13]

[13]The percentage of cases needing locating was the same for both rounds of the survey. However, MPR managed to find telephone numbers for only 73 percent of the cases in2003. Our ability to obtain a higher percentage of telephone numbers in in 2004, compared to 2003 is attributable, in large part, to our use of a different on-line national database.

During the field period, personalized refusal-conversion letters were sent to sample members who had refused the telephone interview. A few days after the refusal-conversion letter was mailed, interviewers called the sample member again to encourage participation. Initially, 20 percent (n = 928) of the sample members refused to be interviewed. About 49 percent (n = 455) of this group did complete interviews—75 percent (n = 341) after telephone interviewer refusal conversion attempts and 25 percent (n = 114) by mail.[14]

To further encourage participation, we allowed proxy responses for sample members unable to complete the interview due to a physical or cognitive impairment or due to a language barrier. The proxies were required to be familiar with the health care experiences of the sample member. Five percent (n = 177) of the interviews were completed by proxy.

The CATI instrument was translated into Spanish using the CAHPS 2002 Spanish-language instrument as a template. Bilingual interviewers used the Spanish instrument for 69 interviews completed in Spanish, in addition to using their bilingual skills to contact households even if the interview could be conducted in English.

Self-administered questionnaires were mailed to anyone who did not complete a telephone interview by May 26th (2,142 cases, or 49 percent of the initial sample release). Eighteen percent (n = 382) returned usable mail questionnaires. Mail responses were entered into the CATI program.

[14]In 2003, approximately 14 percent of the sample members initially refused to be interviewed. MPR managed to complete interviews with about 40 percent of these individuals.

G. ANALYTIC METHODS AND INTERPRETATION

We conducted our analysis of the survey results in several steps. First, we calculated five key measures for the entire survey sample to provide an overview of the extent of access problems in the 11 targeted sites:

1. Percentage of Medicare beneficiaries who had a problem finding a personal doctor they were happy with since joining Medicare
2. Percentage of Medicare beneficiaries who in the past six months had a problem seeing a specialist they needed to see (among those needing a specialist)
3. Percentage of Medicare beneficiaries who in the past six months never, sometimes, or usually (versus always) got a timely appointment for routine care (among those making appointments)[15]
4. Percentage of Medicare beneficiaries who in the past six months never, sometimes, or usually (versus always) got an appointment for care needed right away as soon as wanted (among those needing these appointments)
5. Percentage of Medicare beneficiaries who say the ease of seeing a doctor in the past year or two has become harder, easier, or stayed the same

We also examined other measures in the 2003 and 2004 surveys, such as the existence of a usual source of care and the rating of the availability of specialist care, to develop a broader profile of the types of access problems that are occurring and their prevalence in the 11 selected markets. In addition, we examined reasons given by beneficiaries for problems and calculated the percentage of all beneficiaries with problems due to any reasons, problems due to Medicare physician participation issues (including decisions not to not accept Medicare patients or limit the number of Medicare patients), and problems due to Medicare physician willingness to accept Medicare patients or other physician availability issues.

[15] Items in the survey instrument define "routine care" as "not counting the times you needed care right away".

Next, we assessed the extent of change in rates of problems between 2003 to 2004 to assess whether access to physicians was getting better or worse between the two years. This trend analysis was conducted for beneficiaries in all 11 markets, as well as for specific subgroups with vulnerable characteristics, and those living in specific markets. As we discuss in the next chapter, we generally did not find substantial changes in rates of problems over time, but did find that the extent of access problems continues to be greater for certain subgroups. Therefore, we documented the lack of change, but also decided to conduct further examination of subgroup differences using pooled data from both surveys. In particular, we conducted additional subgroup comparisons, including groups defined based on combinations of vulnerable characteristics, and we developed multivariate models to test the independent effects of subgroup characteristics on rates of problems, controlling for other measured factors.

Estimates for categorical response measures were calculated as frequency percentages—for example, the percentage who reported a large or small problem finding a personal doctor they were happy with since joining Medicare. In general, we reported estimates of the percentage of beneficiaries giving a particular response based on the number of beneficiaries who were actually asked a particular question. For example, we reported the number of beneficiaries who had a problem seeing a specialist in the past six months as a percentage of beneficiaries who said they saw or needed to see a specialist during this period. We also reported the percentage of beneficiaries who said they saw or needed to see a specialist to provide an indication of the proportion of beneficiaries for whom such problems are a potential problem during the period.

Since estimates were subject to sampling variability, we tested the statistical significance (at the 0.05 level) of differences between years, or between markets or subgroups within years.

We typically divided categorical measures into binary variables (for example, large or small problems, versus no problems). We performed a chi-square test to assess whether the observed

variation across geographic areas or multiple category subgroups (such as multiple age categories) is greater than would be expected by chance alone. When variation was statistically significant for a particular measure, we identified particular areas or groups with notably high or low rates. When comparing two subgroups to one another (for example, males versus females), we calculated a t-test for the difference in proportions. We conducted t-tests to test for differences over time (between 2003 and 2004). We used SUDAAN to generate unbiased estimates and confidence intervals to account for the sampling design and unequal weighting.

Because the targeted areas were not chosen at random, statistical tests of geographic variation, variation among subgroups, or differences over time, did not tell us anything about whether the targeted areas or particular subgroups in this study have higher or lower rates of problems than the nation as a whole, or whether access problems have increased or decreased over time for the nation. Instead, they only allowed us to determine whether the observed variation among sites or subgroups was greater than expected given random variation associated with sampling error. Findings of statistically significant geographic or subgroup variation also did not give us any information about the extent of variation nationwide among subgroups or markets. While it seems likely that geographic variation among a set of nationally representative sites would be greater than among these purposively selected sites, our results cannot confirm this.

In assessing whether there was variation in access to care in general among subgroups or across geographic areas, we did not focus on any one measure or statistically significant result. Instead, we attempted to identify consistent patterns among the five key measures described above for a market or subgroup. In identifying patterns, we looked for statistically significant results for at least some measures, as well as consistent patterns among all measures even if some were not statistically different.

We decided to look for patterns of results, rather than focusing on individual statistically-significant results, for three reasons. First, when performing a large number of statistical tests, some significant results for individual measures will arise by chance alone. Second, individual measures alone are unlikely to provide a complete picture of access experiences in a community or for a particular subgroup.[16] Third, with moderate sample sizes for geographic areas and certain subgroups, we have limited power to detect differences which could be of notable magnitude. In most cases, we found that subgroups or geographic areas with higher or lower rates of problems on one measure were likely to score significantly higher or lower on at least some other measures as well. On the other hand, groups or markets rarely scored consistently high or low across *all* measures we examined.

A major challenge for this study lies in the difficulty in attributing any changes in rates of problems over time to prior changes in Medicare physician payment policy. On a conceptual level, there was no certain hypothesis about what should be the effect on physician behavior of the last several years of payment changes. It was not clear whether a one-time cut in payment that occurred nearly two years ago was likely to be a major factor in physicians' recent decisions about Medicare participation. While the payment cut received considerable attention and raised concerns about physician willingness to see Medicare patients and access to care for beneficiaries, recent congressional action to increase rates again may have sent an subsequent signal that Medicare does not intend to reduce funding for physician services, despite the one-time fee cut. On the other hand, the fact that the underlying payment mechanism remains in

[16] Another approach in dealing with multiple related measures is to combine measures into composites. However, we chose not to create composite measures, because these measures are usually more difficult to interpret, and because composites are often very sensitive to how individual measures are weighted to produce the composite.

place, and threatens to reduce payments again in the future, may continue to play a role in physicians' ongoing consideration about their participation in Medicare.

In addition, as our framework above indicates, many other factors beyond payment may contribute to physician availability and beneficiary access to care. Beneficiaries may continue to face access barriers even with adequate physician participation in the Medicare program. Moreover, since the overall Medicare payment update was implemented on nationwide basis, there is no "natural experiment" available with which to empirically isolate the effect of the physician payment update from these other factors. Finally, any one-year change in access rates observed from these data may not be evidence of a significant trend that will hold in the future.

None of the results reported in this report should be interpreted as nationally representative estimates. Instead, estimates derived from this study reflect the experiences of beneficiaries in these 11 sites only.

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

III. TRENDS IN ACCESS TO MEDICARE PHYSICIAN SERVICES, 2003-2004

This chapter presents a comparison of results for the 2003 and 2004 targeted beneficiary surveys on access to physician services in 11 targeted geographic areas. We found that rates of access problems remained relatively low in both years, with few statistically significant changes over time for all beneficiaries, for selected subgroups or in particular geographic areas.

A. TRENDS AMONG ALL BENEFICIARIES IN 11 TARGETED MARKETS

In 11 geographic areas targeted because of potential indications of access difficulties, we found that rates of access problems generally did not change between 2003 and 2004, and the proportion of beneficiaries experiencing major physician access problems remained small. Depending on the physician access measure, 8 to 20 percent of beneficiaries reported having access problems (big or small) in 2004 (Table III.1). Similarly, 8 to 27 percent of beneficiaries reported problems in 2003.

Of the key access outcomes measured, the only significant change from 2003 to 2004 occurred in the proportion of those reporting problems getting timely routine care appointments among those needing an appointment. Among beneficiaries needing a routine care appointment in the last six months, the percentage saying that they always got an appointment as soon as needed increased by 6 percent from 2003 to 2004—indicating a potentially improvement for this measure of access. However, most of the change from 2003 to 2004 reflects a shift in responses from “usually getting routine care appointments as soon as needed” to “always getting routine

TABLE III.1
ACCESS TO PHYSICIAN SERVICES AMONG MEDICARE BENEFICIARIES IN 11 TARGETED SITES, 2003 AND 2004

	Percent of Medicare FFS Beneficiaries					
	All Beneficiaries			Transitioning Beneficiaries[a]		
	2003	2004	Difference	2003	2004	Difference
Percentage of Beneficiaries with Problems Getting a Personal Doctor They Are Happy with Since Joining Medicare[b]						
No problem	91.9	91.8	-0.1	88.9	89.9	1.0
Any problem (big or small)	8.1	8.2	0.1	11.1	10.1	-1.0
Big problem	4.2	3.6	-0.6	6.5	5.8	-0.7
Percentage of Beneficiaries with Problems Seeing a Specialist in the Past Six Months, Among Those Needing One						
No problem	91.1	91.4	0.3	85.1	86.2	1.1
Any problem (big or small)	8.9	8.6	-0.3	14.9	13.8	-1.1
Big problem	3.3	4.1	0.8	7.6	7.7	0.1
Percentage of Beneficiaries Getting Routine Care Appointments As Soon As Needed in the Past Six Months, Among Those Making Appointments						
Always	72.7	79.1	6.4[c]	72.7	72.8	0.1
Never, sometimes, or usually (versus always)	27.3	20.9	-6.4[c]	27.3	27.2	-0.1
Never or sometimes	6.7	6.5	-0.2	8.6	9.0	0.4
Percentage of Beneficiaries Getting Appointments for Care Needed Right Away in the Past Six Months Among, Those Needing Urgent Care						
Always	83.0	84.4	1.4	82.4	78.7	-3.7
Never, sometimes, or usually (versus always)	17.0	15.6	-1.4	17.6	21.3	3.7
Never or sometimes	7.9	6.4	-1.5	8.8	10.2	1.4
Percentage of Beneficiaries Who Think That Ease of Seeing a Doctor in the Past Year or Two Has:						
Gotten harder	7.1	6.9	-0.2	10.0	7.8	-2.2
Gotten easier	4.5	3.5	-1.0	5.8	6.0	0.2
Stayed the same	88.4	89.6	1.2	84.2	86.2	2.0

Source: 2003 and 2004 targeted beneficiaries survey (TBS) conducted by MPR for CMS.

[a]Transitioning enrollees include those who disenrolled from a Medicare HMO, those who became eligible for Medicare FFS, and those who moved to the area in the past six months.

[b]About 8 percent of all beneficiaries in 2003 and 2004 said that they did not get a new doctor since joining Medicare when asked this question. These beneficiaries were treated as missing and excluded from the calculation.

[c]T-test showing that the difference between 2003 and 2004 is significantly different at the .05 level.

care appointments as soon as needed," suggesting an improvement among a group with minimal problems to begin with.[1]

For beneficiaries in some form of transition (moving to a new area, recently joining Medicare, or disenrolling from an HMO), the only notable change was (a 4 percentage point decline) in the proportion always getting appointments for care needed right away in the past six months, among those needing it. However, the sample size (among those needing urgent care) for this measure was relatively small, and this change was not statistically significant. For all other physician access measures, transitioning beneficiaries showed no significant changes between 2003 and 2004 (Table III.1). While beneficiaries, in general, were less likely to have problems getting routine care appointments in 2004 than in 2003, we did not find this trend for transitioning beneficiaries.

We also found a lack of significant changes between 2003 and 2004 in other relevant areas of access to care, including relationships with a personal doctor, the extent of unmet needs for care for a medical condition, and satisfaction with physician availability (Table III.2). In 2004, we found that most beneficiaries continued to have a personal doctor (90 percent), and that relatively few had made changes in this relationship or were planning to do so. In the area of unmet needs, a small percentage of beneficiaries had a condition that was not treated by a doctor in the past six months, and only about a third (31 percent) of these beneficiaries attempted to see a doctor for their condition. Few beneficiaries said they had delayed or put off care in the past six months. Regarding satisfaction with physician availability, the majority of beneficiaries rated the ease of getting to see a doctor (68 percent) and availability of specialists (71 percent) as excellent or very good.

[1] Survey items refer to routine care appointments as "not counting times you need care right away".

Transitioning beneficiaries also did not exhibit significant changes in access to care in these areas (Table III.2). In either year, though, transitioning beneficiaries appeared to have had less stable relationships with a personal doctor, and were less likely to rate the ease of getting to a doctor and the availability of specialists as excellent or very good.

B. TRENDS AMONG SUBGROUPS

With a few exceptions, potentially vulnerable subgroups (defined in terms of selected socioeconomic or health characteristics) did not exhibit significant changes in physician access from 2003 to 2004. While the rates of access problems for these groups remained relatively high compared to other beneficiaries, their experience did not appear to worsen or improve during the period. (Major findings are highlighted here. Additional details on 2004 results for subgroups are shown in Tables C.6, C.7, and C.8 in Appendix C.)

We found three major exceptions to the overall finding of no significant changes among particular subgroups. First, consistent with overall results, many subgroups we studied experienced an improvement in the percentage of those getting timely routine care appointments when needing them in the past six months, although not all results were statistically significant, given smaller sample sizes for these groups (data not shown).

Second, we found a few significant changes in the percentage who said that seeing a doctor had become harder in the past year or two for some selected subgroups. The percentage significantly increased among those aged <65 (disabled) and those with a medical condition interfering with independence. Conversely, beneficiaries who recently disenrolled from an HMO experienced a significant improvement (of about 8 percentage points) in this measure. These selected findings are highlighted in Figure III.1.

TABLE III.2

ADDITIONAL MEASURES RELATED TO PHYSICIAN ACCESS IN 11 TARGETED SITES, 2003 AND 2004

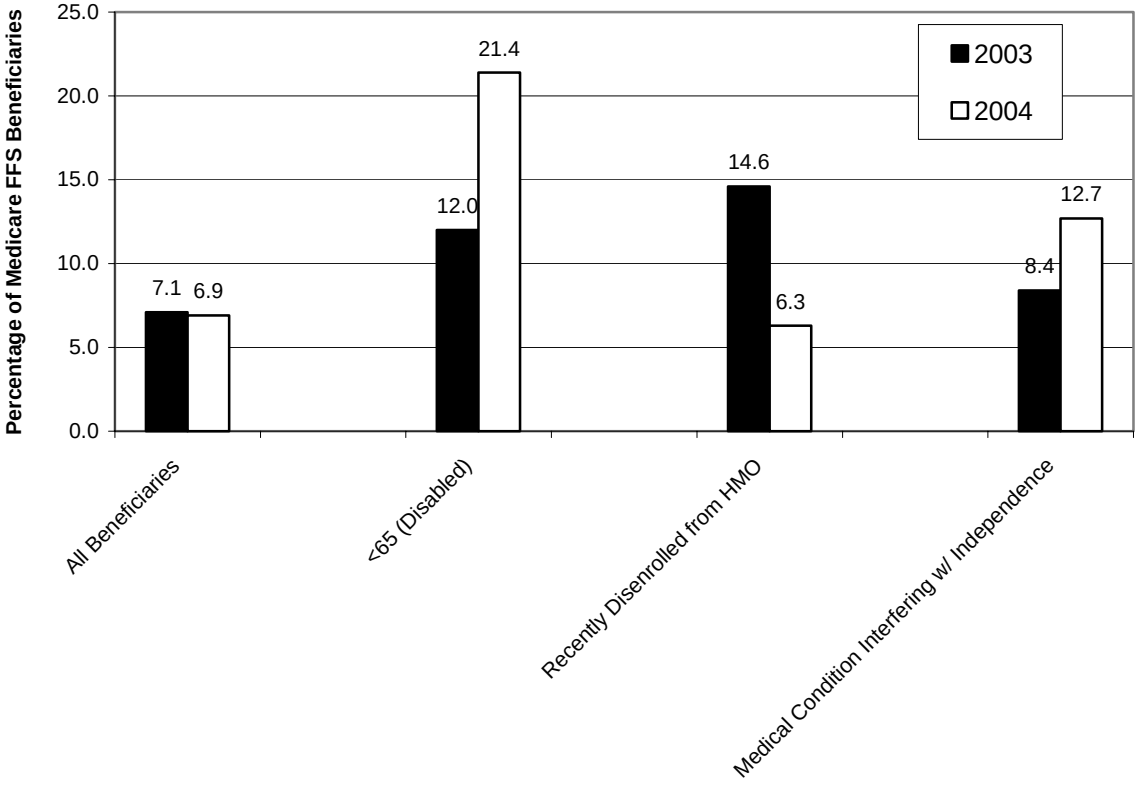
	Percent of Medicare FFS Beneficiaries					
	All Beneficiaries			Transitioning Beneficiaries[a]		
	2003	2004	Difference	2003	2004	Difference
Relationship with Primary Care Doctor						
Have one person who is personal doctor	90.1	90.4	0.3	85.5	84.8	-0.7
Got a new personal doctor in the past six months	10.2	11.0	0.8	16.7	17.9	1.2
Currently looking for a new doctor	4.3	4.5	0.2	7.6	8.0	0.4
Considering changing to a new doctor in the next 6 months	3.4	4.3	0.9	6.4	5.7	-0.7
Unmet Needs						
Has condition not treated by doctor in past six months	7.8	6.8	-1.0	9.4	9.4	0.0
Attempted to see doctor this condition, among those with untreated condition	32.8	31.2	-1.6	32.4	36.9	4.5
Delayed or put off care in the past six months	12.2	11.4	-0.8	14.1	13.8	-0.3
Satisfaction with Physician Access						
Rating of Ease of Getting to a Doctor						
Excellent/very good	69.4	68.4	-1.0	65.8	65.3	-0.5
Good	22.4	22.8	0.4	24.4	24.1	-0.3
Fair/poor	8.2	8.8	0.6	9.8	10.6	0.8
Rating of Availability of Specialist Care						
Excellent/very good	71.2	71.0	-0.2	66.9	68.3	1.4
Good	23.4	22.4	-1.0	24.1	22.8	-1.3
Fair/poor	5.4	6.6	1.2	9.0	8.9	-0.1

Source: 2003 and 2004 targeted beneficiaries survey (TBS) conducted by MPR for CMS.

[a]Transitioning enrollees include those who disenrolled from a Medicare HMO, those who became eligible for Medicare FFS, and those who moved to the area in the past six months.

NOTE: None of changes from 2003 to 2004 was statistically significant at the $p < 0.05$ level.

Figure III.1
Selected Differences Between 2003 and 2004: Percentage of Medicare Beneficiaries Who Said Seeing a Doctor Has Gotten Harder in the Past Year or Two



NOTE: This figures highlights only those subgroups that showed significant 2003-2004 changes in this measure ($p < .05$); all other subgroups did not show significant change.

Third, HMO disenrollees were less likely to report rates of problems (big or small) in getting a personal doctor they were happy with since joining Medicare (a decrease of 9 percentage points), and less likely to have had problems seeing a specialist (an increase of 12 percentage points) (data not shown). These results, combined with those noted for this group in the previous paragraph, may indicate an improvement in access for this subgroup of disenrollees during the year.[2]

[2] About 1.7 percent of beneficiaries had recently disenrolled from Medicare managed care in 2004. About 1.0 percent disenrolled in 2003.

C. TRENDS IN SPECIFIC MARKET AREAS

In addition, we found few significant changes in access problems among beneficiaries living in specific market areas. As with other subgroups, beneficiaries in many areas experienced a increase in the percentage always getting timely routine care appointments among those needing them, although results were not always statistically significant. Otherwise, statistically significant changes within market areas were quite rare. We found that among all beneficiaries in San Francisco, the percentage who reported a problem getting a personal doctor they were happy with since joining Medicare decreased from 2003 to 2004. Among all beneficiaries living in Seattle, we found a significant decrease in the percentage who said that seeing a doctor had grown more difficult in the past year or two. Given the large number of comparisons made for the 11 sites, it is possible that these differences are due to random chance alone.[3]

D. TRENDS IN REASONS FOR ACCESS PROBLEMS

When beneficiaries reported access problems in the 2003 and 2004 targeted beneficiaries surveys, we also asked beneficiaries for the reasons for problems in open-ended, follow-up questions. Beneficiaries often gave multiple reasons for access problems they encountered, and their reasons varied according to the type of problem.

Responses to follow-up questions about the reasons for problems were coded by interviewers in one or more of several categories. Responses coded by interviewers relating to Medicare physician participation reasons included (1) physicians were not taking any Medicare patients, (2) physicians were not taking new Medicare patients, and (3) physicians were not

[3] Since we looked for differences that were statistically significant at the $p < 0.05$ level, on average, about 5 percent of comparisons would be significant by chance alone. See Table C.3, C.4 and C.5 in Appendix C for more detail on geographic specific results for 2004.

accepting Medicare assignment.[4] Other reasons given for problems gaining access to physicians included difficulty getting referrals; physicians no longer accepting any new patients; no appointments available with current physician or inability to schedule a timely or convenient appointment; death, retirement, or relocation of a physician; and transportation to and geographic location of the physician. To assess the extent to which problems are caused by Medicare physician participation decisions, we classified problems into two main categories: problems due to any reason given and problems due to the three Medicare participation issues listed above. Since beneficiaries may not always know when physicians are making decisions related to Medicare participation versus more general limits on their practices, we also added a third category of problems that includes Medicare participation reasons as well as other reasons related to general physician availability, such as physicians not taking any new patients.

Analysis of 2004 beneficiary survey responses indicates that the extent of problems attributed to Medicare physician participation issues were low, and had not changed substantially since 2003 (Table III.3).[5] In 2004, about a quarter of all beneficiaries reported having at least one physician access problem (including problems finding a personal doctor or specialist, or not getting or delaying needed routine or urgent care), but about 3 percent of all beneficiaries (or about one-tenth of those with any problem) cited an access problem due to physicians' decisions not to take Medicare beneficiaries or limit their Medicare practices issues, and 9 percent of all beneficiaries (or about one-third of those with any problem) reported problems due to any physician availability issue (i.e., physicians' unwillingness to see Medicare patients or other

[4] Refusal to take Medicare assignment means that physicians charge patients for the balance of a bill not paid by Medicare.

[5] Table C.9 in Appendix C provides more detail on the specific reasons beneficiaries gave for particular types of problems.

TABLE III.3

REASONS FOR ACCESS PROBLEMS AMONG MEDICARE FFS BENEFICIARIES IN 11 GEOGRAPHIC AREAS, 2003 AND 2004

	Percentage of Medicare FFS Beneficiaries		
	2003	2004	Difference
Reported at least one physician access problem (any reason)[a]	25.4	24.2	-1.2
Problems due to Medicare physician participation issues	4.0	3.4	-0.6
Problems due to Medicare physician participation or other physician availability issues[b]	8.7	9.0	0.3
Reported Problem Finding a Personal Doctor Since Joining Medicare or Seeing a Specialist in the Past 6 Months	11.0	11.2	0.2
Problems due to Medicare physician participation issues	3.6	3.3	-0.3
Problems due to Medicare physician participation or other physician availability issues[b]	6.5	7.3	0.8
Reported Not Getting or Delaying Needed Routine or Urgent Care in the Past 6 Months	13.4	12.4	-1.0
Problems due to Medicare physician participation issues	0.5	0.3	-0.2
Problems due to Medicare physician participation or other physician availability issues[b]	2.0	1.6	-0.4
Rated Availability of Doctors as Fair or Poor	10.1	12.3	2.2
Problems due to Medicare physician participation issues	0.5	0.2	-0.3
Problems due to Medicare physician participation or other physician availability issues[b]	2.5	3.1	0.6

Source: 2003 and 2004 targeted beneficiaries survey of Medicare FFS beneficiaries conducted by MPR for CMS.

[a]Includes only access problems in the three categories listed below this one.

[b]Other physician availability issues include response categories such as “doctors not taking any new patients” or “found doctor, but appointments hard to get,” indicating limited physician availability that is not specific to Medicare. However, these responses may represent some cases in which a beneficiary is not aware of a doctor’s decision to limit or cease his or her participation in Medicare.

N0TE: None of the changes from 2003 to 2004 was statistically significant at the $p < 0.05$ level.

physician availability issues, such as a overall shortage of physicians). These results were very similar to 2003 results—differing by less than one percentage point in each case—and differences were not statistically significant.

Findings are also similar when physician access problems are separated by category of access problem: problems finding a personal doctor, not getting or delaying needed routine or urgent care in the past six months, and rating availability of primary care physician or specialist as fair or poor (Table III.3). While 11 percent of all beneficiaries reported a problem finding a doctor or seeing a specialist in 2004, three percent of all beneficiaries cited problems related to physicians' willingness to accept Medicare patients and seven percent of all beneficiaries had problems due to physicians' willingness to accept Medicare patients or other availability issues. These 2004 results also did not vary by more than one percentage point from 2003, and none of the differences were statistically significant.

IV. ANALYSIS OF BENEFICIARY CHARACTERISTICS AND ACCESS TO PHYSICIAN SERVICES, USING 2003 – 2004 POOLED SURVEY DATA

Given the lack of significant changes in rates of access problems from 2003 and 2004, discussed in Chapter III, and the findings of higher rates of access problems among certain subgroups in our first report, we decided to conduct additional analysis of subgroup differences, using data pooled together from the two survey rounds in 2003 and 2004. The larger sample size (nearly 6,600 beneficiaries) that a pooled data set afforded allowed us to look at particular subgroup and market location differences with greater statistical precision.

First, we used the pooled data to identify variation in access problems according to subgroup and geographic area on the key measures over the combined 2003 – 2004 period. We looked at differences according to whether beneficiaries were in some form of transition, and then at differences according to other subgroup characteristics among all beneficiaries and among transitioning beneficiaries. The larger sample size of the pooled data allowed us to examine subgroup variation within the transitioning group of beneficiaries with a fair degree of precision.

Second, we examined variation in rates of access problems attributed to Medicare physician participation issues, according to vulnerable subgroup characteristics and geographic location. As part of this analysis, we looked more closely at groups with certain combinations of characteristics, such as those who had no supplemental coverage *and* poor or fair health status, to see if these groups had particularly high rates of problems compared to others.

Third, we developed a basic set of multivariate models to estimate the independent effects of beneficiary characteristics on the likelihood of access problems. We ran these regression models for all beneficiaries and also for three beneficiary subgroups of interest—transitioning beneficiaries, beneficiaries with no Medicare supplemental coverage, and beneficiaries under age

65 (disabled)—to see if the effects of vulnerable characteristics varied for these groups. We selected these three subgroups because they were thought to be especially vulnerable to changes in physician availability as well as other personal circumstances including declines in health or financial status.

Finally, we used these models to develop regression-adjusted estimates of the rates of access problems in each of the 11 markets, controlling for population characteristic differences. This allowed us to assess whether differences among selected markets changed when controlling for any population differences.

A. VARIATION IN ACCESS ACCORDING TO BENEFICIARY CHARACTERISTICS

Beneficiaries making some form of transition (disenrolling from an HMO, recently joining Medicare, or moving to a new area) reported higher rates of problems than other beneficiaries, as anticipated (Table IV.1).[1] Differences were largest for beneficiaries who had recently become eligible for Medicare. For example, 11 percent of newly eligible beneficiaries reported that seeing a doctor had become harder in the past year or two, while less than 7 percent of non-transitioning beneficiaries reported this problem. Sixteen percent of newly eligible beneficiaries had problems getting a personal doctor they were happy with since joining Medicare, compared to 8 percent of those not making these transitions. Similarly, 17 percent of beneficiaries newly eligible beneficiaries who needed a specialist in the past six months reported a problem, compared to only 8 percent of beneficiaries not making transitions. In addition, nearly 30 percent of newly eligible beneficiaries reported difficulty getting appointments for

[1]Transitioning beneficiaries represented about 8 percent of Medicare fee-for-service (FFS) beneficiaries in 2004; about three-quarters of these were beneficiaries who recently became eligible for Medicare. See Table C.10 in Appendix C for more detail on beneficiary characteristics.

TABLE IV.1

ACCESS TO PHYSICIANS , ACCORDING TO TRANSITIONING STATUS, 2003-2004 POOLED DATA

	Percentage of Medicare FFS Beneficiaries						
	Who Say That Seeing a Doctor in the Past Year or Two Has:			Problems Getting a Personal Doctor They Are Happy With Since Joining Medicare	Problems Seeing Specialist, Among Those Needing One in the Past Six Months	Didn't Always Get Timely Routine Care Appointment, Among Those Seeking Appointments in Past Six Months	Didn't Always Get Timely Care Needed Right Away, Among Those Needing Urgent Care in Past Six Months
	Gotten Harder	Gotten Easier	Stayed the Same				
Transitioning Beneficiaries	8.9[a]	5.9[a]	85.2[a]	10.5[a]	14.3[a]	27..3[a]	19.6
Disenrolled from HMO in last 6 months	8.8	5.4	85.8	9.1	14.1	27.7	18.9
Moved to area in last 6 months	7.7	6.2	86.1	11.7	13.6	24.7	21.7
Eligible for Medicare in last 6 months	11.2	8.5	80.3	16.4	17.3	29.7	18.3
Non-Transitioning Beneficiaries	6.9	3.9	89.3	8.0	8.3	23.9	16.1
All Beneficiaries	7.0	4.0	89.1	8.1	8.8	24.1	16.3

Source:2003 and 2004 targeted survey of Medicare FFS beneficiaries conducted by MPR for CMS.

[a]The difference between estimated proportion for all transitioning vs. proportion for non-transitioning beneficiaries is statistically significant, with $p<0.05$.

routine care as soon as they wanted (among those needing them), compared with about 24 percent of non-transitioning beneficiaries.

Beneficiaries with other vulnerable characteristics—including those eligible for Medicare because they are disabled (under age 65), those in poor or fair health, those with activity limitations, those with lower incomes, those without supplemental coverage, and those in non-white racial groups—reported significantly higher rates of problems than other beneficiaries, when looking at pooled 2003 – 2004 data (see Table IV.2). Subgroup effects were largest for problems getting a specialist in the past six months among those needing one. For example, beneficiaries who were new to Medicare, disabled (under age 65), in poor or fair health, without Medicare supplemental coverage, and non-white were more than twice as likely as other beneficiaries to say they had a problem getting a specialist when needing one. (Overall, nearly 9 percent of beneficiaries needing a specialist reported a problem seeing one in the past six months.) We found similar differences according to these beneficiary characteristics when examining them for transitioning beneficiaries only (see Table IV.3).

B. GEOGRAPHIC SITE VARIATION AMONG ALL BENEFICIARIES AND TRANSITIONING BENEFICIARIES

We found significant geographic variation in rates of access problems for four of the five key measures we studied in 2003 – 2004, including: (1) reports that seeing a doctor had gotten harder in the past year or two, (2) problems getting a personal doctor since joining Medicare, (3) not always getting timely routine care appointments in the past six months, and (4) not always getting timely urgent care in the past six months (Table IV.4).[2]

[2] Variation in rates of problem getting a specialist among those needing one in the past six months was not statistically significant.

TABLE IV.2

ACCESS TO PHYSICIANS ACCORDING TO BENEFICIARY CHARACTERISTICS, AMONG ALL BENEFICIARIES, 2003-2004 POOLED DATA

	Percentage of Medicare FFS Beneficiaries						
	Who Say That Seeing a Doctor in the Past Year or Two Has:			Problems Getting a Personal Doctor They Are Happy With Since Joining Medicare	Problems Seeing Specialist, Among Those Needing One in the Past Six Months	Didn't Always Get Timely Routine Care Appointment, Among Those Seeking Appointments in Past Six Months	Didn't Always Get Timely Care Needed Right Away, Among Those Needing Urgent Care in Past Six Months
	Gotten Harder	Gotten Easier	Stayed the Same				
Age							
<65 (disabled)	16.7[a]	6.0[a]	77.3[a]	16.8[a]	26.6[a]	28.0[a]	26.7[a]
65-69[b]	7.3	5.0	87.7	8.3	10.2	25.9	16.4
70-74	4.5	3.7	91.8	8.1	5.5	24.5	15.3
75-79	5.9	3.0	91.1	7.1	5.2	21.8	14.9
80-84	5.8	3.8	90.4	6.3	6.5	24.2	11.8
85+	6.8	3.0	90.3	6.0	4.5	19.2	14.9
Health Status							
Poor/fair	11.1[b]	3.8	85.1[b]	10.1[b]	13.4[b]	27.2[b]	18.3
Good/very good/excellent	5.5	4.0	90.5	7.4	6.6	22.7	15.3
Hospitalized in Past Year							
Yes	7.7	5.1	87.3	8.0	8.8	25.5	19.0[b]
No	6.8	3.8	89.4	8.0	8.4	23.5	10.8
Medical Condition Interfering with Independence							
Yes	10.4[b]	3.8	85.8[b]	10.9[b]	13.3[b]	29.4[b]	18.5
No	5.6	4.1	90.3	7.1	6.5	21.7	14.4
Limits on Activities of Daily Living							
Moderate activities	9.4[b]	4.7	85.9[b]	10.3[b]	11.6[b]	27.4[b]	17.5
Climbing stairs	9.4[b]	3.5	87.1	9.7[b]	11.7[b]	28.3[b]	16.2
Accomplished less than desired	10.3[b]	3.4	86.3[b]	11.6[b]	11.8[b]	29.2[b]	17.5[b]
Limited in kind of work performed	9.9[b]	3.9	86.2[b]	11.3[b]	12.3[b]	28.1[b]	16.0
Medicare Supplemental Policy							
Yes	6.5	3.8	89.7[b]	7.5[b]	7.6[b]	24.2	15.7
No	9.7	5.0	85.3	11.6	18.0	22.1	19.5

TABLE IV.2 *(continued)*

	Percentage of Medicare FFS Beneficiaries						
	Who Say That Seeing a Doctor in the Past Year or Two Has:			Problems Getting a Personal Doctor They Are Happy With Since Joining Medicare	Problems Seeing Specialist, Among Those Needing One in the Past Six Months	Didn't Always Get Timely Routine Care Appointment, Among Those Seeking Appointments in Past Six Months	Didn't Always Get Timely Care Needed Right Away, Among Those Needing Urgent Care in Past Six Months
	Gotten Harder	Gotten Easier	Stayed the Same				
Annual Income							
<$10,000	9.7[a]	4.7	85.6[a]	12.6[a]	13.0[a]	28.0	21.0
$10,000-$25,000	7.8	4.2	88.0	9.1	9.5	24.7	16.6
>$25,000	6.4	3.8	89.8	7.2	7.8	24.9	14.7
Hispanic							
Yes	4.6	8.1	87.3	5.6	10.8	17.0	8.9
No	7.1	3.9	89.0	8.2	8.7	24.3	16.6
Race							
White	6.8	3.8[a]	89.3	8.0	7.8[a]	24.0	16.2
Black	7.3	2.9	89.7	6.7	14.4	22.0	13.0
Other	6.5	7.1	86.5	9.5	15.5	25.1	19.1
Gender							
Male	6.2	4.4	89.4	8.2	8.5	22.6	17.7
Female	7.6	3.7	88.7	8.2	9.0	25.3	15.0
All Beneficiaries	7.0	4.0	89.0	8.2	8.8	24.1	16.3

Source: 2003 and 2004 targeted survey of Medicare FFS beneficiaries conducted by MPR for CMS.

[a]For subgroup with more than two categories, Chi Squared test rejecting the hypothesis that the proportion with access problem examined is equal across all subgroups defined by this characteristic at the 0.05 significance level.

[b]The difference between estimated proportions for the subgroups is statistically significant, with $p<0.05$.

TABLE IV.3

ACCESS TO PHYSICIANS ACCORDING TO BENEFICIARY CHARACTERISTICS, AMONG TRANSITIONING BENEFICIARIES, 2003-2004 POOLED DATA

	Percentage of Medicare FFS Beneficiaries						
	Who Say That Seeing a Doctor in the Past Year or Two Has:			Problems Getting a Personal Doctor They Are Happy With Since Joining Medicare	Problems Seeing Specialist, Among Those Needing One in the Past Six Months	Didn't Always Get Timely Routine Care Appointment, Among Those Seeking Appointments in Past Six Months	Didn't Always Get Timely Care Needed Right Away, Among Those Needing Urgent Care in Past Six Months
	Gotten Harder	Gotten Easier	Stayed the Same				
Age							
<65 (disabled)	13.0[a]	7.4	79.6[a]	15.0[a]	22.9[a]	33.1[a]	27.5[a]
65-69[b]	8.6	5.3	86.1	8.4	11.3	26.4	17.3
70-74	5.6	7.0	87.5	13.7	12.4	28.1	20.6
75-79	6.9	6.2	87.0	9.9	11.2	28.3	16.5
80-84	4.9	7.4	87.7	11.9	14.3	15.4	14.1
85+	8.0	4.8	87.2	11.9	13.7	18.7	2.7
Health Status							
Poor/fair	14.5[b]	7.5[b]	78.0[b]	15.9[b]	21.4[b]	32.2[b]	25.5[b]
Good/very good/excellent	6.7	5.3	88.1	8.6	10.4	24.8	14.3
Hospitalized in Past Year							
Yes	7.8	9.7[b]	82.6	11.2	12.6	27.0	16.5
No	9.0	5.1	85.9	10.4	15.0	27.4	21.4
Medical Condition Interfering with Independence							
Yes	13.6[b]	8.1[b]	78.3[b]	15.5[b]	19.8[b]	31.0[b]	24.8[b]
No	6.7	5.1	88.2	8.4	10.7	25.0	14.2
Limits on Activities of Daily Living							
Moderate activities	13.6[b]	7.5[b]	79.0[b]	15.1[b]	18.8[b]	30.6[b]	23.3[b]
Climbing stairs	12.4[b]	7.3[b]	80.3[b]	15.3[b]	16.5[b]	31.2[b]	23.6[b]
Accomplished less than desired	12.7[b]	7.8[b]	79.5[b]	16.1[b]	19.1[b]	29.2[b]	21.8[b]
Limited in kind of work performed	12.2[b]	8.2[b]	79.7[b]	14.3[b]	17.5[b]	29.4[b]	22.1[b]
Medicare Supplemental Policy							
Yes	8.9	5.8	85.4	9.6[b]	12.7[b]	27.2	18.6
No	8.6	6.6	84.8	14.0	21.4	27.1	22.9

TABLE IV.3 *(continued)*

	Percentage of Medicare FFS Beneficiaries						
	Who Say That Seeing a Doctor in the Past Year or Two Has:			Problems Getting a Personal Doctor They Are Happy With Since Joining Medicare	Problems Seeing Specialist, Among Those Needing One in the Past Six Months	Didn't Always Get Timely Routine Care Appointment, Among Those Seeking Appointments in Past Six Months	Didn't Always Get Timely Care Needed Right Away, Among Those Needing Urgent Care in Past Six Months
	Gotten Harder	Gotten Easier	Stayed the Same				
Annual Income							
<$10,000	8.1	8.4[a]	83.5	13.4[a]	17.0[a]	29.2	16.6[a]
$10,000-$25,000	9.0	6.3	84.8	12.8	16.8	27.4	25.1
>$25,000	8.9	4.8	86.3	8.7	11.0	28.6	17.7
Hispanic							
Yes	9.1	9.2	81.7	11.3	17.1	25.6	15.1
No	8.9	5.7	85.5	10.5	14.0	27.1	19.2
Race							
White	8.9	5.4[a]	85.7	10.1	12.9[a]	27.1	18.1
Black	7.4	5.7	86.9	12.9	18.0	23.2	29.8
Other	7.9	11.7	80.4	13.2	23.8	25.9	19.8
Gender							
Male	8.9	5.6	85.5	10.0	13.3	28.4	20.1
Female	8.9	6.2	85.0	11.0	15.6	26.5	19.3
All Beneficiaries	8.9	5.9	85.2	10.5	14.3	27..3	19.6

Source: 2003 and 2004 targeted survey of Medicare FFS beneficiaries conducted by MPR for CMS.

[a]For subgroup with more than two categories, Chi Squared test rejecting the hypothesis that the proportion with access problem examined is equal across all subgroups defined by this characteristic at the 0.05 significance level.

[b]The difference between estimated proportions for the subgroups is statistically significant, with $p<0.05$.

TABLE IV.4

VARIATION IN ACCESS TO PHYSICIANS ACROSS 11 TARGETED SITES, 2003-2004 POOLED DATA

	Percentage of Medicare FFS Beneficiaries						
	Seeing a Doctor in the Past Year or Two Has:			Problems Getting a Personal Doctor They Are Happy With Since Joining Medicare[a]	Problems Seeing Specialist in Past Six Months, Among Those Needing One	Didn't Always Get Timely Routine Care Appointments, Among Those Seeking Them in the Past Six Months [a]	Didn't Always Get Timely Care Needed Right Away, Among Those Needing Care in the Past Six Months[a]
Geographic Site	Gotten Harder[a]	Gotten Easier	Stayed the Same[a]				
Alaska (State)							
All beneficiaries	10.4	3.5	86.1	16.7	17.9	26.9	21.2
Transitioning beneficiaries	10.6	5.2	84.3	17.8	20.6	26.7	25.5
Phoenix, AZ							
All beneficiaries	7.8	4.9	87.3	6.2	11.4	28.3	25.3
Transitioning beneficiaries	7.9	3.8	88.2	9.7	10.5	28.6	26.7
San Diego, CA							
All beneficiaries	9.1	4.4[b]	86.5[b]	5.9	7.1[b]	32.1	13.7
Transitioning beneficiaries	11.4	11.8	76.8	8.4	14.2	30.1	11.9
San Francisco, CA							
All beneficiaries	5.0[b]	2.9	92.2[b]	4.4[b]	6.0[b]	19.6[b]	13.1
Transitioning beneficiaries	9.7	4.9	85.3	9.0	12.8	31.7	21.4
Denver, CO							
All beneficiaries	10.5	3.8	85.7[b]	17.2	10.6	29.1	15.3
Transitioning beneficiaries	10.9	6.9	82.2	18.5	16.3	28.7	19.6
Tampa, FL							
All beneficiaries	6.9	3.6	89.5	6.4	6.5	23.3	14.3
Transitioning beneficiaries	9.7	2.4	87.9	6.2	12.0	26.8	21.4
Springfield, MO							
All beneficiaries	4.7[b]	3.7	91.7	6.6	8.5[b]	19.2	10.9
Transitioning beneficiaries	9.3	5.2	85.5	8.3	18.5	22.1	17.2
Las Vegas, NV							
All beneficiaries	5.8[b]	5.7	88.5	7.6	7.8[b]	24.1	19.9
Transitioning beneficiaries	10.4	4.7	85.0	10.0	20.2	29.6	20.2
Brooklyn, NY							
All beneficiaries	3.5	5.0	91.5[b]	5.3	8.6	19.4	16.0
Transitioning beneficiaries	4.6	7.5	87.9	9.5	13.1	18.6	22.5
Ft. Worth, TX							
All beneficiaries	8.3	4.1	87.6	12.2	7.2	19.8	8.6
Transitioning beneficiaries	8.4	5.3	86.3	17.4	11.7	27.8	15.0
Seattle, WA							
All beneficiaries	6.0	2.1[b]	91.9	9.0	9.1	18.9	18.5
Transitioning beneficiaries	5.1	5.9	89.0	7.5	13.1	25.7	17.9
Median Site							
All beneficiaries	6.9	3.8	88.5	6.6	8.5	23.3	15.3
Transitioning beneficiaries	9.7	5.2	85.5	9.5	13.1	27.8	20.2
Lowest Access Site							
All beneficiaries	3.5	2.1	85.7	4.4	6.0	18.9	8.6
Transitioning beneficiaries	4.6	2.4	76.8	6.2	10.5	25.7	17.9
Highest Access Site							
All beneficiaries	10.5	5.7	92.2	17.2	17.9	32.1	25.3
Transitioning beneficiaries	11.4	11.8	89	18.5	20.6	31.7	26.7

Source: 2003 and 2004 targeted surveys of Medicare FFS beneficiaries conducted by MPR for CMS.

[a] Chi Squared test showing geographic difference of site estimates for all beneficiaries is statistically significant, with $p<0.05$.
[b] T-test showing that the difference between transitioning beneficiaries and continuous beneficiaries is statistically significant, $p<0.05$.

Denver, Colorado and the state of Alaska stood out as having had consistently high rates of problems across multiple measures with significant geographic variation, which is consistent with our findings from analysis of 2003 data alone (Lake et al. 2003).[3] Denver had the highest rates of problems among all beneficiaries for two measures (seeing a doctor has gotten harder, and problems getting a personal doctor), and ranked second and sixth on two others (not always getting timely routine care appointments in past six months and not always getting timely urgent care). Alaska had the second highest rates of problems for three measures (seeing a doctor has gotten harder, problems getting a personal doctor, and not always getting timely urgent care); and ranked fourth in another area (not always getting timely routine care appointments).

Phoenix, Arizona and Seattle, Washington were also notable for having high rates of problems on selected measures. For example, Phoenix ranked first and third highest, respectively, in not always getting timely urgent care and not always getting timely routine care. Seattle ranked fourth highest for two measures (problems getting a personal doctor and not always getting timely urgent care).

Within geographic sites, we found transitioning beneficiaries tended to have higher rates of problems than non-transitioning beneficiaries, consistent with results for all 11 sites combined. Results were not always statistically significant, given smaller sample sizes for each site, but

[3] We excluded from our discussion problems getting a specialist in the past six months, since geographic variation was not statistically significant. However, it is notable that Alaska and Denver also appear to have relatively high rates of problems in this area as well, ranking first and third, respectively on this measure.

differences were particularly notable (and consistent in statistical significance) in San Francisco, California, where for rates of problems for transitioning beneficiaries were generally nearly twice as high as those for all beneficiaries in that market area.

C. ANALYSIS OF REASONS FOR ACCESS PROBLEMS, USING 2003-2004 POOLED DATA

We observed the same kinds of subgroup and geographic differences when examining rates of any problems reported or rates of any problems that beneficiaries attributed to physicians' not taking Medicare patients or limiting their Medicare practices or other physician availability issues (Table IV.5). Denver and Alaska again stand out as having relatively high rates of problems regardless of the reason. More than a third of beneficiaries in Alaska reported at least one problem with access to care, and more than 10 percent of beneficiaries in the state reported at least one problem related to physicians' willingness to accept Medicare patients. About 29 percent of beneficiaries in Denver reported at least one access problem, and nearly 10 percent had a problem related to physicians' willingness to accept Medicare patients. Similarly, we found that subgroups with vulnerable characteristics—such as those in transition, those disabled, those in fair or poor health, and those with low income—also had higher rates of problems than those without these characteristics.

In our report on the 2003 results (Lake et al. 2003), we found some preliminary evidence that beneficiaries with combinations of characteristics, such as poor or fair health and no supplemental coverage, may be especially vulnerable. However, sample sizes of these groups were small when limited to data from the first-round 2003 survey, and the differences were not statistically significant.

TABLE IV.5

ACCESS PROBLEMS ASSOCIATED WITH PHYSICIANS' WILLINGNESS TO ACCEPT MEDICARE PATIENTS, BY GEOGRAPHIC AREA AND SELECTED BENEFICIARY CHARACTERISTICS, 2003-2004 POOLED DATA

	Percentage of Medicare FFS Beneficiaries With:		
	At Least One Access Problem (Any Reason)[a]	At Least One Access Problem Related to Physicians' Willingness to Accept Medicare Patients	At Least One Access Problem Related to Physicians' Willingness to Accept Medicare Patients or Other Physician Availability Issues[b]
All Beneficiaries	24.8	3.7	8.9
Geographic Location			
Alaska (state)	34.8[c]	11.2[c]	19.9[c]
Phoenix, AZ	23.9	3.1	7.2
San Diego, CA	26.2	2.6	7.3
San Francisco, CA	18.3	1.0	4.5
Denver, CO	29.4	9.5	16.5
Tampa, FL	22.7	2.7	6.2
Springfield, MO	23.0	2.2	8.9
Las Vegas, NV	25.0	1.3	6.1
Brooklyn, NY	27.4	1.1	6.6
Fort Worth, TX	26.4	7.2	14.1
Seattle, WA	22.5	3.7	8.9
Enrollment Status			
Transitioning beneficiaries	28.7[c]	5.4[c]	12.1[c]
Continuous beneficiaries	24.5	3.5	8.6
Age			
Under age 65 (disabled)	50.9[c]	9.9[c]	24.4[c]
65-69	23.9	4.0	10.0
70-74	21.7	3.3	7.0
75-79	23.6	3.5	7.4
80-84	23.4	1.3	5.5
85+	18.1	2.0	4.9
Health Status			
Fair or poor	37.8[c]	5.0[c]	14.0[c]
Excellent, very good, or good	20.4	3.2	7.1
Annual Income			
Less than $10,000	31.1[c]	5.4[c]	12.6[c]
$10,000-$25,000	31.5	3.2	9.6
More than $25,000	21.7	3.8	8.1
Medicare Supplemental coverage			
No	32.1[d]	6.2[d]	14.3[d]
Yes	23.5	3.2	7.9

Source: 2003 and 2004 targeted surveys of Medicare FFS beneficiaries conducted by MPR for CMS.

[a]Includes one or more problems with finding a personal doctor or specialists, untreated medical conditions, delays in receiving care, and poor or fair ratings of the availability of primary care doctors or specialists.

[b] Other physician availability issues include response categories such as "doctors not taking any new patients" or "found doctor, but appointments hard to get", indicating limited physician availability that is not specific to Medicare. However, these responses may represent some cases in which a beneficiary is unaware of a doctor's decision to limit participation in Medicare.

[c]The difference between estimated proportions for the subgroups is statistically significant, with $p<0.05$.

Using pooled 2003 – 2004 data, we conducted further analysis looking at this question, focusing our attention on two groups of interest who might be particularly vulnerable if physicians' willingness to see Medicare beneficiaries, or accept Medicare fees as payment in full, declined—beneficiaries in transition, and beneficiaries without supplemental coverage. Transitioning beneficiaries were thought more likely to have been seeking out a new physician, and thus more likely have experienced access problems. Beneficiaries without supplemental coverage would be more vulnerable if physicians had chosen to charge Medicare patients more than the Medicare fee amount. We want to assess rates of access problems were significantly higher when these circumstances were combined with other vulnerable socioeconomic or health characteristics. We found that most subgroups with combinations of characteristics had notably higher rates of problems than other beneficiaries, and results were generally statistically significant (Table IV.6). For example, about 9 percent of beneficiaries who were both in transition and in poor or fair health had at least one problem they attributed to Medicare physician participation decisions—more than twice the rate of all beneficiaries. Similarly, nearly 9 percent of beneficiaries with no supplemental coverage who are under age 65 (disabled) had at least one problem related to physicians' willingness to see Medicare patients or accept Medicare payment.

Our analysis focused on a limited number of combinations, and not all of them were associated with markedly higher rates of problems. For example, disabled beneficiaries without supplemental coverage did not have higher rates of problems than other disabled beneficiaries, although both rates were high. Based on this analysis, we cannot conclude that combinations of characteristics always lead to incrementally higher rates of problems.

TABLE IV.6

ACCESS PROBLEMS ASSOCIATED WITH PHYSICIAN'S WILLINGNESS TO ACCEPT MEDICARE PATIENTS, ACCORDING TO COMBINATIONS OF BENEFICIARY CHARACTERISTICS, 2003-2004 POOLED DATA

	Percentage of Medicare FFS Beneficiaries With:		
	At Least One Access Problem (Any Reason)[b]	At Least One Access Problem Related to Physicians' Willingness to Accept Medicare Patients[b]	At Least One Access Problem Related to Physicians' Willingness to Accept Medicare Patients or Other Physician Availability Issues[b,c]
All Beneficiaries	24.8	3.7	8.9
Transitioning beneficiaries who are:[a]			
Disabled (age < 65)	43.6[d]	8.3[d]	17.6[d]
In poor or fair health	46.2[d]	9.2 [d]	20.4[d]
Low income (< $10,000)	40.7[d]	6.7[d]	17.3[d]
Beneficiaries with no supplemental coverage who are			
In transition	27.2[d]	5.3[d]	11.6[d]
Disabled (age < 65)	45.7[d]	8.7[d]	25.2[d]
Poor or fair health	34.9[d]	3.9[d]	11.9[d]
Low household income (< $10,000)	29.4[d]	4.9	10.4[d]

Source: 2003 and 2004 targeted surveys of Medicare FFS beneficiaries conducted by MPR for CMS.

[a]Beneficiaries who moved into the local area, recently became eligible for Medicare, or disenrolled from a Medicare+Choice plan in the past six months.

[b]Includes one or more problems with finding a personal doctor or specialists, untreated medical conditions, delays in receiving care, and poor or fair ratings of the availability of primary care doctors or specialists.

[c]Other physician availability issues include response categories such as "doctors not taking any new patients" or "found doctor, but appointments hard to get", indicating limited physician availability that is not specific to Medicare. However, these responses may represent some cases in which a beneficiary is not aware of a doctor's decision to limit or cease his or her participation in Medicare.

[d]The difference between estimated proportions, for the subgroups and all other beneficiaries is statistically significant, with $p<0.05$.

D. MULTIVARIATE ANALYSIS OF SUBGROUP EFFECTS ON ACCESS PROBLEMS

To estimate the independent effects of subgroup characteristics on access, we conducted a multivariate analyses predicting the probability of the three types of access problems defined earlier in this chapter: (1) any access problem (for any reason), (2) access problems related to physicians' decisions not to see Medicare patients or limit their Medicare practices, and (3) access problems related to physicians' willingness to see Medicare patients and/or other physician availability issues. Three separate logistic regressions were specified, one for each type of outcome, using 2003 – 2004 data. The dependent variable for each regression was the probability of having an access problem, and the independent variables included selected vulnerable subgroup characteristics. We ran the set of three regressions for all beneficiaries, and again for three subgroups of interest—transitioning beneficiaries, beneficiaries with no supplemental coverage and disabled beneficiaries—to see if effects were substantially different characteristics, based on the underlying coefficients from the regressions. We also present the underlying odds ratios for all beneficiaries, the three subgroups, and their mirror reference groups in Appendix D.[4]

[4] A marginal effect is the estimated percentage point change in the probability of access problems associated with a particular subgroup characteristic, assuming mean population characteristics for all other variables.

1. Results for All Beneficiaries

After controlling for other measured factors, we found that only some vulnerable subgroup characteristics had significant independent effects on the probability of access problems (Table IV.7).[5]

Disability status (those under age 65) was strongly associated with an increased likelihood of access problems. Aged beneficiary subgroups (those 65 or older) had substantially lower predicted probabilities of access problems than the disabled reference group, with differences as large as 16 to 24 percentage points. The likelihood of access problems appears to decline with age after age 65.

When controlling for other factors, poor or fair health status (versus excellent, very good, or good health) also increased rates of access problems substantially (Table IV.7), particularly for problems due to any reason and problems due to any type physician availability issue. Poorer health status is likely associated with greater health care needs, and thus, a greater probability of exposure to access barriers, including decisions by physicians to limit their practices. However, health-related effects on problems due specifically to physician willingness to accept Medicare patients were smaller and not statistically significant.

[5] Our sample size for the analysis discussed here was 5,225 beneficiaries. Questions on income were the most likely to have missing responses. To increase sample size and examine potential bias due to missing responses for this variable, we imputed responses for this variable, based on the median known responses, increasing the sample size to 5,994 beneficiaries. Results were substantively similar, with only marginal gains in statistical precision.

TABLE IV.7

LOGISTIC REGRESSION MODELS PREDICTING ANY ACCESS PROBLEMS AND PROBLEMS RELATED TO PHYSICIANS' WILLINGNESS TO ACCEPT MEDICARE PATIENTS, 2003-2004 POOLED DATA

	Dependent Variables for Three Logistic Regressions:					
	Any Access Problem		Any Problem Related to Physicians' Willingnessto Accept Medicare Patients		Any Problem Related to Physicians' Willingness to Accept Medicare Patients or Other Physician Availability Issues	
	Marginal effect[a]	p-value	Marginal effect[a]	p-value	Marginal effect[a]	p-value
Transitioning Status (vs. Non-Transitioning)	0.7	0.651	1.1	0.150	1.1	0.333
Age						
<65 (disabled)[b]						
65-69	-16.2**	0.000	-4.8*	0.043	-8.1**	0.007
70-74	-19.1**	0.000	-5.5*	0.011	-12.2**	0.000
75-79	-17.5**	0.000	-4.8*	0.048	-10.2**	0.001
80-84	-19.6**	0.000	-8.1**	0.000	-13.1**	0.000
85+	-23.9**	0.000	-7.8**	0.001	-14.1**	0.000
Poor/Fair Health Status (vs. Excellent, Very Good, or Good Health	13.4**	0.000	1.1	0.263	5.2**	0.000
No Supplemental Coverage (vs. Supplemental Coverage)	1.1	0.653	2.1	0.138	2.3	0.145
Income						
<$10,000[b]						
$10,000-$25,000	2.8	0.349	-1.7	0.171	-1.2	0.536
>$25,000	-4.7	0.107	-0.6	0.687	-1.8	0.371
Hispanic	-0.2	0.979	-1.4	0.427	-3.4	0.183
Race						
White[b]						
Black	-4.3	0.261	-1.9	0.223	-2.0	0.364
Other	0.4	0.906	0.2	0.929	0.6	0.791
Female (vs. Male)	4.7**	0.008	1.2	0.138	2.0	0.076

Source: 2003 and 2004 targeted surveys of Medicare FFS beneficiaries conducted by MPR for CMS.

Note: A set of dummy variables indicating the 11 targeted geographic sites (not shown here) were also included in the regressions to control for differences in geographic location.

[a]The marginal effect refers to the estimated change in the percentage of beneficiaries with access problems given this characteristic (vs. not), with mean characteristics for all other variables.

[b]Omitted reference group.

*Effect is statistically significant, $p < 0.05$
**Effect is statistically significant, $p < 0.01$

We found that women had a significantly higher predicted probability of any access problems, compared with men, when controlling for other factors. Women also showed an increased likelihood of problems related to physicians' willingness to accept Medicare patients and problems due to any physician availability, although these effects were not significant. These results are notable since women did not appear to have substantially higher rates of problems in our bivariate analyses.

2. Results for Key Subgroups

As shown in Tables IV.8, IV.9, and IV.10, we found similar results, as well as some notable differences, when examining the effects of these vulnerable characteristics for three key subgroups: (1) transitioning beneficiaries, (2) beneficiaries without supplemental coverage, and (3) disabled (under age 65) beneficiaries.[6]

Transitioning Beneficiaries. Among transitioning beneficiaries, we found a few notable, differential effects of subgroup characteristics. Effects of poor/fair health status and lower income were relatively large for this group. At the same time, disability had relatively small effects on access problems, compared to effects for other beneficiaries (see Table IV.8). This may indicate that while transitioning status itself does not have a significant effect on access, transitioning beneficiaries may especially vulnerable to health or income related circumstances. On the other hand, the relatively small effect of being disabled may indicate that the severity of

[6] All differences in effects noted here between the subgroup versus its mirror reference group (for example, transitioning versus non-transitioning beneficiaries) are statistically significant based on a t-test at the $p < 0.05$ level. Side-by-side comparisons of underlying odds ratios for each subgroup and its mirror reference group can be seen in Tables D.1, D.2, and D.3 in Appendix D.

TABLE IV.8

LOGISTIC REGRESSION MODELS PREDICTING ANY ACCESS PROBLEMS AND PROBLEMS RELATED TO PHYSICIANS' WILLINGNESS TO ACCEPT MEDICARE PATIENTS, AMONG BENEFICIARIES IN TRANSITION, 2003-2004 POOLED DATA

	Dependent Variables for Three Logistic Regressions:					
	Any Access Problem		Any Problem Related to Physicians' Willingness to Accept Medicare Patients		Any Problem Related to Physicians' Willingness to Accept Medicare Patients or Other Physician Availability Issues	
	Marginal effect[a]	p-value	Marginal effect[a]	p-value	Marginal effect[a]	p-value
Transitioning (vs. Non-Transitioning)						
Age						
<65 (disabled)						
65-69	-6.7*	0.033	-0.2	0.880	-1.0	0.639
70-74	-2.4	0.620	-1.7	0.269	1.7	0.549
75-79	-4.9	0.312	-2.9	0.079	1.1	0.717
80-84	-6.9	0.209	-1.8	0.240	-2.0	0.543
85+	-0.4	0.968	1.0	0.677	2.2	0.581
Poor or Fair Health (vs. Excellent, Very Good, or Good Health)	19.1**	0.000	3.9**	0.000	9.0**	0.000
No Supplemental Coverage (vs. Supplemental Coverage)	-0.4	0.847	-0.8	0.340	-1.4	0.379
Income						
<$10,000[b]						
$10,000-$25,000	-6.0	0.080	-0.7	0.584	-3.8	0.084
>$25,000	-10.5**	0.002	-0.7	0.547	-4.8*	0.025
Hispanic (vs. Non-Hispanic)	-2.5	0.564	-2.5	0.122	-2.1	0.448
Race						
White[b]						
Black	4.4	0.281	0.7	0.649	2.8	0.246
Other	6.1	0.080	0.5	0.745	3.7	0.138
Female (vs. Male)	3.8	0.065	0.6	0.418	0.7	0.584

Source: 2003 and 2004 targeted surveys of Medicare FFS beneficiaries conducted by MPR for CMS.

Note: A set of dummy variables indicating the 11 targeted geographic sites (not shown here) were also included in the regressions to control for differences in geographic location.

[a]The marginal effect refers to the estimated change in the percentage of beneficiaries with access problems given this characteristic (vs. not) with mean characteristics for all other variables.

[b]Omitted reference group.

*Effect is statistically significant, $p < 0.05$
**Effect is statistically significant, $p < 0.01$

disability (and thus its effect on access problems) may be less for those who are making transitions.

The effects of lacking supplemental coverage for transitioning beneficiaries was in the opposite direction of the effect for all beneficiaries, although the main effects for this group were not statistically significant.

Beneficiaries Without Supplemental Coverage. We also found a few notable differential effects for those without supplemental coverage. A surprising finding was the lack of a large income effect. We expected those without supplemental coverage would to be more likely than those with such coverage to feel the effects of low income on affordability of physician services. On the other hand, the effect of poor or fair health status was relatively large for those without supplemental coverage, with a predicted 22 percentage point increase in rates of problems (Table IV.9). Blacks and those of other race were substantially less likely than whites to experience problems. In addition, the likelihood of problems declines substantially with age after age 65.

Disabled Beneficiaries. Disabled beneficiaries also experienced differential effects in a few notable areas. However, given a relatively small sample, the main effects of characteristics for this group were not statistically significant (Table IV.10). The effects of transitioning status on access to care for disabled beneficiaries (under age 65) ran in the opposite direction of those for beneficiaries over 65. For disabled beneficiaries, transitioning status (moving, prior membership in an HMO, or recent Medicare eligibility) may indicate a relatively low level of disability, or a better capacity to navigate the health care system, compared to disabled beneficiaries who are not in transition. These factors may outweigh any increased likelihood of disruptions in care due to the transitions themselves. (This result may be analogous to findings noted above that effect of disability for transitioning beneficiaries was also relatively small.)

TABLE IV.9

LOGISTIC REGRESSION MODELS PREDICTING ANY ACCESS PROBLEMS AND PROBLEMS RELATED TO PHYSICIANS' WILLINGNESS TO ACCEPT MEDICARE PATIENTS, AMONG BENEFICIARIES WITHOUT SUPPLEMENTAL COVERAGE, 2003-2004 POOLED DATA

	Dependent Variables for Three Logistic Regressions:					
	Any Access Problem		Any Problem Related to Physicians' Willingness to Accept Medicare Patients		Any Problem Related to Physicians' Willingness to Accept Medicare Patientsor Other Physician Availability Issues	
	Marginal effect[a]	p-value	Marginal effect[a]	p-value	Marginal effect[a]	p-value
Transitioning Status (vs. Non-Transitioning)	0.2	0.957	0.4	0.346	2.0	0.383
Age						
<65 (disabled)[b]						
65-69	-17.4*	0.017	-1.2	0.457	-3.6	0.547
70-74	-20.8*	0.010	-2.4	0.085	-7.5	0.223
75-79	-21.6*	0.025	-1.5	0.437	-11.2	0.065
80-84	-21.6*	0.038	-3.3**	0.000	-16.8*	0.014
85+	-34.5**	0.001	-3.1**	0.004	-17.4**	0.000
Poor or Fair Health (vs. Excellent, Very Good, or Good Health)	22.3*	0.000	0.2	0.677	7.0*	0.036
Income						
<$10,000[b]						
$10,000-$25,000	3.5	0.517	-0.2	0.703	-1.2	0.686
>$25,000	-4.0	0.550	0.3	0.717	-1.4	0.715
Hispanic (vs. Non-Hispanic)	7.0	0.418	0.5	0.488	3.9	0.413
Race						
White[b]						
Black	-14.6*	0.032	-0.2	0.737	-1.0	0.806
Other	-15.0*	0.036	-0.3	0.760	-3.6	0.390
Female (vs. Male)	8.0	0.101	0.0	0.930	2.4	0.351

Source: 2003 and 2004 targeted surveys of Medicare FFS beneficiaries conducted by MPR for CMS.

Note: A set of dummy variables indicating the 11 targeted geographic sites (not shown here) were also included in the regressions to control for differences in geographic location.

[a]The marginal effect refers to the estimated change in the percentage of beneficiaries with access problems given this characteristic (vs. not) with mean characteristics for all other variables.

[b]Omitted reference group.

*Effect is statistically significant, $p < 0.05$
**Effect is statistically significant, $p < 0.01$

TABLE IV.10

LOGISTIC REGRESSION MODELS PREDICTING ANY ACCESS PROBLEMS AND PROBLEMS RELATED TO PHYSICIANS' WILLINGNESS TO ACCEPT MEDICARE PATIENTS, AMONG BENEFICIARIES UNDER AGE 65 (DISABLED), 2003-2004 POOLED DATA

	Dependent Variables for Three Logistic Regressions:					
	Any Access Problem		Any Problem Related to Physicians' Willingness to Accept Medicare Patients		Any Problem Related to Physicians' Willingness to Accept Medicare PatientsOther Physician Availability Issues	
	Marginal effect[a]	p-value	Marginal effect[a]	p-value	Marginal effect[a]	p-value
Transitioning Status (vs. Non-Transitioning)	-4.9	0.1696	-0.8	0.6791	-2.4	0.2058
Poor or Fair Health (vs. Excellent, Very Good, or Good Health)	9.7*	0.0483	0.6	0.8738	4.6	0.1644
No Supplemental Coverage (vs. Supplemental Coverage)	3.8	0.5184	2.5	0.5336	0.8	0.8134
Income						
<$10,000[b]						
$10,000-$25,000	16.4*	0.0077	3.3	0.3552	0.1	0.9829
>$25,000	-0.3	0.9653	0.1	0.9794	-0.6	0.8810
Hispanic (vs. Non-Hispanic)	-5.6	0.4933	-4.8	0.1813	-7.1*	0.0303
Race						
White[b]						
Black	-0.2	0.9868	-0.9	0.8611	-3.4	0.4137
Other	7.5	0.4271	-1.3	0.7664	4.7	0.3594
Female (vs. Male)	5.4	0.2535	0.1	0.9703	-1.1	0.6785

Source: 2003 and 2004 targeted surveys of Medicare FFS beneficiaries conducted by MPR for CMS.

Note: A set of dummy variables indicating the 11 targeted geographic sites (not shown here) were also included in theegressions to control for differences in geographic location.

[a]The marginal effect refers to the estimated change in the percentage of beneficiaries with access problems given this characteristic (versus not) with mean characteristics for all other variables.

[b]Omitted reference group.

*Effect is statistically significant, $p < 0.05$
**Effect is statistically significant, $p < 0.01$

We found that the effect of poor/fair health status on access problems was relatively small for disabled beneficiaries. A possible explanation for this finding is that a much larger percentage of disabled beneficiaries say they are in poor or fair health, and that even those in good, very good, or excellent health may still have some minimum level of health care need that does not exist for healthy aged beneficiaries. Thus, differences in the likelihood of confronting access barriers according to health status may be smaller for disabled beneficiaries.

E. REGRESSION-ADJUSTED SITE-LEVEL ESTIMATES

As part of the regression analysis, we also produced regression-adjusted site-level estimates to see if our findings about site level differences drawn from our bivariate analysis changed when we take into account population characteristic differences between sites.

As Table IV.11 shows, Denver, Colorado and the state of Alaska continued to stand out with higher than average rates of access problems, even when controlling for population differences.[7] Ft. Worth, Texas also appears to have had relatively high rates of access problems when other beneficiary characteristics are held constant. When we calculated regression-adjusted site-level rates of access problems for subgroups—including transitioning beneficiaries, beneficiaries without supplemental coverage, and beneficiaries without supplemental coverage—we again found relatively high predicted rates in these markets. Site-level results for beneficiaries without supplemental coverage and disabled beneficiaries should be interpreted with caution, however, given the relatively low sample sizes (in the range of 30 to 60 beneficiaries) used for these estimates. Because transitioning beneficiaries were oversampled in each market, sample sizes were larger (nearly 300 beneficiaries per site); thus estimates this group are more precise.

[7] This table predicts what access rates in local communities would be if they had average population characteristics across all 11 sites.

TABLE IV.11

REGRESSION-ADJUSTED SITE-LEVEL ESTIMATES OF THE PERCENTAGE OF MEDICARE BENEFICIARIES WITH ACCESS PROBLEMS

	Regression-Adjusted Percentage of Medicare FFS Beneficiaries with:[a]		
Geographic site	At Least One Access Problem	At Least One Access Problem Related to Physicians' Willingness to Accept Medicare Patients	At Least One Access Problem Related to Physicians' Willingness to Accept Medicare Patientsor Other Physician Availability Issues
All Beneficiaries			
Alaska (state)	34.8	14.2	20.9
Phoenix, AZ	25.4	4.1	8.2
San Diego, CA	27.1	3.3	9.7
San Francisco, CA	20.6	1.2	5.5
Denver, CO	27.1	11.1	15.9
Tampa, FL	21.0	2.6	5.7
Springfield, MO	20.1	3.0	8.8
Las Vegas, NV	26.2	2.0	7.1
Brooklyn, NY	23.2	1.5	5.3
Ft. Worth, TX	25.2	11.0	15.5
Seattle WA	22.3	5.9	10.3
Transitioning Beneficiaries			
Alaska (state)	41.7	14.6	23.1
Phoenix, AZ	30.3	6.0	10.1
San Diego, CA	25.5	1.5	7.8
San Francisco, CA	24.5	4.7	8.7
Denver, CO	34.0	11.7	18.2
Tampa, FL	23.6	2.6	7.5
Springfield, MO	31.8	5.8	13.5
Las Vegas, NV	30.3	2.7	10.5
Brooklyn, NY	21.4	2.7	8.4
Ft. Worth, TX	33.6	10.3	19.9
Seattle, WA	26.2	30.2	10.2
Beneficiaries With No Supplemental Coverage			
Alaska (state)	42.7	8.5	17.1
Phoenix, AZ	36.3	5.4	7.2
San Diego, CA	29.4	0.0	9.5
San Francisco, CA	30.7	3.5	7.5
Denver, CO	26.8	7.9	11.5
Tampa, FL	12.9	0.0	4.3
Springfield, MO	26.6	1.8	12.1
Las Vegas, NV	43.2	2.7	9.6
Brooklyn, NY	27.8	0.3	5.3
Ft. Worth, TX	37.9	12.7	25.6
Seattle WA	22.9	5.5	10.2

Geographic site	Regression-Adjusted Percentage of Medicare FFS Beneficiaries with:[a] At Least One Access Problem	At Least One Access Problem Related to Physicians' Willingness to Accept Medicare Patients	At Least One Access Problem Related to Physicians' Willingness to Accept Medicare Patientsor Other Physician Availability Issues
Disabled Beneficiaries			
Alaska (state)	23.6	13.6	12.8
Phoenix, AZ	38.1	11.1	5.7
San Diego, CA	20.8	7.8	13.7
San Francisco, CA	19.2	11.3	10.5
Denver, CO	29.6	17.7	16.4
Tampa, FL	14.1	9.1	7.9
Springfield, MO	27.2	10.5	12.1
Las Vegas, NV	24.1	7.7	6.5
Brooklyn, NY	12.4	0.4	4.4
Ft. Worth, TX	16.9	14.7	15.3
Seattle WA	33.1	21.7	19.5

Source: 2003 and 2004 targeted surveys of Medicare FFS beneficiaries conducted by MPR for CMS.

Note: Sample sizes used for generating site-level estimates for those with no supplemental coverage and those disabled are small (in the range of 30 to 60 beneficiaries) and thus estimated site-level differences should be interpreted with caution.

[a]Site estimates are adjusted for measured factors according to mean population characteristics in each site, including transitioning status, age, health status, medical conditions, limits on functioning, hospital use, income, supplemental coverage, race, ethnicity, and gender, using multivariate logistic regressions shown in Tables IV.7-IV.11. This analysis is intended to predict what rates of access problems in each area would have been if it had average population characteristics across the 11 sites.

V. CONCLUSIONS

A. SUMMARY OF FINDINGS

In response to concern about access to physician services after cuts in Medicare physician payments in 2002 and early 2003, CMS sponsored two rounds of targeted surveys of Medicare beneficiaries in 2003 and 2004, in 11 geographic areas that were thought to have particularly high or increasing rates of problems. Most of the areas were in the top 10 percent in terms of rates of problems reported in the 2001 Medicare CAHPS-FFS survey, and CMS regional offices identified many in 2002 as having increasing problems as a result of the declining participation of Medicare physicians.

Overall, we found that most beneficiaries did not report access problems in these 11 areas; only a small percentage reported problems attributed to Medicare physician participation issues. Depending on the measure, 8 to 21 percent of beneficiaries in these areas experienced some type of problem in 2004; less than 4 percent report problems attributed to Medicare physician participation. We also found that there was little change from 2003 to 2004 in the rates of reported access problems among all beneficiaries, particular subgroups, or those living in specific geographic areas. Notably, beneficiaries making some form of transition (for example, moving, recently joining Medicare, or disenrolling from an HMO), who were thought to be especially vulnerable to changes in physician participation in Medicare, experienced no major changes in rates of access problems.

Major exceptions to these findings include a significant increase in the percentage of all beneficiaries who said they always got timely routine care appointments among those making appointments—indicating a potential improvement in access in this area. However, we found no change in the percentage who said that they always or *usually* got timely routine care

appointments, because of an equal decrease among those reporting they usually got timely routine care appointments. As another exception, we saw improvement in several access measures for beneficiaries who recently disenrolled from an HMO. These beneficiaries were significantly less likely in 2004 (compared to 2003) to say that getting a doctor has become more difficult in the past year or two, to report a problem getting a personal doctor they were happy with since joining Medicare, or to report a problem getting a specialist in the last six months when they needed one.

Given the general lack of change over time, we decided to pool the 2003 and 2004 data to examine the effects of beneficiary subgroup characteristics on the likelihood of access problems. Previous analysis of 2003 data showed that certain subgroup were more likely to have problems (Lake et al. 2003); thus, we wanted to look at these differences more closely, and with more statistical precision, given a larger sample size than pooled data would afford.

In multivariate analysis of the pooled data, several beneficiary characteristics were found to have independent effects on the rates of access problems, when controlling for other measured variables. In particular, transitioning status, disability status, poor/fair health, lack of supplemental coverage, lower income, and being female increased the likelihood of problems, when holding other factors constant.

The effects of beneficiary characteristics were not always consistent for particular subgroups. For example, we found that the effect of transitioning status on access problems was limited to beneficiaries who were 65 or older. Disabled beneficiaries (under 65) who were in transition were predicted to be *less* likely to have problems, possibly indicating that these transitions are associated with a lower level of disability and/or better ability to access needed medical care, despite the disruptions that transitions may cause. An alternative explanation is that, as a result of being disabled, these beneficiaries had relationships with providers for the

disability that they kept when they became Medicare eligible. At the same time, the effect of health status on access problems was relatively large for beneficiaries in transition or who lack supplemental coverage, but it was relatively small for disabled beneficiaries.

We also found significant differences in access rates according to geographic area when examining the pooled 2003-2004 data. Alaska and Denver, Colorado stood out has having consistently higher rates of problems for multiple measures, with Phoenix, Arizona and Seattle, Washington showing higher rates of problems than other sites on selected measures. Furthermore, Alaska and Denver had high predicted rates when we controlled for differences in population characteristics in multivariate analysis. When accounting for population differences, Fort Worth had relatively high rates of problems.

B. STUDY LIMITATIONS

Caveats and limitations to this study should be noted. First, since we chose markets thought to represent areas with a high level of access problems, the results presented here are not nationally representative. Instead, we tried to confirm and enumerate the extent of access problems in these areas, then explore the reasons for the problems.

Second, all the results are based on beneficiaries' perceptions of access issues and the reasons for the problems they experienced. We were not able to identify the true causes of problems or to determine whether specific problems reported actually had significant consequences for beneficiaries. For example, some beneficiaries with access difficulties may have been unaware of physician supply or Medicare participation issues, while others may have mistakenly attributed the difficulties to these issues; thus, these results may have either understated or overstated the actual extent of the problem. Although the validity and reliability of these questions on the reasons for access problems have not been tested, beneficiaries nonetheless offer an important individual perspective, not available from other sources.

C. CONCLUSIONS

The results from this study are generally reassuring. We attempted to target areas with severe access problems; yet we found the proportion of beneficiaries who reported problems to be small. We also found little indication that problems have worsened in these areas in the past year or so. Rates of access problems reported by all beneficiaries, and among vulnerable subgroups, generally remained stable in 2003 and 2004. In both years, a small percentage of beneficiaries said that seeing a doctor had become more difficult in the past year or two, while a large majority reported no change.

Still, some of our findings are grounds for concern. In 2003, we found that rates of access problems were higher (though still moderate in size) in a few market areas and among beneficiaries with certain characteristics, such as those who had made recent transitions in location or health coverage and thus were more likely to be looking for a new physician. Further, some beneficiaries with problems cited reasons that appear closely associated with the Medicare fee schedule.

The situation for vulnerable subgroups did not change dramatically in 2004. Access has not grown worse for these groups, but it has not improved, either. An analysis of 2003 and 2004 pooled data reveals that beneficiary characteristics have independent effects on access problems, when controlling for other factors. In particular, beneficiaries who were disabled or who were in relatively poor health were significantly more likely to report access problems, when controlling for other factors. Among transitioning beneficiaries, the effect of health status was especially large. The effects of these characteristics may vary for particular subgroups, and those with a certain combination of characteristics may be especially likely to have problems. Beneficiaries with these vulnerable characteristics may feel the greatest impact if access barriers increase in the future.

We cannot say conclusively whether increases in payment set for most of 2003 and 2004, and planned for 2005 have offset any potentially negative effects of cuts in 2002 and early 2003. This study was not designed to measure directly the effect of Medicare physician payment changes on physician access to care. Payment changes over the past few years were made nationwide; thus, we cannot estimate directly what would have happened in absence of these changes by observing a group of beneficiaries not exposed to these changes. Nonetheless, the results from this study indicate that there has been no major deterioration in access to care in the 11 targeted markets thought to have problems, over a one-year period following the recent cuts in Medicare fees.

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

REFERENCES

Aday, Lu Ann, and Ronald Anderson. *Access to Medical Care*. Ann Arbor, MI: Health Administration Press.

Centers for Medicare and Medicaid Services. "CMS to Increase Physician Payment Rates for 2003." Medicare News, Friday, February 26, 2003. (www.cms.gov/media/press/release)

Centers for Medicare and Medicaid Services. "Medicare Announces Physician Pay Changes for 2003" Medicare News, Friday, December 20, 2002. (www.cms.gov/media/press/release)

Chromy, James R. "Sequential Sample Selection Methods." In *Proceedings of the American Statistical Association Survey Research Section*, 401-6, 1979.

Gold, Marsha, Timothy Lake, and Randall Brown. "Geographical Areas to Survey Report: Design and Implementation of a Targeted Beneficiary Survey on Access to Physician Services Among Medicare Beneficiaries." Report submitted to the Centers for Medicare & Medicaid Services. Washington DC: Mathematica Policy Research, Inc. December 2002.

Holtz-Eakin, Douglas. "Medicare's Physician Fee Schedule." CBO Testimony Before the Subcomittee on Health and Commerce, U.S. House of Representatives. May 5, 2004.

Kalton, G and Kasprzyk, D (1986) The treatment of missing survey data. Survey Methodology 12, 1-6

Lake, Timothy, Marsha Gold, Anne Ciemnecki, Michael Sinclair, Nuria Diaz-Tena, Collettee Lamothe-Galette, So Limpa-Amara. "Results from the 2003 Targeted Beneficiary Survey on Access to Physician Services Among Medicare Beneficiaries." Report submitted to the Centers for Medicare & Medicaid Services. Cambridge, MA: Mathematica Policy Research, Inc. October 2003.

Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy*. Washington, DC, March 2004.

Rosenbaum P. R. and Rubin D. B. the central role of the Propensity score in observational studies for causal effects. *Biometrika*, 70, 41-55, 1983.

Russell, Thomas R., MD, American College of Surgeons. "Testimony on a Hearing on Medicare Payment Policy: Ensuring Stabilizing and Access Through Physician Payment." Subcommittee on Health, The Committee on Energy and Commerce, February 14, 2002.

Schwarz, N., D. Park, B. Knauper, and S. Sudman, eds. *Cognition, Aging and Self-Reports*. Philadelphia, PA: Psych Press, 1998.

Strunk, Bradley and Peter Cunningham. "Trends in Americans' Access to Needed Medical Care, 2001-2003." Tracking Report, No. 10. Washington DC: Center for Studying Health System Change.

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

APPENDIX A

ADDITIONAL DETAILS ON THE SURVEY SAMPLING METHODS, RESPONSE RATES, AND WEIGHTING METHODOLOGY

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

SAMPLING METHODS

A. SUMMARY OF FRAME COUNTS AND SAMPLE SIZES

Table A.1 presents a detailed summary of the sampling frame exclusions from the EDB. Table A.2 provides a summary of the sampling frame counts of TBS as of February, 2004, the initial sample sizes selected, the released sample sizes, and the number of completed interviews by site and stratum. There are two strata within each site, based on the beneficiary status in the period between July 1, 2003 and January 1, 2004: (1) the transitioning beneficiaries (newly entitled to Medicare, the beneficiaries who moved into one of the 11 sites from an area outside the site,[1] and the beneficiaries who switched from M+C to FFS) and (2) the continuing beneficiaries (those beneficiaries who have been in the same site and the same FFS Medicare plan). CMS gave MPR the right to use the EDB Database after MPR completed the *Application for Access to CMS Computer Systems.*

[1]For the state of Alaska, we evaluated movers on regional basis by dividing the counties into six regions:

1. The South East region, with county codes: 030, 100, 110, 130, 190, 200, 210, 220, 228, 230, 280
2. The South West region, with county codes: 010, 050, 060, 070, 150
3. The Anchorage region, with county codes: 020, 120, 999
4. The Matanuska region, with county codes: 080, 170, 260, 760
5. The Fairbanks region, with county codes: 090, 098, 160, 240, 250, 290
6. The North region, with county codes: 040, 140, 180, 270

An Alaska mover is defined as someone who moved into one of the Alaskan regions between July 1, 2003 and January 1, 2004.

TABLE A.1

SAMPLE FRAME EXCLUSIONS FROM EDB

Exclusions from the Sample Frame
Medicare Beneficiaries:
• Who are under age 18
• Who are deceased
• Who are in a Medicare group health plan (HMO or other managed care plan)
• Who live outside the 11 selected sites (geo-units)
• Who are dually eligible for Medicare and Medicaid
• Who are living in a hospice, nursing home, or other institution
• For whom Medicare is not the primary payer
• Who have only Medicare Part A coverage (not Part B)
• Whose Medicare Part B entitlement started in February 2004
• Whose residence information from the EDB did not match the EDB county code

TABLE A.2

SAMPLING FRAME, SAMPLE SIZES, AND COMPLETED INTERVIEWS, PER SITE AND PER STRATUM

	Frame (Population		Sample		
Largest County in Site Stratum	Count	Percent	Initial Count	Released Count	Completed Interviews
11 Sites Total	1,071,742	100.00	6,600	4,640	3,287
Transitioning	84,230	7.86	3,300	2,320	1,656
Other	987,512	92.14	3,300	2,320	1,631
Alaska (State)					
Total	28,541	100.00	600	380	305
Transitioning	2,304	8.07	300	190	147
Other	26,237	91.93	300	190	158
Phoenix, AZ					
Total	180,739	100.00	600	420	292
Transitioning	16,959	9.38	300	210	146
Other	163,780	90.62	300	210	146
San Diego, CA					
Total	119,671	100.00	600	440	302
Transitioning	9,253	7.73	300	220	147
Other	110,418	92.27	300	220	155
San Francisco, CA					
Total	63,038	100.00	600	480	302
Transitioning	4,090	6.49	300	240	145
Other	58,948	93.51	300	240	157
Denver, CO					
Total	81,247	100.00	600	380	295
Transitioning	6,350	7.82	300	190	149
Other	74,897	92.18	300	190	146
Tampa, FL					
Total	108,725	100.00	600	400	299
Transitioning	8,370	7.70	300	200	157
Other	100,355	92.30	300	200	142
Springfield, MO					
Total	87,341	100.00	600	380	306
Transitioning	5,277	6.04	300	190	155
Other	82,064	93.96	300	190	151
Las Vegas, NV					
Total	76,329	100.00	600	460	313
Transitioning	8,301	10.88	300	230	160
Other	68,028	89.12	300	230	153
Brooklyn, NY					
Total	98,221	100.00	600	500	301
Transitioning	7,035	7.16	300	250	160
Other	91,186	92.84	300	250	141
Ft. Worth, TX					
Total	102,406	100.00	600	400	287
Transitioning	7,732	7.55	300	200	146
Other	94,674	92.45	300	200	141
Seattle, WA					
Total	125,484	100.00	600	400	285
Transitioning	8,559	6.82	300	200	144
Other	116,925	93.18	300	200	141

RESPONSE RATES

Table A.3 presents a summary of the weighted and unweighted response rates for this study by site. The unweighted response rates are based on the counts of cases responding to the survey, and an estimate of the number of eligible cases. The weighted response rates are computed using the same techniques, but the counts are weighted by the sampling weight.[2]

The specific formulas used for the response rate computations are given in (1) and (2):

$$(1)\quad \text{Unweighted Response Rate} = \frac{\text{Number of completed cases}}{\text{Estimated number of eligible cases}}$$

$$(2)\quad \text{Weighted Response Rate} = \frac{\text{Weighted number of completed cases}}{\text{Weighted estimated number of eligible cases}}$$

As an example of these computations, consider the Alaska site in Table A.3. In Alaska we released a total of 380 sampled beneficiaries for interviewing, of which 332 were located and 48 unlocated. Among the 332 located beneficiaries, we were able to determine the eligibility status for 327, of which 305 completed the interview, 16 did not complete the interview and 6 were ineligible. Using hot deck imputation, we imputed the eligibility for the 5 located cases with unknown eligibility and only 1 of the 5 was imputed as ineligible and the other 4 as eligible. As a result, we ended up with 305 completes, 7 ineligibles (6 known and 1 imputed), 20 eligible noncompletes (16 known and 4 imputed) and 48 unlocated. Using these numbers in (1) we have a response rate of 81.99 percent. This response rate is the ratio of the complete cases (305) and the estimated eligible cases (371.99). The number of estimated cases is computed by adding

[2]The sampling weight is the inverse of the probability of selection for the selected beneficiaries, which accounts for the oversampling of transitioning beneficiaries in the sample design.

TABLE A.3

UNWEIGHTED AND WEIGHTED RESPONSE RATES, BY SITE

Site	Unweighted					Weighted				
	Total Sample Released	Completed Interviews	Eligible Noncompletes[2]	Ineligible Interviews[2]	Response Rate (Percent)	Total Sample Released	Completed Interviews	Eligible Noncompletes[2]	Ineligible Interviews[2]	Response Rate (Percent)
Total	**4,640**	**3,287**	**584**	**170**	**73.95**	**1,071,742**	**752,091**	**147,861**	**42,200**	**73.47**
1. Alaska	380	305	20	7	81.99	28,541	23,601	1,628	589	84.62
2. Phoenix, AZ	420	292	51	17	72.97	180,739	125,657	19,500	6,966	72.86
3. San Diego, CA	440	302	47	17	71.98	119,671	83,977	12,553	5,313	74.04
4. San Francisco, CA	480	302	76	17	65.75	63,038	41,033	9,752	2,347	68.10
5. Denver, CO	380	295	34	15	81.17	81,247	62,532	8,713	2,305	79.46
6. Tampa, FL	400	299	50	11	77.11	108,725	77,823	16,810	3,680	74.36
7. Springfield, MO	380	306	36	12	83.35	87,341	69,524	8,274	2,758	82.42
8. Las Vegas, NV	460	313	47	7	69.37	76,329	51,028	8,188	1,551	68.60
9. Brooklyn, NY	500	301	104	36	65.55	98,221	55,931	25,479	7,072	61.89
10. Ft. Worth, TX	400	287	60	15	74.85	102,406	72,390	17,100	4,058	73.89
11. Seattle, WA	400	285	59	16	74.56	125,484	88,595	19,863	5,561	74.22

[1]Counts are weighted by the inverse probabilities of selection for the sampled beneficiaries. See formulas (1) and (2).

[2]The counts include located cases with undetermined eligibility who were imputed to be eligible or ineligible.

the complete cases (305), the eligible noncompletes (20) and the estimated eligible cases among the nonlocated cases (46.99). The estimated eligible cases among the nonlocated is computed by multiplying the number of nonlocated cases (48) by the eligibility rate (0.98). And the eligibility rate is estimated by the ratio of eligible cases (305 completes and 20 eligible noncompletes) to the cases with known eligibility (305 completes, 20 eligible noncompletes and 7 ineligible cases).

Table A.4 examines the response rates in more detail based on a subset of the available characteristics from the EDB. Specifically, we examine the weighted response rates for each site by four characteristics: stratum membership, gender, age group, and race. In telephone surveys, our experience indicated that survey response is heavily dependent on the ability to locate a phone number for, and make contact with, the sampled beneficiary. Therefore, we divided the response rate into two components, with the first reflecting the rate of located phone numbers with contact among the sampled cases, and the second, the rate of survey participation among the eligible located beneficiaries. Furthermore, we anticipated that the factors affecting locatability would not necessarily be the same as those that influenced whether a person would participate once located. These two rates are defined in equations (3) and (4) below:

$$(3)\quad \text{Weighted Location Rate} = \frac{\text{Weighted number of located cases}}{\text{Weighted number of released cases}}$$

$$(4)\quad \text{Weighted Response Rate Among Located and Eligible} = \frac{\text{Weighted number of completed eligible cases}}{\text{Weighted number of located eligible cases}}$$

The rates in table B4 confirm that the factors affecting locatability are not the same as those for participation. For example, in the Alaska site the beneficiaries who are harder to locate are the transitioning (84 percent for transitioning and 91 percent for other), while the response rate is similar for the two groups (94 percent). Similarly, the location rate for males and females is very

TABLE A.4

WEIGHTED RESPONSE RATES, BY SITE AND CHARACTERISTICS

Site	Weighted Location Rate	Weighted Response Rate Among Eligible Cases	Weighted Response Rate
Total 11 Sites			
Total	87.91	83.57	73.47
Stratum			
Transition	86.65	85.98	74.50
Other	88.02	83.37	73.38
Gender			
Male	85.85	83.51	71.69
Female	89.53	83.62	74.86
Age			
Less 65	71.35	89.16	63.62
65 to 74	89.56	84.03	75.26
75 to 84	88.64	83.05	73.62
85+	92.45	79.31	73.32
Race			
White	89.52	84.05	75.24
Not white	76.92	79.79	61.37
San Diego, CA			
Total	85.10	87.00	74.04
Stratum			
Transition	80.91	85.96	69.55
Other	85.45	87.08	74.41
Gender			
Male	82.38	87.94	72.44
Female	87.58	86.04	75.44
Age			
Less 65	61.62	89.93	55.41
65 to 74	85.55	85.52	73.16
75 to 84	87.78	87.93	77.19
85+	90.11	90.94	81.95
Race			
White	87.70	86.84	76.16
Not white	71.01	87.98	62.47

Site	Weighted Location Rate	Weighted Response Rate Among Eligible Cases	Weighted Response Rate
Alaska			
Total	90.46	93.55	84.63
Stratum			
Transition	83.68	94.23	78.85
Other	91.05	93.49	85.12
Gender			
Male	90.72	91.84	83.32
Female	90.21	95.17	85.85
Age			
Less 65	82.92	87.60	72.64
65 to 74	90.97	94.62	86.08
75 to 84	94.07	94.20	88.61
85+	82.26	89.00	73.21
Race			
White	91.94	93.96	86.39
Not white	82.25	90.95	74.81
San Francisco, CA			
Total	84.29	80.80	68.11
Stratum			
Transition	80.00	78.80	63.04
Other	84.58	80.93	68.45
Gender			
Male	83.52	80.83	67.51
Female	84.86	80.77	68.54
Age			
Less 65	85.31	93.13	79.45
65 to 74	84.08	78.46	65.97
75 to 84	83.41	81.53	68.00
85+	86.34	79.22	68.40
Race			
White	87.34	83.72	73.12
Not white	77.10	73.09	56.35

Site	Weighted Location Rate	Weighted Response Rate Among Eligible Cases	Weighted Response Rate
Phoenix, AZ			
Total	84.17	86.57	72.87
Stratum			
Transition	87.62	83.43	73.10
Other	83.81	86.90	72.83
Gender			
Male	80.03	85.34	68.30
Female	87.41	87.45	76.44
Age			
Less 65	56.17	87.03	48.88
65 to 74	88.45	89.16	78.86
75 to 84	85.16	85.29	72.63
85+	85.03	77.41	65.82
Race			
White	84.66	87.44	74.03
Not White	77.38	73.76	57.08
Denver, CO			
Total	90.53	87.77	79.46
Stratum			
Transition	90.53	92.44	83.68
Other	90.53	87.79	79.47
Gender			
Male	89.43	92.12	82.39
Female	91.42	85.00	77.71
Age			
Less 65	68.40	92.60	63.34
65 to 74	94.63	84.23	79.71
75 to 84	92.22	91.26	84.16
85+	91.32	89.70	81.91
Race			
White	92.88	89.02	82.68
Not white	71.95	75.53	54.34

TABLE A.4 *(continued)*

Site	Weighted Location Rate	Weighted Response Rate Among Eligible Cases	Weighted Response Rate
Tampa, FL			
Total	90.42	82.24	74.36
Stratum			
Transition	89.50	89.71	80.29
Other	90.50	81.61	73.86
Gender			
Male	89.00	81.71	72.72
Female	91.45	82.62	75.56
Age			
Less 65	78.05	89.37	69.75
65 to 74	95.05	83.13	79.02
75 to 84	84.73	79.89	67.69
85+	96.37	80.41	77.49
Race			
White	92.83	82.52	76.60
Not white	61.88	77.42	47.91
Brooklyn, NY			
Total	90.08	68.70	61.88
Stratum			
Transition	86.00	81.22	69.85
Other	90.40	67.79	61.28
Gender			
Male	86.81	70.87	61.52
Female	92.34	67.23	62.08
Age			
Less 65	81.74	83.69	68.41
65 to 74	88.75	68.08	60.42
75 to 84	90.52	60.52	54.78
85+	99.65	75.52	75.26
Race			
White	92.57	66.20	61.28
Not white	84.38	74.88	63.18
Springfield, MO			
Total	92.23	89.36	82.42
Stratum			
Transition	94.21	89.60	84.41
Other	92.11	89.35	82.30
Gender			
Male	90.63	86.41	78.31
Female	93.49	91.64	85.67
Age			
Less 65	81.35	93.58	76.13
65 to 74	89.86	86.73	77.94
75 to 84	96.82	94.79	91.78
85+	100	81.07	81.07
Race			
White	92.03	89.05	81.95
Not white	100	100	100
Ft. Worth, TX			
Total	91.35	80.89	73.89
Stratum			
Transition	89.50	84.88	75.97
Other	91.50	80.57	73.92
Gender			
Male	89.10	78.79	70.20
Female	93.03	82.44	76.69
Age			
Less 65	80.81	83.41	67.40
65 to 74	91.69	83.07	76.17
75 to 84	92.48	79.14	73.19
85+	95.14	72.96	69.41
Race			
White	93.8	81.17	76.20
Not white	74.00	78.61	58.17
Las Vegas, NV			
Total	79.61	86.17	68.60
Stratum			
Transition	80.00	87.91	70.33
Other	79.57	85.96	68.40
Gender			
Male	79.50	86.80	69.01
Female	79.72	85.60	68.24
Age			
Less 65	62.21	98.65	61.37
65 to 74	83.02	82.36	68.38
75 to 84	78.90	92.52	73.00
85+	83.65	75.92	63.51
Race			
White	79.76	86.18	68.74
Not white	78.64	86.13	67.73
Seattle, WA			
Total	90.86	81.69	74.22
Stratum			
Transition	89.00	84.21	74.95
Other	91.00	81.50	74.17
Gender			
Male	90.37	80.38	72.64
Female	91.24	82.73	75.48
Age			
Less 65	65.03	86.75	56.41
65 to 74	92.29	85.40	78.82
75 to 84	92.49	79.60	73.62
85+	95.83	70.88	67.92
Race			
White	92.7	81.08	74.73
Not white	76.53	89.87	68.78

similar (91 percent for males and 90 percent for females), but the response rate among females is higher than it is for males (95 percent for females and 92 percent for males).

SURVEY WEIGHTING METHODOLOGY

A. OVERVIEW

In this section of the appendix, we review the computational methods and properties of the four weights discussed in the main report.

Weighting Components	
W1	A sample-release-adjusted weight based on the inverse value of the probability of selection
W2	A weight with nonresponse adjustment using weighting class adjustment to account for differences between the released sampled beneficiaries for which we could locate a working phone number and make contact, and those for which we could not
W3	A weight with a propensity score nonresponse adjustment to account for differences between the survey participants and those whom we found to be eligible but who did not complete the survey
W4	A poststratified weight to align the sum of the weights to match the totals obtained from the EDB-based frame by site and stratum

B. WEIGHT ONE: SAMPLE SELECTION

We prepared the first weight based on the sample selection probabilities. This weight reflects the product of the inverse probability of initially selecting the beneficiary (denoted by $1/\pi$) and a ratio adjustment factor to account for the utilization of only a random subset of the initial sample selected. For the starting sample, we selected a relatively large sample and divided it into random replicates of equal size to allow us to begin the data collection with a subset of the sample that, based on an 80 percent completion rate, would be sufficient to yield the desired number of interviews. With this approach we planned that, if the actual response rate turned out to be lower, we could supplement the original sample with some of the unused replicates to reach the interview targets. With the release of only a random subset of the full sample, we computed

the ratio adjustment factor within site and set it equal to the number of replicates released by the total number created. A mathematical expression for the first weight is:

$$(5) \quad W1_{site,h} = \frac{1}{\pi_{site,h}} \times Released\ Adjustment_{site} = \frac{N_{site,h}}{n_{site,h}} \times \frac{Number\ \ Replicates\ Created_{site}}{Number\ Replicates\ Released_{site}}$$

In (5) we use *N* as the count of beneficiaries in the target population and *n* as the corresponding initial sample size, with subscripts to limit these counts to a specified subgroup. For the subscripts we use *site* to index each of the 11 geographical areas studied, *h* to index the two strata used for sampling in each site (transitioning, other).

To illustrate these computations, we provide an example from the Alaska site. In Alaska, the EDB sampling frame contained a total of 2,304 transitioning beneficiaries and 26,237 other beneficiaries.[3] From each of these two sampling strata we selected a starting sample of 300 beneficiaries. As a result, the inverse probabilities of selection for the beneficiaries in these two strata, $1/\pi$, were equal to 2,304 ÷ 300 = 7.68 for the transitioning and 26,237 ÷ 300 = 87.46 for the other. We then divided each of these samples into 30 random replicates with 10 beneficiaries each and released for interviewing 19 replicates (190) cases from each stratum. Hence, the second part of this component is equal to 30 divided by 19, or 1.578. Multiplying the inverse probability of selection by the replicate release adjustment, we obtained the first component weights for the 190 released cases of 12.13 (7.68 × 1.578) for the transitioning and 138.09 (87.46 × 1.578) for the other.

[3]As shown in table A.2.

C. CLASSIFICATION OF THE DATA COLLECTION OUTCOMES FOR SURVEY WEIGHTING PURPOSES

To prepare the second through the fourth weights, we needed to conduct a variety of data processing, review, and analysis steps to identify the call outcome status of each sample case and to identify the potential factors and the relationships among them that contributed to survey nonresponse. As the starting step, we needed to classify the sampled cases based on their survey outcomes into a set of weighting groups. Our goal was to isolate cases for which we were unable to locate a phone number or make contact from other nonrespondents whom we contacted but who failed to complete the interview. From this classification we examined the characteristics to determine that a separate nonresponse adjustment was needed for each situation. Likewise, we needed to identify from the sampled cases which ones had their eligibility status determined and, from those, the ones that were eligible and ineligible. Table A.5 presents a summary of the survey outcome codes and our assignment of three outcomes for weighting purposes, with "Located Phone Number" = "Yes" indicating we found a phone number for the case and made contact, and "Completed Survey" = "Yes" to indicate that the beneficiary completed the study. Similarly, "Eligible" = "Yes" or "No" designates that we determined eligibility status and what it was, while "Unknown" implies that the status was not determined.

D. WEIGHT TWO, SURVEY LOCATION ADJUSTMENT

For the location adjustment, we tried to use a propensity modeling approach to best utilize the available data from the EDB on the sampled beneficiaries. However, we could not construct a logistic propensity model that explained the variation between located and nonlocated beneficiaries. We opted for using the traditional weighting class adjustment creating cells by joining the beneficiaries in the same site, stratum and age category in the same weighting class. If any cell with nonlocated beneficiaries had less than 20 located beneficiaries, the cell was

TABLE A.5

SUMMARY OF THE LOCATABILITY, ELIGIBILITY, AND RESPONSE STATUS FOR EACH CALL OUTCOME

Survey Outcome Code	Survey Outcome Description	Located Phone Number and Made Contact	Eligible	Completed Survey	Released Sample	Percent
All	**Total Released Sample**				**4,640**	**100.00**
322	Max number of calls without contact	No	Unknown	No	63	1.36
330	Effort ended-case retired	No	Unknown	No	166	3.58
590	Final unlocatable by phone center	No	Unknown	No	370	7.97
321	Max number of calls with contact	Yes	Unknown	No	49	1.06
400	Language barrier (non-Spanish)	Yes	Unknown	No	49	1.06
410	Physical/cognitive barrier	Yes	Unknown	No	28	0.60
420	Institutionalized	Yes	No	No	15	0.32
423	Hospice	Yes	No	No	14	0.30
424	Nursing home	Yes	No	No	80	1.72
440	Deceased	Yes	No	No	44	0.95
450	Moved out of fielding area	Yes	No	No	9	0.19
200	Refusal by known respondent	Yes	Yes	No	302	6.51
210	Refusal by gatekeeper	Yes	Yes	No	44	0.95
220	Refusal by an unknown person	Yes	Yes	No	90	1.94
430	Unavailable during field period	Yes	Yes	No	24	0.52
470	No proxy available	Yes	Yes	No	6	0.13
10	CATI complete	Yes	Yes	Yes	2,739	59.03
11	CATI complete—proxy	Yes	Yes	Yes	166	3.58
50	Self-administered hard copy complete	Yes	Yes	Yes	371	8.00
51	Self-administered hard copy complete—proxy	Yes	Yes	Yes	11	0.24

joined with the contiguous age category in the same site and stratum, until we had more than 20 located beneficiaries by cell. If the cells had enough located beneficiaries to do so, they were subdivided into white and nonwhite, male and female, and "movers" (those who moved into one of the 11 sites) and non-movers. The located beneficiaries' weights were then inflated in each cell to account for the nonlocated beneficiaries, as shown in equation (6).

$$(6) \quad W2_{cell(site,h,age,white,gender,mover)} = W1_{site,h} \times \frac{\text{Weighted Number Released}_{cell}}{\text{Weighted Number Located}_{cell}}$$

For example, there are 42 beneficiaries in Alaska, in the transitioning group, among 65 to 74 years old, white, male and who did not move in the last 6 months. Only 34 of these 42 cases were located. Those 34 cases represented a population of 412.29 beneficiaries and the whole cell represented a population of 509.31 beneficiaries. The location adjustment for this specific cell is 1.24 (509.31 weighted released cases in cell/412.29 weighted located cases in cell).

E. ASSIGNING ELIGIBILITY TO THE UNKNOWN ELIGIBILITY CASES

With the survey outcome classifications in Table A.5, we were able to classify the cases that were eligible, ineligible and the ones whose eligibility was unknown. Because we found that site and age were the primary factors influencing the eligibility of the sample, we decided to impute eligibility for the unknown located cases by hot deck imputation. We created imputation cells based on site, stratum, and age category. We then sorted the imputation cells by gender and age. The hot deck procedure randomly chose the case sorted before or after the unknown eligibility case as the eligibility donor. Table B5 shows that there are 126 cases located with unknown eligibility, 3,753 that were eligible and 162 ineligible. After imputing the 126 located cases with unknown eligibility, 118 were imputed as eligible and 8 as ineligible cases. The initial average eligibility rate among located cases was 95.86 percent and the final average eligibility rate after the imputations was 95.79 percent.

F. WEIGHT THREE: SURVEY RESPONSE ADJUSTMENT

For the participation or response adjustment, we used a propensity modeling approach. The propensity score methodology creates a logistic regression model to predict response status among the eligible sample beneficiaries based on sets of indicator variables that describe their

characteristics. For this study we developed one model to predict survey participation status among eligible cases whom we located and made contact with.

The first step in developing the model was to review the response patterns by the beneficiary characteristic categories available from the EDB. From the EDB, we had information on the beneficiary's age, gender, representative payee status, recent mover status, term in FFS, disability status and length of disability term, and race (white and nonwhite). We studied the response rate overall and by each site across some characteristic categories. The results as shown in this appendix (Table A.4) indicated that influence of these factors on survey participation were, in general, not consistent and varied by site membership. For example, the response rate in Brooklyn, NY among located eligible beneficiaries is much higher among transitioning (81 percent) than for the others (68 percent), while in Phoenix, AZ the other beneficiaries had a somewhat larger response rate among eligibles (87 percent) than the transitioning (83 percent). The female beneficiaries have a higher response rate among eligibles in Springfield, MO than the males (92 percent for women and 86 percent for males), but in Denver, CO the response rate among eligibles is higher for men than for women (92 percent for men and 85 percent for women). As a result, in planning the modeling approach, we needed to consider that these characteristics might interact within or across sites in different ways.

To account for possible interactions among characteristics under a propensity modeling approach, one can basically apply one of two techniques. In the first approach, one can create indicator variables to use in the modeling approach for such interactions in addition to the main effects. For example, age may not have the same influence on survey cooperation status in each site. To capture this, one can create specific site-by-age group indicator variables. The other approach is to prepare separate models for each site. For our approach we decided to construct one model with site as a main effect and as an interaction term with other characteristics to

account for differences in the influence of these characteristics on survey participation by site. We did not construct 11 different models, one for each site, because each model has very few observations and therefore less power to predict each model.

Our approach to create the indicator variables was to create one for each EDB characteristic category. In contrast to the use of continuous or multiple category predictor variables, this approach ensures that any non-linear trends between the characteristic categories and the outcome are accounted for in the models. Specifically, we coded:

- Age: 64 and under; 65 to 74; 75 to 84; and 85 and older
- Disability: not disabled; disabled for 4 years or less; disabled for 5 years or longer
- New to FFS
- Mover (including movers that are new to FFS)
- Race: white, nonwhite
- Gender: female, male

For building the models, we had both SUDAAN and CHAID software packages available for conducting the analysis and used them to their advantage in finalizing the prediction equations. CHAID identified relevant main effects and interactions to include in the model. We ran the main CHAID tree with all the possible variables available for the model. We then ran a second CHAID tree without identified correlated variables and the first node main effect of the first tree. And we kept drawing trees eliminating the first node main effect of the previous tree. This technique helped in identifying other main effects and interaction terms that did not appear in the main tree. We then prepared a stepwise SUDAAN model that included any significant interaction terms identified in the first CHAID tree run and all the main effects. We kept adding more main effects (found in posterior CHAID trees) and interaction terms to the SUDAAN

model if they did not distort the previous estimate and were significant at .30 or less.[4] We also ran a companion model in SAS for the identical set of predictors to evaluate the Hosmer-Lemeshow (HL) goodness-of-fit test. [5] Note that we chose a significance level of .30 or less because in our experience this cutoff achieves the appropriate balance between bias reduction (in general, bias decreases as the number of predictors increases) and weight variation (in general, precision in the survey estimates is reduced as the number of less-significant variables increases).

From the predicted probabilities from the model we prepared a propensity score equal to the inverse of these values to form the adjustment as given in (7), where the α term reflects the estimated intercept in the logistic regression model, and the β_i terms reflect the estimated coefficients associated with each of the characteristic indicators x_i (for example, being age 85 or older) and j to index the beneficiaries in the sample.

$$(7) \quad Participation\ Adjustment_j = \left[\frac{e^{\alpha + \beta_i \cdot X_{i,j}}}{1 + e^{\alpha + \beta_i \cdot X_{i,j}}} \right]^{-1} = prob_j^{-1}$$

For example, a responding beneficiary in Alaska who had a response probability of 80 percent received a third weight component adjustment value equal to 1 ÷ .80, or 1.25, to inflate this beneficiary's weight to compensate for the 20 percent of the beneficiaries in the sample who did not participate in the survey. Then their weight adjusted for nonresponse is computed as in (8).

[4]We included in the model main effects with a significance level of higher than .30 if an interaction term containing them was found to be significant at .30 or less.

[5]See Hosmer, D.W., and S. Lemeshow. *Applied Logistic Regression.* John Wiley and Sons, 1989, pp. 140-145.

(8) $W3_j = W2_{cell} \cdot Participation\ Adjustment_j$

Details on the specific factors that were found to be significant predictors of the outcomes, as well as the model coefficients and model evaluation statistics, are available from MPR upon request.

G. WEIGHT FOUR: POSTSTRATIFICATION

With the use of a propensity score approach, the adjustments may not reproduce the population totals exactly. Therefore, we prepared the fourth weight as shown in (9) to ensure that the weighted counts matched those obtained from the EDB-based frame by site and sampling stratum, gender and age category. This adjustment is based simply on a ratio adjustment equal to the count from the EDB of the number of beneficiaries (in each site and stratum, gender, age category) divided by the sum of the weight adjusted for response.

(9) $$W4_j = W3_j \cdot \frac{Population_{site,h,gender,agecategory}}{Weighted\ sample\ of\ respondents\ and\ ineligible_{site,h,gender,agecategory}}$$

As the final step, we reviewed the total adjustment (multiplying the location, response, and poststratification adjustments) and we trimmed 6 weights among the transitioning beneficiaries because their total adjustment was larger than 2.5 and they were larger than any other weight in that site, and 4 weights were trimmed in the other stratum. For example, the largest total adjustment in the transitioning beneficiaries was in Alaska (3.5 total adjustment) with a weight of 43, this weight was trimmed to 30 to obtain a final adjustment of less than 2.5. In the other group the largest adjustment was in Phoenix (9.0) with a weight of 7,030 and this weight was trimmed to 1,900 to obtain an adjustment of less than 2.5. After trimming these values, we

spread the sum of the trimmed portion of their contribution to the weights among all other cases in the same site and stratum.

H. SUMMARY

Table A.6 provides a summary of the final weights for each site and shows the sum of the weights, the design effect[6] due to unequal weighting, and the effective sample sizes. The left half of the table considers the full released sample of 4,640 beneficiaries and calculates the design effect caused by the initial sample weights. For comparison, the right side of the table shows the corresponding values for the completed interviews (n=3,287) after applying the final survey weights. The relative differences between the pre- and post-adjusted samples in the effective sample sizes reflect the loss in precision that resulted from survey nonresponse and our attempts to correct for any bias that it would introduce. Overall, the table shows that the adjustments for nonresponse increased the design effects only slightly (on average from 1.97 to 2.02) for the combined sample. For the transitioning and other strata considered separately, the effective sample sizes for completes across all 11 sites are 1,324 and 1,393, respectively, which are not much smaller than the number of corresponding completed interviews at 1,656 and 1,631.[7]

[6]The disproportionate sample allocation plan used in this study introduces what we refer to as a study design effect that reflects the ratio of the actual variability in the estimates to what would result with a proportionally allocated sample. For example, a design effect of 1.2 indicates that the design introduced 20 percent more variation in the survey estimates relative to a design of the same size using a simple random sampling process with a proportional allocation scheme. Dividing the sample size by the design effect determines the effective sample size that can be used to determine the precision level of the estimates using standard normal-distribution-theory-based confidence intervals. The design effects presented are based on the variation in the survey weights and as such do not account for differences in the variability of the survey questionnaire items.

[7]For the total sample, the number of completed interviews is 3,287, which, with the combined effects of the oversampling of transitioning enrollees and the weight adjustments, produces an effective sample size of 1,628.

TABLE A.6

SUMMARY OF SAMPLING WEIGHTS FOR THE RELEASED SAMPLE AND THE COMPLETED INTERVIEWS

		Released Sample (4,640)				Completed Interviews (3,287)			
Site	Stratum	Sample Size	Sum of Weights	Design Effect	Effective Sample Size	Sample Size	Sum of Weights	Design Effect	Effective Sample Size
Total	**Total**	**4,640**	**1,071,742**	**1.97**	**2,359**	**3,287**	**1,024,876**	**2.02**	**1,628**
	Transitioning	**2,320**	**84,230**	**1.22**	**1,903**	**1,656**	**80,612**	**1.25**	**1,324**
	Other	**2,320**	**987,512**	**1.15**	**2,018**	**1,631**	**944,264**	**1.17**	**1,393**
1. Alaska	Total	380	28,541	1.71	223	305	27,902	1.66	183
	Transitioning	190	2,304	1.00	190	147	2,260	1.01	146
	Other	190	26,237	1.00	190	158	25,642	1.01	156
2. Arizona	Total	420	180,739	1.66	253	292	172,344	1.69	173
	Transitioning	210	16,959	1.00	210	146	15,977	1.03	141
	Other	210	163,780	1.00	210	146	156,367	1.01	144
3. California, SD	Total	440	119,671	1.72	256	302	113,619	1.69	179
	Transitioning	220	9,253	1.00	220	147	8,904	1.02	144
	Other	220	110,418	1.00	220	155	104,716	1.01	153
4. California, SF	Total	480	63,038	1.76	273	302	60,271	1.72	175
	Transitioning	240	4,090	1.00	240	145	3,897	1.01	143
	Other	240	28,948	1.00	240	157	56,374	1.02	154
5. Colorado	Total	380	81,247	1.71	222	295	78,811	1.76	167
	Transitioning	190	6,350	1.00	190	149	6,054	1.01	148
	Other	190	74,897	1.00	190	146	72,757	1.02	144
6. Florida	Total	400	108,725	1.72	233	299	104,897	1.86	160
	Transitioning	200	8,370	1.00	200	157	8,156	1.02	154
	Other	200	100,355	1.00	200	142	96,741	1.03	137
7. Missouri	Total	380	87,341	1.77	214	306	84,472	1.82	168
	Transitioning	190	5,277	1.00	190	155	5,099	1.01	154
	Other	190	82,064	1.00	190	151	79,373	1.01	149
8. Nevada	Total	460	76,329	1.61	285	313	74,454	1.66	189
	Transitioning	230	8,301	1.00	230	160	8,191	1.02	156
	Other	230	68,028	1.00	230	153	66,263	1.01	152
9. New York	Total	500	98,221	1.74	288	301	90,951	1.89	159
	Transitioning	250	7,035	1.00	250	160	6,478	1.03	156
	Other	250	91,186	1.00	250	141	84,473	1.02	138
10. Texas	Total	400	102,406	1.72	232	287	97,918	1.77	162
	Transitioning	200	7,732	1.00	200	146	7,441	1.02	143
	Other	200	94,674	1.00	200	141	90,477	1.01	139
11. Washington	Total	400	125,484	1.75	229	285	119,237	1.77	161
	Transitioning	200	8,559	1.00	200	144	8,155	1.03	140
	Other	200	116,925	1.00	200	141	111,082	1.00	141

APPENDIX B

2004 TARGETED BENEFICIARY SURVEY INSTRUMENTS (TELEPHONE AND MAIL)

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

Targeted Beneficiary Survey

2004

PROGRAMMER:

THE INPUT RECORD NEEDS THE FOLLOWING VARIABLES TO ADMINISTER THIS INTERVIEW AND PRODUCE REPORTS:

- SAMPLE MEMBER NAME
- TYPE OF SAMPLE (NEWLY ENTITLED, NEW TO FEE-FOR-SERVICE, MOVERS, ALL OTHERS)
- SITE – use the following fills for site name:

  - Alaska = the State of Alaska

  - Maricopa, AZ = the Phoenix area

  - San Diego, CA = the San Diego area

  - San Francisco, CA = the San Francisco area

  - Denver, CO = the Denver area

  - Hillsborough, FL = the Tampa area

  - Greene, MO = the Springfield area

  - Clark, NV = the Las Vegas area

  - Kings, NY = the Brooklyn area

  - Tarrant, TX = the Ft. Worth area

  - King, WA = the Seattle area

>mode< IS THIS INTERVIEW BEING COMPLETED FROM:

<1> AN OUTGOING (INTERVIEWER-DIALED)CALL
<2> AN INCOMING CALL (ON THE TOLL-FREE LINE)
<3> A SELF-ADMINISTERED MAIL QUESTIONNAIRE

[@]

INTRODUCTION

DIALING AND ESTABLISHING CONTACT WITH SAMPLE MEMBER

>dial< DIAL THIS NUMBER: ([fill AREA]) [fill PRFX] – [fill SUFX: 0]
RESPONDENT TIME: [fill RSTM: 0] [fill TZON] in [fill STAT]

<a> AUTODIAL THE NUMBER

<1> SOMEONE ANSWERS [goto helo]
<2> NO ANSWER [goto T180]
<3> BUSY [goto T182]
<4> ANSWERING MACHINE [goto T181]
<5> COMPUTER/FAX LINE [goto T171]
<6> TEMPORARILY NOT IN SERVICE; TROUBLE ON THE LINE [goto T185]
<7> CIRCUIT PROBLEMS; CIRCUITS OVERLOADED [goto T184]
<8> FAST BUSY; FAST RING; NO RING [goto T186]
<9> NOT IN SERVICE; DISCONNECTED; NONWORKING [goto T171]
<c> CHANGED TO NEW NUMBER [goto nwac]

<h> SHOW HISTORY

<0> MISTAKE -- DON'T WANT THIS CASE [goto T199]

<d> DON’T KNOW
<r> REFUSED

[@]

ESTABLISHING HOUSEHOLD STATUS

>helo< Hello, may I speak to [fill SAMPLE MEMBER]?

<1> SAMPLE MEMBER ANSWERS [goto smem]
<2> SAMPLE MEMBER UNAVAILABLE [goto thar]
<3> SAMPLE MEMBER HOSPITALIZED [goto hosp]
<4> SAMPLE MEMBER INCAPACITATED [goto prx1]
<5> SAMPLE MEMBER CAN’T SPEAK ENGLISH [goto span]
<6> SAMPLE MEMBER DECEASED [goto T163]
<7> WHO’S CALLING?/WHAT ABOUT?[goto WHAT]
<8> NO SUCH PERSON AT THIS NUMBER [goto T170]
<9> ANSWERING SERVICE [goto ans]

<97> CALLBACK [goto T140]
<98> PROBLEM FOR SUPERVISOR [goto T160]

<d> DON’T KNOW
<r> REFUSED [goto T150]

[@]

>what< My name is _____. I am calling from Mathematica, a Research Company in Princeton, New Jersey. We are conducting a research study for the Medicare program to learn whether Medicare beneficiaries in your area have any trouble getting care from doctors. A letter describing the study was sent to [fill SAMPLE MEMBER] at this address.

Could I please speak to [fill SAMPLE MEMBER]?

<1> SAMPLE MEMBER ANSWERS [goto tsmm]
<2> SAMPLE MEMBER UNAVAILABLE [goto thar]
<3> SAMPLE MEMBER HOSPITALIZED [goto hosp]
<4> SAMPLE MEMBER INCAPACITATED [goto T105]
<5> SAMPLE MEMBER CAN'T SPEAK ENGLISH [goto span]
<6> SAMPLE MEMBER DECEASED [goto T163]
<7> SAMPLE MEMBER IN HOSPICE PROGRAM [goto screenout1]
<8> SAMPLE MEMBER LIVING IN A NURSING HOME [goto screenout2]
<9> CALLBACK [goto T140]
<10> PROBLEM FOR SUPERVISOR [goto T160]

<d> DON'T KNOW
<r> REFUSED [goto T150]

[@]

>thar< Can [fill SAMPLE MEMBER NAME] usually be reached at this number?

<1> SAMPLE MEMBER AT THIS NUMBER [goto T140]
<2> SAMPLE MEMBER NOT AT THIS NUMBER [goto ware]
<3> SAMPLE MEMBER HOSPITALIZED [goto hosp]
<4> SAMPLE MEMBER INCAPACITATED [goto T105]
<5> SAMPLE MEMBER CAN'T SPEAK ENGLISH [goto span]
<6> SAMPLE MEMBER DECEASED [goto T163]
<7> SAMPLE MEMBER IN HOSPICE PROGRAM [goto screenout1]
<8> SAMPLE MEMBER LIVING IN A NURSING HOME [goto screenout2]

<9> CALLBACK [goto T140]
<d> DON'T KNOW
<r> REFUSED [goto T150]

[@]

>ware< Where can I reach [fill SAMPLE MEMBER NAME]?

<1> NEW PHONE NUMBER [goto nwac]
<2> DON'T KNOW [goto T170]
<3> SAMPLE MEMBER HOSPITALIZED [goto hosp]
<4> SAMPLE MEMBER INCAPACITATED [goto T105]
<5> SAMPLE CAN'T SPEAK ENGLISH [goto span]
<6> SAMPLE MEMBER DECEASED [goto T163]
<7> CALLBACK [goto T140]
<8> PROBLEM WITH SUPERVISOR [goto T160]

<d> DON'T KNOW [goto T170]
<r> REFUSED [goto T150]

[@]

>hosp< Is [fill SAMPLE MEMBER NAME] capable of completing an interview by telephone?

<1> YES [goto nwac]
<2> NO [goto T105]
<3> CALLBACK [goto T140]
<4> PROBLEM FOR SUPERVISOR [goto T160]

<d> DON'T KNOW
<r> REFUSED [goto T150]

[@]

>span< **INTERVIEWER: CODE WITHOUT ASKING IF KNOWN.**

Does [fill SAMPLE MEMBER NAME] speak Spanish?

<1> YES [goto nwac]
<2> NO [goto T105]
<3> CALLBACK [goto T140]
<4> PROBLEM FOR SUPERVISOR [goto T160]

<d> DON'T KNOW
<r> REFUSED [goto T150]

[@]

>prx1< My name is _____. I am calling from Mathematica, a Research Company in Princeton, New Jersey. We are conducting a research study for the Medicare program. A letter describing the study was sent to [fill SAMPLE MEMBER NAME] at this address. I'm calling now to do the interview over the telephone. Is there someone I can speak to who is knowledgeable about [fill SAMPLE MEMBER NAME] and might be able to answer some questions on [fill his] behalf (or interpret for him/her)?

PROBE: The purpose of the study is to learn whether Medicare beneficiaries in your area have any trouble getting care from doctors.

<1> PRESENT RESPONDENT CAN BE PROXY [goto prx4]
<2> PROXY COMES TO PHONE [goto prx3]
<3> PROXY NOT THERE NOW [goto cb@a]
<4> NO PROXY EXISTS [goto T172]
<7> CALLBACK [goto T140]
<8> PROBLEM FOR SUPERVISOR [goto T160]

<d> DON'T KNOW
<r> REFUSED [goto T152]

[@]

>cb@a< Could I please have your/ proxy's name so I will know to ask for when I call back?

<2> NEED TO ENTER OR CORRECT NAME/PHONE

<3> NO, DO NOT WANT TO GIVE NAME

>prx2< Is there someone else I can speak to who is knowledgeable about [fill SAMPLE MEMBER] who can answer the questions on [fill his] behalf (or interpret for him/her)?

<1> PRESENT RESPONDENT CAN BE PROXY [goto prx4]
<2> PROXY COMES TO PHONE [goto prx3]
<3> PROXY NOT THERE [goto T115]
<4> NO PROXY EXISTS [goto T172]
<7> CALLBACK [goto T140]
<8> PROBLEM FOR SUPERVISOR [goto T160]

<d> DON'T KNOW
<r> REFUSED [goto T152]

[@]

>prx3< Hello, my name is _____. I am calling from Mathematica, a research company in Princeton, New Jersey. We are calling people in the Medicare program to interview them over the telephone. Your name was given to us as a person who is knowledge about [fill SAMPLE MEMBER] and might be able to answer some questions on [fill his] behalf.

<1> YES PROCEED WITH INTERVIEW [goto T131]
<7> CALLBACK [goto T142]
<8> PROBLEM FOR SUPERVISOR [goto T160]

<d> DON'T KNOW
<r> REFUSED [goto T152]

[@]

>prx4< May we begin the interview now?

<1> YES PROCEED WITH INTERVIEW [goto T131]
<7> CALLBACK [goto T142]
<8> PROBLEM FOR SUPERVISOR [goto T160]

<d> DON'T KNOW
<r> REFUSED [goto T152]

[@]

>smem< Hello, my name is _____. I am calling from Mathematica, a Research Company in Princeton, New Jersey. We are conducting a research study for the Medicare program. The purpose of the study is to learn if Medicare beneficiaries in your area have any trouble getting care from doctors. You may have received a letter about the study.

You were selected to take part in this study because you are on Medicare. For the study we would like to ask you some questions over the telephone about your experiences getting care from doctors.

I will not try to sell you anything or ask for a donation. This is a research study.

<1> PROCEED WITH INTERVIEW [goto T130]
<2> NEVER GOT THE LETTER [goto letr]
<3> WANTS MORE INFORMATION [goto inf1]
<7> CALLBACK [goto T141]
<8> PROBLEM FOR SUPERVISOR [goto T160]
<m> WILL ONLY COMPLETE BY MAIL [SKIP TO ADDRESS VERIFICATION AND UPDATE FIELD]

<d> DON'T KNOW [goto letr]
<r> REFUSED [goto T152]

[@]

>letr< The letter described the study and explained that your name was randomly selected from a list of Medicare beneficiaries who live in the [fill SITE]. It went on to explain that your participation in the study is voluntary , but very important.

ADDRESS: [fill ADD1]
[fill ADD2]
[fill ADD3]
[fill ADD4]
[fill CITY] [fill STAT] [fill ZIP]

INTERVIEWER: IF RESPONDENT REQUESTS LETTER, WRITE RESPONDENT'S NAME AND ADDRESS ON AN ENVELOPE.

<1> PROCEED WITH INTERVIEW [goto T130]
<2> WANTS MORE INFORMATION [goto inf1]
<7> CALLBACK [goto T141]
<8> PROBLEM FOR SUPERVISOR [goto T160]

<d> DON'T KNOW
<r> REFUSED [goto T152]

[@]

>infl< **SAMPLE MEMBER IS TOO OLD/FRAIL/CONFUSED TO PARTICIPATE**
The interview takes about 15 minutes and we can divide it into two or three parts if that would make it easier for SAMPLE MEMBER. If that is not possible, Someone can answer the questions on SAMPLE MEMBER's behalf.

HOW DID YOU GET MY NAME?
Your name was randomly selected from a list of Medicare beneficiaries. CMS, the government agency that runs the Medicare program, gave your name to Mathematica for this study.

<1> PROCEED WITH INTERVIEW [goto T130]
<2> WANTS MORE INFORMATION [goto inf2]
<7> CALLBACK [goto T141]
<8> PROBLEM FOR SUPERVISOR [goto T160]

<d> DON'T KNOW
<r> REFUSED [goto T152]

[@]

>inf2< **I DON'T KNOW A LOT ABOUT HEALTH INSURANCE/MEDICARE**
That is okay. Most of the questions are about you, your health, and how easy or hard it is for you to get care from doctors.

CAN YOU CALL SOMEONE ELSE
You were specially selected to represent other Medicare beneficiaries in your community. We selected people based on their age, how long they have lived in their community, and how long they have been in the regular Medicare program. It is really important that we hear your opinions.

WILL MY DOCTORS KNOW THAT I TOOK PART IN THIS SURVEY
No. All the information you give will be completely confidential.

<1> PROCEED WITH INTERVIEW [goto T130]
<7> CALLBACK [goto T141]
<8> PROBLEM FOR SUPERVISOR [goto T160]

<d> DON'T KNOW
<r> REFUSED [goto T152]

[@]

>ans< Is this the answering service for [fill SAMPLE MEMBER]?

<1> YES [goto T140]
<0> NO [goto T170]

<d> DON'T KNOW, WON'T SAY (SPECIFY] [specify] END WITH //
<r> REFUSED [goto T152]

[@] [goto T183]

>nwac< ENTER NEW TELEPHONE NUMBER.
OLD NUMBER: ([fill AREA]) [fill PRFX]-[fill SUFX:0]

AREA CODE ===>

>nwex< EXCHANGE

[@]

>nwnm< NUMBER

[@]

>nwtz< NEW PHONE NUMBER : ([fill nwac]) [fill nwex]-[fill nwnm:0]

ENTER TIMEZONE

<7> EASTERN
<6> CENTRAL
<5> MOUNTAIN
<4> PACIFIC
<3> ALASKA

<d> DON'T KNOW
<r> REFUSED [goto T152]

[@]

[PROGRAMMER NOTE: Please set up logic to leave the following message on an answering machine after 4, 8, and 10.

NO ANSWERS:

Hello, my name is _____, and I am calling [fill SAMPLE MEMBER] from Mathematica, a research company. We are not selling anything or asking for a donation. This is a research study for the Medicare program. The purpose of the study is to see if Medicare beneficiaries are having trouble getting care from doctors. We would like to interview you for this study. It will take only 15 minutes by telephone. Please call us back, toll-free, at 1-888-633-8344.

[PROGRAMMER: NEED TO ASK THE NEXT THREE ITEMS FOR ALL PROXY INTERVIEWS]

>prxrel< Before we begin, can you please tell me how you are related to [fill SAMPLE MEMBER]?

<1> SPOUSE
<2> CHILD
<3> SIBLING
<4> PARENT
<5> NIECE/NEPHEW
<6> FRIEND/OTHER RELATIVE
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@]

>prxwhy< Can you also tell me why [fill SAMPLE MEMBER] needs your help completing this interview?

<1> TOO OLD, TOO FRAIL
<2> TOO ILL
<3> HARD OF HEARING
<4> SHOULD NOT BE BOTHERED
<5> WON'T BE ABLE TO ANSWER QUESTIONS
<6> MEMORY IS BAD
<7> GENERALLY NOT MENTALLY ABLE
<8> LANGUAGE PROBLEM
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@]

[**PROGRAMMER:**
fill you, if R=sample member, you=you; if R=proxy and sample member=male, you=he;
if R=proxy and sample member=female, you=she]

>prxinst< This interview is about [fill SAMPLE MEMBER]'s experiences getting care from medical doctors. Please answer these questions as [fill you] would, if possible. *If that is not possible, give us your best answer.* If you are unsure of an answer, please tell me.

TYPE <g> TO CONTINUE[@]

A. SCREENERS, CHANGES IN PROVIDERS, DIFFICULTY FINDING NEW PROVIDERS

[**PROGRAMMER:**
fill **are you**, if R=sample member, are you=are you; if R=proxy and sample member=male, are you=is he; if R=proxy and sample member=female, are you=is she]

fill do you, if R=sample member, do you=do you; if R=proxy and sample member=male, do you=does he; if R=proxy and sample member=female, do you=does she

fill your, if R=sample member, your=your; if R=proxy and sample member=male, your=his; if R=proxy and sample member=female; your=her]

fill you name, if R=sample member, you name=you; if R=proxy, you name=sample member name

fill are you name, if R=sample member, are you name=are you; if R=proxy, are you name=is sample member name

fill have you name, if R=sample member, have you name=have you; if R=proxy, have you name=has sample member name

fill your name, if R=sample member, your name=your; if R=proxy , your name=sample member name's

fill do you name, if R=sample member, do you name=do you; if R=proxy, do you name=does sample member name]

>A1< Let's begin with a few easy questions. [fill Are you] male or female?

<1> MALE
<2> FEMALE

<d> DON'T KNOW
<r> REFUSED

[@]

>A2< How long [fill have you name] lived at [fill your] current address?

<1> LESS THAN 6 MONTHS
<2> 6 MONTHS TO (LESS THAN) ONE YEAR
<3> 1-(LESS THAN) 5 YEARS [goto A4]
<4> 5-(LESS THAN) 10 YEARS [goto A4]
<5> TEN YEARS OR MORE [goto A4]

<d> DON'T KNOW [goto A4]
<r> REFUSED [goto A4]

[@]

>A3< Is the distance between where [fill you] live now and where [fill you] lived before far enough that [fill you] thought about changing doctors when you moved?

<1> YES
<0> NO
<d> DON'T KNOW
<r> REFUSED

[@]

>A4< What is [fill your name] age now?

<18-103> YEARS

INTERVIEWER: IF RESPONDENT IS YOUNGER THAN 65, PLEASE VERIFY AGE.

<d> DON'T KNOW
<r> REFUSED

[@]

>A5< [fill Are you name] now in a hospice program?

PROBE: A hospice is a program designed to care for the dying and their special needs.

<1> YES **[goto screenout 1]**
<0> NO

<d> DON'T KNOW
<r> REFUSED

[@]

>A6< [fill Are you name] living in a nursing home?

<1> YES **[goto screenout 2]**
<0> NO

<d> DON'T KNOW
<r> REFUSED

[@]

[**PROGRAMMER:** fill you name think if R=sample member, you name think=you think; if R=proxy and sample member=male, you name think=he thinks; if R=proxy and sample member female, you name think=she thinks]

>A7< A personal doctor or nurse is the health provider who knows you best. This can be a general doctor, a specialist doctor, a physician assistant, or a nurse.

[Fill Do you name] have one person [fill you] think of as [fill your] personal doctor or nurse?

<1> YES **[goto A9]**
<0> NO

<d> DON'T KNOW **[goto A9]**
<r> REFUSED **[goto A9]**
[# This question was taken from Medicare CAHPS-FFS.]
[@]

[**PROGRAMMER:** fill **don't you name**, if R=sample member don't you name=don't you; if R=proxy, don't you name=doesn't sample member name]

>A8< [PROGRAMMER: SET UP AS MULTIPLE RESPONSE]

Why [fill don't you name] have one person who [fill you] think of as [fill your] personal doctor or nurse?

PROBE: Were there any other reasons?

INTERVIEWER: CODE ALL THAT APPLY

<1> HAVE MORE THAN ONE DOCTOR OR NURSE **[goto test before A9]**
<2> NEW TO AREA
<3> LEFT MEDICARE HMO AND COULDN'T KEEP DOCTOR
<4> NEW TO MEDICARE AND PREVIOUS DOCTOR DOESN'T PARTICIPATE **[goto A8a]**
<5> DOCTOR STOPPED TAKING MEDICARE **[goto A8a]**
<6> DOCTOR DOES NOT ACCEPT MEDICARE ASSIGNMENT**[goto A8a]**
<7> DIDN'T LIKE DOCTOR
<8> OLD DOCTOR WASN'T CONVENIENTLY LOCATED
<9> DOCTOR DIED/MOVED FROM AREA/RETIRED
<10> HAD DIFFICULTY GETTING APPOINTMENT WITH OLD DOCTOR
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
<n> NO OTHER
[@] **[ALL goto A11]**

>A8a< [**PROGRAMMER:** fill **is not accepting Medicare at all** if A8=4; fill **stopped taking Medicare** if A8=5; **is not accepting Medicare assignment** if A8=6]

Did the doctor's office explain why it (is not accepting Medicare at all/stopped taking Medicare/is not accepting Medicare assignment)?

<1> YES
<0> NO **[goto A11]**

<d> DON'T KNOW **[goto A11]**
<r> REFUSED **[goto A11]**

[@]

>A8b< What was that explanation?

<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@] **[goto A11]**

[**PROGRAMMER:**
fill **this person**, if A8 = 1 (more than one doctor or nurse), **this person** = the personal doctor or nurse you see most often; if A8 = blank**, this person** = this person]

>A9< Is [fill this person] . . .

<1> a general doctor,
<2> a specialist doctor,
<3> a physician assistant, or
<4> a nurse?

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare CAHPS-FFS.]

[@]

[**PROGRAMMER:**
fill **have you**, if R=sample member, have you=have you; if R=proxy and sample member=male, have you=has he; if R=proxy and sample member=female, have you=has she

fill **have you name**, if R=sample member, have you name=have you; if R=proxy have you name=has sample member name]

>A9a< Did [fill you] have the same personal doctor or nurse before [fill you] joined Medicare?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED

[@]

>A10< How many months or years [fill have you] been going to [fill your] personal doctor or nurse?

PROBE, IF MORE THAN ONE DOCTOR OR NURSE: How many months or years have you been going to the personal doctor or nurse you see the most?

<1> LESS THAN 6 MONTHS
<2> AT LEAST SIX MONTHS BUT LESS THAN A YEAR
<3> 1 TO 2 YEARS
<4> MORE THAN 2 YEARS BUT LESS THAN 5 YEARS
<5> 5 OR MORE YEARS
<6> I DON'T HAVE A PERSONAL DOCTOR OR NURSE **[goto A7 AND CORRECT]**

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare CAHPS-FFS.]
[@]

[**PROGRAMMER:** fill **you name are**, if R=sample member, you name are=sample member name is]

>A11< Since you joined Medicare, how much of a problem, if any, was it to get a personal doctor or nurse [fill you name are] happy with? Would you say . . .

<1> a big problem,
<2> a small problem, or
<3> not a problem? **[goto A13]**

<n> DID NOT GET A NEW DOCTOR OR NURSE **[goto A13]**
<d> DON'T KNOW **[goto A13]**
<r> REFUSED **[goto A13]**
[# This question was taken from 2002 Medicare CAHPS-FFS.]
[@]

>A12< [PROGRAMMER: SET UP AS MULTIPLE RESPONSE]

Why did [fill you] have a problem finding a doctor or nurse?

PROBE: Were there any other reasons?

INTERVIEWER: CODE ALL THAT APPLY

<1> COULD NOT FIND DOCTOR TAKING NEW MEDICARE PATIENTS **[goto A12a]**
<2> COULD NOT FIND DOCTOR TAKING ANY NEW PATIENTS
<3> COULD NOT FIND DOCTOR ACCEPTING MEDICARE AT ALL **[goto A12a]**
<4> COULD NOT FIND DOCTOR ACCEPTING MEDICARE ASSIGNMENT **[goto A12a]**
<5> COULD NOT AFFORD WHAT THE DOCTOR WANTED TO CHARGE ME
<6> THERE WERE VERY FEW DOCTORS IN MY AREA
<7> FOUND DOCTOR(S), BUT APPOINTMENTS TOO HARD TO GET
<8> CAN'T GET A GOOD RECOMMENDATION OR REFERRAL
<9> NOT SURE WHERE/HOW TO LOOK
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
<n> NO OTHER

[@] **[goto A13]**

>A12a< [**PROGRAMMER:** fill **taking new Medicare patients** if A12=1; fill **accepting Medicare at all** if A12=3; fill **accepting Medicare assignment** if A12=4]

Did the doctor's office explain why it is not (taking new Medicare patients/accepting Medicare at all/accepting Medicare assignment)?

<1> YES
<0> NO **[goto A13]**

<d> DON'T KNOW **[goto A13]**
<r> REFUSED **[goto A13]**

[@]

>A12b< What was that explanation?

<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@]

>A13< In the last 6 months, did [fill you name] get a new doctor or nurse?

<1> YES
<0> NO **[goto A15]**

<d> DON'T KNOW **[goto A15]**
<r> REFUSED **[goto A15]**
[# This question was taken from 2002 Medicare CAHPS-FFS.]
[@]

>A14< [PROGRAMMER: SET UP AS MULTIPLE RESPONSE]

Why did [fill you] get a new doctor or nurse?

PROBE: Were there any other reasons?

INTERVIEWER: CODE ALL THAT APPLY

<1> NEW TO AREA
<2> LEFT MEDICARE HMO AND COULDN'T KEEP DOCTOR
<3> NEW TO MEDICARE AND PREVIOUS DOCTOR DOESN'T PARTICIPATE **[goto a14a]**
<4> DOCTOR STOPPED TAKING MEDICARE **[goto a14a]**
<5> DIDN'T LIKE DOCTOR
<6> OLD DOCTOR WASN'T CONVENIENTLY LOCATED
<7> DOCTOR DIED/MOVED FROM AREA/RETIRED
<8> HAD DIFFICULTY GETTING APPOINTMENT WITH OLD DOCTOR
<9> DOCTOR CHARGED MORE THAN MEDICARE WOULD PAY **[goto a14a]**
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
<n> NO OTHER
[@] **[goto a15]**

>A14a< [**PROGRAMMER:** fill **is not accepting Medicare at all** if A14=3; fill **stopped taking Medicare** if A14=4; fill **charged more than Medicare would pay** if A14=9]

Did the doctor's office explain why it (is not accepting Medicare at all/stopped taking Medicare/it charged more than Medicare would pay?

<1> YES
<0> NO **[goto A15]**

<d> DON'T KNOW **[goto A15]**
<r> REFUSED **[goto A15]**
[@]

>A14b< What was that explanation?

<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@]

>A15< [fill Are you name] currently looking for a new doctor or nurse?

<1> YES
<0> NO **[goto A18]**

<d> DON'T KNOW **[goto A18]**
<r> REFUSED **[goto A18]**

[@]

>A16< How long [fill have you] been looking for a new doctor or nurse?

<1> LESS THAN ONE MONTH
<1-6> MONTHS
<7> MORE THAN SIX MONTHS

<d> DON'T KNOW
<r> REFUSED

[@]

[**PROGRAMMER:**
fill **haven't you**, if R = sample member, haven't you = haven't you; if R = proxy and sample member = male, haven't you = hasn't he; if R = proxy and sample member = female, haven't you = hasn't she]

>A17< [PROGRAMMER: SET UP AS MULTIPLE RESPONSE]

Why [fill haven't you] been able to find a new doctor or nurse?

PROBE: Were there any other reasons?

INTERVIEWER: CODE ALL THAT APPLY

<1> DOCTOR(S) WASN'T TAKING NEW MEDICARE PATIENTS **[goto A17a]**
<2> DOCTOR(S) WASN'T TAKING ANY NEW PATIENTS

<3> COULD NOT FIND DOCTOR ACCEPTING MEDICARE AT ALL **[goto A17a]**
<4> COULD NOT FIND DOCTOR ACCEPTING MEDICARE ASSIGNMENT **[goto A17a]**
<5> CANNOT AFFORD WHAT DOCTORS CHARGE
<6> THERE ARE VERY FEW DOCTORS IN MY AREA
<7> FOUND DOCTOR(S), BUT APPOINTMENTS TOO HARD TO GET
<8> CAN'T GET A GOOD RECOMMENDATION
<9> NOT SURE WHERE/HOW TO LOOK
<10> JUST STARTED LOOKING/HAVEN'T HAD MUCH TIME TO LOOK
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
<n> NO OTHER

[@] **[ALL goto A20]**

>A17a< [**PROGRAMMER:** fill **taking new Medicare patients** if A17=2; fill **accepting Medicare at all** if A17=3; fill **accepting Medicare assignment** if A17=4]

Did the doctor's office explain why it is not (taking new Medicare patients/accepting Medicare at all/accepting Medicare assignment)?

<1> YES
<0> NO **[goto A20]**

<d> DON'T KNOW **[goto A20]**
<r> REFUSED **[goto A20]**

[@]

>A17b< What was that explanation?

<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@] **[GOTO A18]**

>A18< [fill Are you name] considering changing to a new doctor in the next 6 months?

<1> YES
<0> NO **[goto A20]**

<d> DON'T KNOW**[goto A20]**
<r> REFUSED **[goto A20]**

[@]

>A19< [PROGRAMMER: SET UP AS MULTIPLE RESPONSE]

Why [fill are you] thinking of changing [fill your] doctor?

PROBE: Are there any other reasons?

INTERVIEWER: CODE ALL THAT APPLY

<1> MY DOCTOR IS DROPPING MEDICARE **[goto A19a]**
<2> MY DOCTOR PLANNING TO RETIRE OR MOVE
<3> MY DOCTOR CHARGES MORE THAN MEDICARE PAYS
<4> MY DOCTOR IS TOO FAR AWAY OR INCONVENIENT
<5> DISSATISFIED WITH THE CARE RECEIVED
<6> DIFFICULT TO GET AN APPOINTMENT WITH MY DOCTOR
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
<n> NO OTHER

[@]

>A19a< Did the doctor's office explain why it is dropping Medicare?

<1> YES
<0> NO **[goto A20]**

<d> DON'T KNOW **[goto A20]**
<r> REFUSED **[goto A20]**

[@]

>A19b< What was that explanation?

<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@]

>A20< Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who concentrate in one area of health care.

In the last 6 months, did [fill you name] or [fill your] doctor think [fill you] needed to see a specialist?

<1> YES
<0> NO **[goto B1]**

<d> DON'T KNOW **[goto B1]**
<r> REFUSED **[goto B1]**
[# This question was taken from Medicare CAHPS-FFS.]
[@]

>A21< In the last 6 months, how much of a problem, if any, was it to see a specialist that [fill you] needed to see? Would you say . . .

<1> a big problem,
<2> a small problem, or
<3> not a problem? **[goto B1]**

<d> DON'T KNOW **[goto B1]**
<r> REFUSED **[goto B1]**
[# This question was taken from Medicare CAHPS-FFS.]
[@]

>A22< [PROGRAMMER: SET UP AS MULTIPLE RESPONSE]

Why did [fill you] have a problem seeing a specialist?

PROBE: Were there any other reasons?

INTERVIEWER: CODE ALL THAT APPLY

<1> COULD NOT FIND DOCTOR TAKING NEW MEDICARE PATIENTS **[goto A22a]**
<2> COULD NOT FIND DOCTOR TAKING ANY NEW PATIENTS
<3> COULD NOT FIND DOCTOR ACCEPTING MEDICARE AT ALL **[goto A22a]**
<4> COULD NOT FIND DOCTOR ACCEPTING MEDICARE ASSIGNMENT **[goto A22a]**
<5> COULD NOT AFFORD WHAT THE DOCTOR WANTED TO CHARGE ME
<6> THERE WERE VERY FEW OR NO DOCTORS IN MY AREA
<7> FOUND DOCTOR(S), BUT APPOINTMENTS TOO HARD TO GET
<8> CAN'T GET A GOOD RECOMMENDATION OR REFERRAL
<9> NOT SURE WHERE/HOW TO LOOK
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
<n> NO OTHER
[@]**[goto B1]**

>A22a< [**PROGRAMMER:** fill taking new Medicare patients if A22=1; fill accepting Medicare at all if A22=3; fill accepting Medicare assignment if A22=4]

Did the doctor's office explain why it is not (taking new Medicare patients/accepting Medicare at all/accepting Medicare assignment)?

<1> YES
<0> NO **[goto B1]**

<d> DON'T KNOW **[goto B1]**
<r> REFUSED **[goto A B1]**

[@]

>A22b< What was that explanation?

<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@]

B. ABILITY TO MAKE APPOINTMENTS AND GET NEEDED CARE

[**PROGRAMMER:**
fill **yourself**, if R = sample member, yourself = yourself; if R = proxy and sample member = male, yourself = himself; if R = proxy and sample member = female, yourself = herself]

The next question is about calling doctors' offices.

>B1< In the last 6 months, did [fill you name] call a doctor's office or clinic during regular office hours to get help or advice for [fill yourself]?

PROBE: IF PROXY SAYS SAMPLE MEMBER DID NOT MAKE THESE CALLS, ASK: Did anyone call to get help or advice for [fill SAMPLE MEMBER]?

INTERVIEWER: DO NOT COUNT CALLS TO MAKE APPOINTMENTS

<1> YES
<0> NO **[goto B3]**

<d> DON'T KNOW **[goto B3]**
<r> REFUSED **[goto B3]**
[# This question was taken from Medicare CAHPS-FFS.]
[@]

>B2< In the last 6 months, when [fill you] called during regular office hours, how often did [fill you name] get the help or advice [fill you] needed? Would you say . . .

INTERVIEWER: THIS QUESTION REFERS TO GETTING HELP OR INFORMATION BY TELEPHONE. IT <u>DOES NOT</u> REFER TO MAKING APPOINTMENTS.

<1> never,
<2> sometimes,
<3> usually, or
<4> always?

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare CAHPS-FFS.]
[@]

>B3< A health provider could be a general doctor, a specialist doctor, a physician assistant, a nurse, or anyone else you would see for health care.

In the last 6 months, not counting the times [fill you name] needed health care right away, did [fill you] make any appointments with a doctor or other health care provider?

<1> YES
<0> NO **[goto B6]**

<d> DON'T KNOW **[goto B6]**
<r> REFUSED **[goto B6]**
[# This question was taken from Medicare CAHPS-FFS.]
[@]

>B4< How often did [fill you] get an appointment for health care as soon as [fill you] wanted? Would you say . . .

<1> never,
<2> sometimes,
<3> usually, or
<4> always? **[go to B6]**

<d> DON'T KNOW **[goto B6]**
<r> REFUSED **[goto B6]**
[# This question was taken from Medicare CAHPS-FFS.]
[@]

>B5< In the last 6 months, why didn't [fill you] always get an appointment when [fill you] wanted one?

INTERVIEWER: CODE ALL THAT APPLY

<1> COULD NOT REACH DOCTOR BY PHONE
<2> DOCTOR DID NOT HAVE APPOINTMENT AVAILABLE
<3> DOCTOR HAD AN APPOINTMENT BUT NOT AT A CONVENIENT TIME
<4> DID NOT HAVE/COULD NOT GET TRANSPORTATION
<5> DOCTOR I WANTED TO SEE WAS AWAY/OUT OF TOWN
<6> THOUGHT IT WOULD COST TOO MUCH
<7> DID NOT HAVE TIME
<8> COULDN'T LEAVE OTHER FAMILY MEMBER
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
[@]

>B6< In the last 6 months, did [fill you name] have an illness, injury, or condition that needed care right away from a clinic, emergency room, or doctor's office?

<1> YES
<0> NO **[goto B11]**

<d> DON'T KNOW **[goto B11]**
<r> REFUSED **[goto B11]**
[# This question was taken from Medicare CAHPS-FFS.]
[@]

>B7< In the last 6 months, when [fill you name] needed care right away for an illness, injury, or condition, how often did [fill you] get care as soon as [fill you] wanted? Would you say . . .

<1> never,
<2> sometimes,
<3> usually, or
<4> always? **[goto B9]**

<d> DON'T KNOW **[goto B9]**
<r> REFUSED **[goto B9]**
[# This question was taken from Medicare CAHPS-FFS.]
[@]

>B8< In the last 6 months, why were [fill you name] unable to get the care [fill you] needed right away?

INTERVIEWER: CODE ALL THAT APPLY

<1> COULD NOT REACH DOCTOR BY PHONE
<2> DOCTOR DID NOT HAVE APPOINTMENT AVAILABLE
<3> DOCTOR HAD AN APPOINTMENT BUT NOT AT A CONVENIENT TIME
<4> DID NOT HAVE/COULD NOT GET TRANSPORTATION
<5> DOCTOR I WANTED TO SEE WAS AWAY/OUT OF TOWN
<6> THOUGHT IT WOULD COST TOO MUCH
<7> DID NOT HAVE TIME
<8> COULDN'T LEAVE OTHER FAMILY MEMBER
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
[@]

>B9< In the last 6 months, how many times did [fill you name] go to the emergency room to get help for [fill yourself]?

<0> NEVER **[goto B11]**
<1-25> TIMES

<d> DON'T KNOW **[goto B11]**
<r> REFUSED **[goto B11]**
[# This question was taken from Medicare CAHPS-FFS.]
[@]

>B10< In the last 6 months, why did [fill you name] go to the emergency room instead of the doctor's office?

INTERVIEWER: CODE ALL THAT APPLY

<1> COULD NOT REACH DOCTOR BY PHONE
<2> DOCTOR'S OFFICE FURTHER THAN EMERGENCY ROOM
<3> DOCTOR ADVISED THAT I GO TO EMERGENCY ROOM
<4> DOCTOR'S OFFICE WAS CLOSED WHEN I NEEDED CARE
<5> CALLED EMT/RESCUE SQUAD/FIRST RESPONDERS AND THEY TOOK ME TO THE EMERGENCY ROOM
<6> NEEDED EMERGENCY ROOM CARE FOR EMERGENT SITUATION
<7> THOUGHT DOCTOR COULD NOT DO MUCH ABOUT THE PROBLEM
<0> OTHER [SPECIFY]

<d> DON'T KNOW
<r> REFUSED
[@]

>B11< **PROGRAMMER:** IF B9=0,d, or r, DO NOT READ "not counting times [fill you name] went to emergency room" in B11.

In the last 6 months, (not counting times [fill you name] went to an emergency room), how many times did [fill you] go to a doctor's office or clinic to get care for [fill yourself]?

<0> NONE **[goto B15]**
<1-4> TIMES
<5> FIVE TO NINE TIMES
<10> TEN TIMES OR MORE

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare CAHPS-FFS.]
[@]

>B12< Wait time in a doctor's office or clinic includes the time you had to wait in the waiting room and exam room. In the last 6 months, how often did [fill you] see the person [fill you] came to see within 15 minutes of [fill you name] appointment? Would you say . . .

INTERVIEWER: DO NOT COUNT WAITING TIMES IN THE EMERGENCY ROOM OR WAITING TIMES FOR WALK-IN VISITS WITHOUT APPOINTMENTS

<1> never,
<2> sometimes,
<3> usually, or
<4> always?

<n> HAD NO VISITS [GO BACK AND CORRECT B11]
<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare CAHPS-FFS.]
[@]

>B13< For [fill your name] most recent doctor visit, how long did [fill you] have to wait between the day [fill you] made the appointment and the day [fill you] actually saw the doctor?

<0> SAME DAY **[goto B15]**
<1-10>

<n> MADE APPOINTMENT AT LAST VISIT **[goto B15]**
<d> DON'T KNOW
<r> REFUSED
[# This question was taken from the CTS Household survey.]
[goto B15]
[@]

>B14< **INTERVIEWER: ENTER TIME PERIOD**

<1> DAYS
<2> WEEKS
<3> MONTHS

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from the CTS Household survey.]
[@]

>B15< In the past year or two, has it gotten harder or easier to see a doctor [fill you] want to see, or is it about the same?

<1> HARDER
<2> EASIER **[goto B17]**
<3> ABOUT THE SAME **[goto B18]**

<d> DON'T KNOW **[goto B18]**
<r> REFUSED **[goto B18]**

[@]

>B16< [PROGRAMMER: SET UP AS MULTIPLE RESPONSE]

How has it become harder?

PROBE: Are there any other reasons?

INTERVIEWER: CODE ALL THAT APPLY

<1> DOCTOR I WANT TO SEE IS NOT ACCEPTING NEW MEDICARE PATIENTS **[goto B16a]**
<2> DOCTOR I WANT TO SEE IS NOT TAKING ANY NEW PATIENTS
<3> DOCTOR I WANT TO SEE IS NOT ACCEPTING MEDICARE AT ALL **[goto B16a]**
<4> DOCTOR I WANT TO SEE IS NOT ACCEPTING MEDICARE ASSIGNMENT **[goto B16a]**
<5> I MOVED FURTHER FROM DOCTOR
<6> DOCTOR MOVED FURTHER FROM ME
<7> HAVE MORE DIFFICULTY GETTING APPOINTMENT
<8> SPEND TOO MUCH TIME WAITING IN THE DOCTOR'S OFFICE
<9> DO NOT LIKE THE DOCTOR
<10> DOCTOR DIED/MOVED FROM AREA/RETIRED
<11> I AM OLDER/FRAILER
<12> TRANSPORTATION IS NO LONGER AVAILABLE/ CONVENIENT
<13> I DO NOT HAVE TIME
<14> I CANNOT LEAVE OTHER FAMILY MEMBERS

<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@] **[goto B18]**

>B16a< [**PROGRAMMER:** fill **taking new Medicare patients** if B16=1; fill **accepting Medicare at all** if B16=3; fill **accepting Medicare assignment** if B16=4]

Did the doctor's office explain why it is not (taking new Medicare patients/accepting Medicare at all/accepting Medicare assignment)?

<1> YES
<0> NO **[goto B18]**

<d> DON'T KNOW **[goto B18]**
<r> REFUSED **[goto B18]**

[@]

>B16b< What was that explanation?

<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@] **[goto B18]**

>B17< [PROGRAMMER: SET UP AS MULTIPLE RESPONSE]

How has it become easier?

PROBE: Are there any other reasons?

INTERVIEWER: CODE ALL THAT APPLY

<1> DOCTOR ACCEPTS MEDICARE
<2> TAKES LESS TIME TO GET AN APPOINTMENT
<3> I MOVED CLOSER TO DOCTOR
<4> DOCTOR MOVED CLOSER TO ME
<5> LESS TIME WAITING TO SEE DOCTOR ONCE IN THE OFFICE
<6> TRANSPORTATION IS AVAILABLE
<7> LIKE NEW DOCTOR BETTER
<8> I AM NOW AN ESTABLISHED PATIENT/NOW A REGULAR PATIENT
<9> MY HEALTH IS BETTER
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@]

>B18< In the last 6 months, did [fill you name] or a doctor believe [fill you] needed any care, tests, or treatment?

<1> YES
<0> NO **[goto B22]**

<d> DON'T KNOW **[goto B22]**
<r> REFUSED **[goto B22]**
[# This question was taken from Medicare CAHPS-FFS.]

[@]

>B19< In the last 6 months, how much of a problem, if any, was it to get the care, tests, or treatment [fill you] or [fill your] doctor believed necessary? Would you say . . .

<1> a big problem,
<2> a small problem, or
<3> not a problem? **[goto B21]**

<d> DON'T KNOW **[goto B21]**
<r> REFUSED **[goto B21]**
[# This question was taken from Medicare CAHPS-FFS.]

[@]

>B20< Why was it a problem to get the care, test, or treatment [fill you] believed necessary?

INTERVIEWER: CODE ALL THAT APPLY

<1> PLACE WHERE I NEEDED TO GO IS NOT ACCEPTING NEW MEDICARE PATIENTS
<2> PLACE WHERE I NEEDED TO GO IS NOT ACCEPTING ANY NEW PATIENTS
<3> PLACE WHERE I NEEDED TO GO IS NOT ACCEPTING MEDICARE AT ALL
<4> PLACE WHERE I NEEDED TO GO IS NOT ACCEPTING MEDICARE ASSIGNMENT
<5> COULD NOT AFFORD CHARGES
<6> DIDN'T HAVE A WAY TO GET TO OFFICE/TAKES TOO LONG TO GET TO THE DOCTOR'S OFFICE
<7> NO PLACE TO GO IN MY AREA
<8> COULDN'T GET APPOINTMENT
<9> TOOK LONG TO GET THROUGH ON TELEPHONE
<10> PROBLEM NOT SERIOUS ENOUGH
<11> COULD NOT GET RECOMMENDATION OR REFERRAL
<12> DON'T HAVE A REGULAR DOCTOR
<13> NOT SURE WHERE TO GO
<14> TOO BUSY WITH OTHER THINGS
<15> COULDN'T LEAVE OTHER FAMILY MEMBER
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
<n> NO OTHER

[@]

>B21< In the last 6 months, did [fill you] need approval from Medicare for any care, tests or treatment?

<1> YES
<0> NO **[goto C1]**

<d> DON'T KNOW **[goto C1]**
<r> REFUSED **[goto C1]**
[# This question was taken from Medicare CAHPS-FFS.]

[@]

>B22< In the last 6 months, how much of a problem, if any, were delays in health care while [fill you] waited for approval from Medicare? Would you say . . .

<1> a big problem,
<2> a small problem, or
<3> not a problem?

<n> HAD NO VISITS NEED FOR CARE, TESTS, OR TREATMENT IN THE LAST SIX MONTHS **[goto C1]**
<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare CAHPS-FFS.]

[@]

C. UNMET NEEDS AND DELAYED CARE

[**PROGRAMMER:**
fill **you think**, if R = sample member, you think = you think; if R = proxy and sample member = male, you think = he thinks; if R = proxy and sample member = female, you think = she thinks]

>C1< In the last 6 months, did [fill you name] have any health condition or problem about which [fill you think] [fill you] should have seen a doctor or other medical person, but did not?

<1> YES
<0> NO **[goto C5]**

<d> DON'T KNOW **[goto C5]**
<r> REFUSED **[goto C5]**
[# This question was taken from MCBS.]
[@]

>C2< Did [fill you] attempt to see a doctor about this?

<1> YES
<0> NO **[goto C5]**

<d> DON'T KNOW **[goto C5]**
<r> REFUSED **[goto C5]**
[# This question was taken from MCBS.]
[@]

[**PROGRAMMER:**
fill **were you**, if R = sample member, were you = were you; if R = proxy and sample member = male, were you = was he; if R = proxy and sample member = female, were you = was she]

>C3< [PROGRAMMER: SET UP AS MULTIPLE RESPONSE]

Why [fill were you name] not able to see a doctor about this condition?

PROBE: Were there any other reasons?

INTERVIEWER: CODE ALL THAT APPLY

<1> DOCTOR I WANTED TO SEE WAS NOT ACCEPTING NEW MEDICARE PATIENTS **[goto C3a]**
<2> DOCTOR I WANTED TO SEE WAS NOT TAKING ANY NEW PATIENTS
<3> DOCTOR I WANTED TO SEE WAS NOT ACCEPTING MEDICARE AT ALL **[goto C3a]**
<4> DOCTOR I WANTED TO SEE WAS NOT ACCEPTING MEDICARE ASSIGNMENT **[goto C3a]**
<5> THOUGHT IT WOULD COST TOO MUCH/COULD NOT AFFORD
<6> NO DOCTOR AVAILABLE/NO PLACE TO GO
<7> COULDN'T GET APPOINTMENT SOON ENOUGH
<8> TOOK LONG TO GET THROUGH ON TELEPHONE
<9> DON'T HAVE A REGULAR DOCTOR/DIDN'T KNOW WHERE TO GO FOR CARE
<10> DIDN'T HAVE TRANSPORTATION TO OFFICE/TAKES TOO LONG TO GET TO THE DOCTOR'S OFFICE
<11> TOO BUSY WITH OTHER THINGS
<12> COULD NOT LEAVE FAMILY MEMBERS
<13> PROBLEM NOT SERIOUS ENOUGH
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
<n> NO OTHER
[# This question was modified with precodes from MCBS.]

[@] **[goto C4]**

>C3a< [**PROGRAMMER:** fill **taking new Medicare patients** if C3=1; fill **accepting Medicare at all** if C3=3; fill **accepting Medicare assignment** if C3=4]

Did the doctor's office explain why it is not (taking new Medicare patients/accepting Medicare at all/accepting Medicare assignment)?

<1> YES
<0> NO **[goto C4]**

<d> DON'T KNOW **[goto C4]**
<r> REFUSED **[goto C4]**

[@]

>C3b< What was that explanation?

<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
[@]

>C4< [PROGRAMMER: PLEASE SET UP AS MULTIPLE RESPONSE]

What were the consequences of not seeing a doctor?

PROBE: Were there any other consequences?

INTERVIEWER: CODE ALL THAT APPLY

<1> NONE
<2> CONDITION GOT WORSE
<3> TOOK LONGER TO RECOVER
<4> STILL DO NOT FEEL WELL
<5> HAD TO GO TO EMERGENCY ROOM
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
<n> NO OTHER
[# This question was modified with precodes from the PPRC survey.]
[@]

[PROGRAMMER: IF C1= YES, ADD THE FOLLOWING PHRASE TO THE BEGINNING OF C5, BESIDES <u>NOT</u> SEEING A DOCTOR THAT WE JUST TALKED ABOUT.]

>C5< Was there any time In the last 6 months when [fill you name] put off or postponed getting medical care [fill you] thought [fill you] needed?

<1> YES
<0> NO **[goto D1]**

<d> DON'T KNOW **[goto D1]**
<r> REFUSED **[goto D1]**
[# This question was modified from CTS household survey with CAHPS time frame.]
[@]

>C6< [PROGRAMMER: SET UP AS MULTIPLE RESPONSE]

Why did [fill you] put off or postpone getting care?

PROBE: Were there any other reasons?

INTERVIEWER: CODE ALL THAT APPLY

<1> DOCTOR I WANTED TO SEE WAS NOT ACCEPTING NEW MEDICARE PATIENTS **[goto C6a]**
<2> DOCTOR I WANTED TO SEE WAS NOT TAKING ANY NEW PATIENTS
<3> DOCTOR I WANTED TO SEE WAS NOT ACCEPTING MEDICARE AT ALL **[goto C6a]**
<4> DOCTOR I WANTED TO SEE WAS NOT ACCEPTING MEDICARE ASSIGNMENT **[goto C6a]**
<5> THOUGHT IT WOULD COST TOO MUCH/COULD NOT AFFORD
<6> NO DOCTOR AVAILABLE/NO PLACE TO GO
<7> COULDN'T GET APPOINTMENT SOON ENOUGH
<8> TOOK LONG TO GET THROUGH ON TELEPHONE
<9> DON'T HAVE A REGULAR DOCTOR/DIDN'T KNOW WHERE TO GO FOR CARE
<10> DIDN'T HAVE TRANSPORTATION TO OFFICE/TAKES TOO LONG TO GET TO THE DOCTOR'S OFFICE
<11> TOO BUSY WITH OTHER THINGS
<12> COULD NOT LEAVE FAMILY MEMBERS
<13> PROBLEM NOT SERIOUS ENOUGH
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
<n> NO OTHER
[# This question was modified with precodes from the CTS household survey.]

[@] **[goto C7]**

>C6a< [**PROGRAMMER:** fill **taking new Medicare patients** if C6=1; fill **accepting Medicare at all** if C6=3; fill **accepting Medicare assignment** if C6=4]

Did the doctor's office explain why it is not (taking new Medicare patients/accepting Medicare at all/accepting Medicare assignment)?

<1> YES
<0> NO **[goto C7]**

<d> DON'T KNOW **[goto C7]**
<r> REFUSED **[goto C7]**

[@]

>C6b< What was that explanation?

<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@]

>C7< [PROGRAMMER: SET UP AS MULTIPLE RESPONSE]

What were the consequences, if any, of putting off getting care?

PROBE: Were there any other consequences?

INTERVIEWER: CODE ALL THAT APPLY

<1> NONE
<2> CONDITION GOT WORSE
<3> TOOK LONGER TO RECOVER
<4> STILL DO NOT FEEL WELL
<5> HAD TO GO TO EMERGENCY ROOM
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
<n> NO OTHER
[# This question was modified with precodes from the PPRC survey.]

[@]

D. SATISFACTION WITH EASE OF GETTING PHYSICIAN SERVICES

[**PROGRAMMER:**
fill **you live**, if R = sample member, you live = you live; if R = proxy and sample member = male, you live = he lives; if R = proxy and sample member = female, you live = she lives

test before D1, if B11 = <0>, **goto E1**]

>D1< In the last 6 months, please tell me how [fill you name] would rate the ease and convenience of getting to a doctor from where [fill you live]. Would [fill you] rate the ease and convenience of getting to the doctor as . . .

<1> excellent, **[goto D3]**
<2> very good, **[goto D3]**
<3> good, **[goto D3]**
<4> fair, or
<5> poor?

<n> HAVE NOT GONE TO THE DOCTOR **[goto E1]**
<d> DON'T KNOW **[goto E1]**
<r> REFUSED **[goto E1]**

[# This question was modified from MCBS to be consistent with CAHPS timeframe. We also switched scales to eliminate high frequency sounds.]

[@]

>D2< [PROGRAMMER: SET UP AS MULTIPLE RESPONSE]

Why do you say that?

PROBE: Are there any other reasons?

INTERVIEWER: CODE ALL THAT APPLY

<1> AVAILABLE DOCTORS DO NOT TAKE NEW MEDICARE PATIENTS **[goto D2a]**
<2> AVAILABLE DOCTORS DO NOT TAKE ANY NEW PATIENTS
<3> AVAILABLE DOCTORS DO NOT TAKE MEDICARE PATIENTS AT ALL **[goto D2a]**
<4> AVAILABLE DOCTORS DO NOT ACCEPT MEDICARE ASSIGNMENT **[goto D2a]**
<5> WAIT TOO LONG FOR APPOINTMENT
<6> AVAILABLE DOCTORS CHARGE TOO MUCH
<7> NO DOCTOR AVAILABLE
<8> DON'T LIKE AVAILABLE DOCTORS
<9> CAN'T GET APPOINTMENT
<10> HAVE TO TRAVEL TOO FAR/HARD TO GET TO
<11> COULDN'T LEAVE OTHER FAMILY MEMBER
<12> DOCTOR REQUIRES UPFRONT PAYMENT
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
<n> NO OTHER

[@] **[goto D3]**

>D2a< [**PROGRAMMER:** fill **taking new Medicare patients** if D2=1; fill **accepting Medicare at all** if D2=3; fill **accepting Medicare assignment** if D2=4]

Did the doctor's office explain why it is not (taking new Medicare patients/accepting Medicare at all/accepting Medicare assignment)?

<1> YES
<0> NO **[goto D3]**

<d> DON'T KNOW **[goto D3]**
<r> REFUSED **[goto D3]**

[@]

>D2b< What was that explanation?

<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@]

[**PROGRAMMER:**
fill **you feel**, if R = sample member, you feel = you feel; if R = proxy and sample member = male, you feel = he feels; if R = proxy and sample member = female, you feel = she feels

fill **you need**, if R = sample member, you need = you need; if R = proxy and sample member = male, you need = he needs; if R = proxy and sample member = female, you need = she needs]

>D3< In the last 6 months, please tell me how [fill you name] would rate the availability of care by specialists when [fill you feel] [fill you need] it. Would [fill you] rate the availability of care by specialists as . . .

<1> excellent, **[goto E1]**
<2> very good, **[goto E1]**
<3> good, **[goto E1]**
<4> fair, or
<5> poor?
<n> DID NOT NEED SPECIALIST CARE **[goto E1] PROGRAMMER NOTE; D3 CANNOT = N IF a20 = YES.**

<d> DON'T KNOW **[goto E1]**
<r> REFUSED**[goto E1]**
[# This question was modified from MCBS to be consistent with CAHPS timeframe. We also eliminated high frequency words.]

[@]

>D4< [PROGRAMMER: SET UP AS MULTIPLE RESPONSE]

Why do you say that?

PROBE: Are there any other reasons?

INTERVIEWER: CODE ALL THAT APPLY

<1> AVAILABLE DOCTORS DO NOT TAKE NEW MEDICARE PATIENTS **[goto D2a]**
<2> AVAILABLE DOCTORS DO NOT TAKE ANY NEW PATIENTS
<3> AVAILABLE DOCTORS DO NOT TAKE MEDICARE PATIENTS AT ALL **[goto D2a]**
<4> AVAILABLE DOCTORS DO NOT ACCEPT MEDICARE ASSIGNMENT **[goto D2a]**
<5> WAIT TOO LONG FOR APPOINTMENT
<6> AVAILABLE DOCTORS CHARGE TOO MUCH
<7> NO DOCTOR AVAILABLE
<8> DON'T LIKE AVAILABLE DOCTORS
<9> CAN'T GET APPOINTMENT
<10> HAVE TO TRAVEL TOO FAR/HARD TO GET TO
<11> COULDN'T LEAVE OTHER FAMILY MEMBER
<12> DOCTOR REQUIRES UPFRONT PAYMENT
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
<n> NO OTHER

[@]**[goto E1]**

>D4a< [**PROGRAMMER:** fill **taking new Medicare patients** if D4=1; fill **accepting Medicare at all** if D4=3; fill **accepting Medicare assignment** if D4=4]

Did the doctor's office explain why it is not (taking new Medicare patients/accepting Medicare at all/accepting Medicare assignment)?

<1> YES
<0> NO **[goto E1]**

<d> DON'T KNOW **[goto E1]**
<r> REFUSED **[goto E1]**

[@]

>D4b< What was that explanation?

<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED

[@]

E. BENEFICIARY CHARACTERISTICS

[**PROGRAMMER:** fill do you name have, if R=sample member, do you name have=do you have; if R=proxy, do you name have=does sample member have]

>E1< Some people who are on Medicare also have other insurance to help pay some of the cost of their health care. [fill Do you name have] any other insurance in addition to Medicare to pay at least some of the cost of [fill your] health care?

<1> YES
<0> NO **[goto E8]**

<d> DON'T KNOW **[goto E8]**
<r> REFUSED **[goto E8]**
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E2< Next, I would like to know about the kinds of insurance [fill you name have]? [fill Do you] have MediGap insurance which is also called Medicare Supplemental Insurance?

PROBE: A Medigap policy is a health insurance plan offered to patients receiving Medicare benefits. These health plans are specially designed to pay what Medicare does not. In other words, these plans fill in the "gaps" in Medicare coverage such as deductibles and coinsurance.

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E3< [fill Do you name have] employer, union, or retiree health coverage?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E4< [fill Do you] have Veteran's Benefits also known as VA benefits?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E5< [fill Do you] have military retiree benefits also known as Tricare?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

PROGRAMMER NOTE: SKIP E6 FOR THE BASE CONTRACT YEAR SURVEY

>E6< [fill Do you name] have Medicaid, also known as State Medical assistance or [fill State-specific name of Medicaid program], which is for some persons with limited incomes and resources?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

PROGRAMMER NOTE: IF E2-E6, ARE ALL ANSWERED "NO," ASK E7, OTHERWISE goto E8

>E7< What is the name of the other health insurance [fill you have]?

INTERVIEWER: RECORD HEALTH INSURANCE ONLY. DO NOT RECORD DENTAL, VISION, HEARING, OR PRESCRIPTION ONLY COVERAGE HERE.

MAJOR MEDICAL COVERAGE IS HEALTH INSURANCE PROVIDING BENEFITS UP TO A HIGH LIMIT FOR MOST TYPES OF MEDICAL EXPENSES INCURRED, SUBJECT TO A DEDUCTIBLE. CONTRACTS MAY CONTAIN LIMITS ON SPECIFIC TYPES OF CHARGES, LIKE ROOM AND BOARD, AND A PERCENTAGE PARTICIPATION CLAUSE (COINSURANCE CLAUSE). POLICIES USUALLY PAY COVERED EXPENSES WHETHER AN INDIVIDUAL IS IN OR OUT OF THE HOSPITAL.

INDEMNITY IS A TYPE OF INSURANCE FOR WHICH AN ANNUAL DEDUCTIBLE IS PAID AND THEN THE INSURANCE COMPANY REIMBURSES THE PATIENT OR PROVIDER AS EXPENSES ARE INCURRED.

<1> MAJOR MEDICAL FROM A JOB OR SPOUSE'S JOB
<2> INDEMNITY
<3> SPECIAL POLICY TO COVER CERTAIN DISEASES
<0> OTHER [specify]

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS. Precodes were added.]
[@]

>E8< Medicare does not pay for prescription medicine unless you are in the hospital. [fill Do you name] have insurance in addition to Medicare to pay at least some of the cost of medicines prescribed by doctors and other health providers?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

[**PROGRAMMER:**
fill **have you**, if R = sample member, have you = have you; if R = proxy and sample member = male, have you = has he; if R = proxy and sample member = female, have you = has she]

>E9< In the last 12 months [fill have you name] been a patient in a hospital overnight or longer?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E10< [fill Do you] now have any physical or medical conditions that have lasted for at least three months?

<1> YES
<0> NO **[goto E12]**

<d> DON'T KNOW **[goto E12]**
<r> REFUSED **[goto E12]**
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E11< [fill Have you name] been taking prescription medicine for at least three months for any of these conditions?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E12< In the last six months, [fill did you] leave a Medicare+Choice plan and return to regular Medicare?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[@]

>E13< In general would [fill you name] say [fill your] health is . . .

<1> excellent,
<2> very good,
<3> good,
<4> fair, or
<5> poor?

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E14< Compared to one year ago, how would [fill you] rate [fill your] general health now? Is it . . .

<1> much better now than one year ago,
<2> somewhat better now than one year ago,
<3> about the same as one year ago,
<4> somewhat worse now than one year ago, or
<5> much worse now than one year ago?

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

[**PROGRAMMER:**
fill **does your**, if R = sample member, does your = does your; if R = proxy and sample member = male, does your = does his; if R = proxy and sample member = female, does your = does her

fill **limit you**, if R = sample member, limit you = limit you; if R = proxy and sample member = male, limit you = limit him; if R = proxy and sample member = female, limit you = limit her]

>E15< [fill Does your] health now [fill limit you] in doing moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E16< [fill Does your] health now [fill limit you] in climbing several flights of stairs?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E17< During the past 4 weeks, [fill have you] accomplished less than [fill you] would like as a result of [fill your] physical health?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E18< During the past 4 weeks, [fill were you name] limited in the kind of work or other regular daily activities [fill you] did as a result of [fill your] health?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E19< [fill Do you name] have a physical or medical condition that seriously interferes with [fill your] independence, participation in the community or quality of life?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E20< Because of any impairment or health problem, [fill do you] need help with [fill your] routine needs such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

<1> YES
<0> NO

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E21< What is the highest grade or level of school that [fill you name] completed?

<1> 8TH GRADE OR LESS
<2> SOME HIGH SCHOOL, BUT DID NOT GRADUATE
<3> HIGH SCHOOL GRADUATE OR GED
<4> SOME COLLEGE OR 2-YEAR DEGREE
<5> 4-YEAR COLLEGE GRADUATE
<6> MORE THAN 4-YEAR COLLEGE GRADUATE

<d> DON'T KNOW
<r> REFUSED
[# This question was taken from Medicare FFS CAHPS.]
[@]

>E22< [fill Are you name] of Hispanic or Latino origin or descent?

<1> YES, HISPANIC OR LATINO
<0> NO, NOT HISPANIC OR LATINO

<d> DON'T KNOW
<r> REFUSED
[# This is the OMB approved race question.]
[@]

>E23< What is [fill your name] race? [fill Are you] . . .

INTERVIEWER: READ ALL CATEGORIES AND CODE ALL THAT APPLY

<1> White,
<2> Black or African American,
<3> Asian,
<4> Native Hawaiian or other Pacific Islander, or
<5> American Indian or Alaska Native?

<d> DON'T KNOW
<r> REFUSED
[# This is the OMB approved race question.]
[@]

>E24< [fill Are you] . . .

<1> married or living as married,
<2> widowed,
<3> divorced,
<4> separated, or
<5> [fill have you] never been married?

<d> DON'T KNOW
<r> REFUSED

[@]

>E25< What is [fill your] annual household income? Is it less than or more than $25,000?

<1> LESS THAN OR EQUAL TO
<2> MORE THAN **[goto E27]**

<d> DON'T KNOW **[goto E25a]**
<r> REFUSED **[goto E25a]**

[@]

>E25a< Can [fill you] tell me [fill your] monthly income?

<1> YES
<0> NO **[goto te29]**

<d> DON'T KNOW NO **[goto te29]**
<r> REFUSED NO **[goto te29]**

[@]

>E25b< What is [fill your] monthly income before taxes?

$<10-10000> DOLLARS **[goto E28]**

<d> DON'T KNOW **[goto te29]**
<r> REFUSED **[goto te29]**

[@]

>E26< Is it less than $10,000?

INTERVIEWER: IF RESPONDENT HAS TOLD YOU INCOME IS EQUAL TO $25,OOO CODE AS 2

<1> LESS THAN OR EQUAL TO **[goto E28]**
<2> MORE THAN **[goto E28]**

<d> DON'T KNOW
<r> REFUSED

[@]

>E27< Is it more than $35,000?

<1> LESS THAN OR EQUAL TO
<2> MORE THAN

<d> DON’T KNOW
<r> REFUSED

[@]

>E28< How many people does this income support?

<1-10>

<d> DON’T KNOW
<r> REFUSED

[@]

>te29< If SM = continuous, goto end.

>E29< PROGRAMMER: IF ANY OF THE FOLLOWING CONDITIONS ARE MET, ASK E29, OTHERWISE GOTO END.

A7=0 AND A8 DOES NOT EQUAL 1;

A11 = 1 OR 2;

A21 = 1 OR 2;

B4 = 1 OR 2;

B7 = 1 OR 2;

B15 = 1;

C1 = 1 AND C2=1;

C5 = 1;

D1 = 4 OR 5;

D3 = 4 OR 5;

You told me that [fill you]

[fill “don’t have a person who you think of as your personal doctor or nurse, if A7=0 AND A8 DOES NOT EQUAL 1],

[fill “had a problem getting a personal doctor”, if A11 = 1 O R 2],

[fill “had a problem seeing a specialist”, if A21= 1 or 2],

[fill “had a problem getting an appointment when you needed it”, if B4=1 or 2],

[fill “had a problem getting care that you needed right away”, if B7=1 or 2],

[fill “find it has gotten harder to see a doctor in the past year or two”, if B15=1],

[fill “thought you needed to see a doctor about a medical problem but did not”, if C1=1 AND C2=1],

[fill “delayed or postponed getting medical care”, if C5=1],

[fill “rated the ease and convenience of getting to the doctor from where [fil you live] as fair or poor”, if D1=4 OR 5],

[fill “rated the availability of care by specialists when you needed it as fair or poor”, if D3=4 OR 5].

IF MORE THAN ONE PROBLEM LISTED FILL “any of these problems”

Did [fill you] experience [this problem/any of these problems] [since [fill your] recent move/since [fill you] became eligible for Medicare/since [fill you] left [fill your] Medicare HMO]?

<1> YES
<0> NO **[goto end]**

<d> DON'T KNOW **[goto end]**
<r> REFUSED **[goto end]**

[@]

>E30< Which of these did [fill you] experience [since [fill your] recent move/since [fill you] became eligible for Medicare/since [fill you] left [fill your] Medicare HMO]?

PROGRAMMER: SET UP AS CODE ALL THAT APPLY. ONLY ALLOW ANSWER CATEGORIES TO BE SELECTED IF CRITERIA ARE MET.

<1> [fill "don't have a person who you think of as your personal doctor or nurse, if A7=0 AND A8 DOES NOT EQUAL 1],

<2> [fill "had a problem getting a personal doctor", if A11 = 1 O R 2],

<3> [fill "had a problem seeing a specialist", if A21= 1 or 2],

<4> [fill "had a problem getting an appointment when you needed it", if B4=1 or 2],

<5> [fill "had a problem getting care that you needed right away", if B7=1 or 2],

<6> [fill "find it has gotten harder to see a doctor in the past year or two", if B15=1],

<7> [fill "thought you needed to see a doctor about a medical problem but did not", if C1=1 AND C2=1],

<8> [fill "delayed or postponed getting medical care", if C5=1],

<9> [fill "rated the ease and convenience of getting to the doctor from where [fill you live] as fair or poor", if D1=4 OR 5],

<10> [fill "rated the availability of care by specialists when you needed it as fair or poor", if D3=4 OR 5].

<d> DON'T KNOW [goto end]
<r> REFUSED [goto end]

[@]

>end< Thank you for your time. Your answers were very helpful for this study.
[@]

>screenout1< Thank you for your time. Because [fill you name] are in a hospice program, I do not need to continue this interview.

[@]

>screenout2< Thank you for your time. Because [fill you name] are in a nursing home, I do not need to continue this interview.

8923-340

TARGETED BENEFICIARY SURVEY

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0890. The time required to complete this information is 10 to 15 minutes per response. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the questionnaire, please write to: CMS, 7500 Security Boulevard, N2-14-266, Baltimore, Maryland 21244-1850.

Expiration Date 3/31/2007

Prepared by Mathematica Policy Research, Inc.

SURVEY INSTRUCTIONS

This survey asks questions about your experiences in receiving healthcare as a person who is on Medicare. The questions ask about the doctors, nurses, and all other medical staff who take care of your health care needs and about the health care services you have received. Please consider your experiences with Medicare as you answer the questions in the survey.

MARKING INSTRUCTIONS

- **Use black or blue ink or a number 2 pencil**
- **Make dark marks in the box**

☒ **Or** ☑

Answer all the questions by marking the box to the left of your answer. For those questions that require written responses, please print on the lines provided for your response.

You are sometimes told to skip over some questions in the survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

1 ☐ Yes
0 ☐ No ➞ **IF NO, GO TO #17**

1. Are you male or female?

1 ☐ Male
2 ☐ Female

2. How long have you lived at your current address?

1 ☐ Less than 6 months
2 ☐ 6 months to one year
3 ☐ 1-5 years
4 ☐ 5-10 years
5 ☐ Ten years or more

GO TO #4

3. Is the distance between where you live now and where you lived before far enough that you thought about changing doctors when you moved?

1 ☐ Yes
0 ☐ No

4. A <u>personal doctor or nurse</u> is the health provider who knows you best. This can be a general doctor, a specialist doctor, a physician assistant, or a nurse.

Do you have one person you think of as your personal doctor or nurse?

1 ☐ Yes ➞ **IF YES, GO TO #6**
0 ☐ No

5. Why don't you have one person who you think of as your personal doctor or nurse?

_____

_____

SKIP TO #9 ON THE NEXT PAGE

6. Is this person . . .

1 ☐ a general doctor,
2 ☐ a specialist doctor,
3 ☐ a physician assistant, or
4 ☐ a nurse?
d ☐ Don't Know

7. Did you have the same personal doctor or nurse before you joined Medicare?

1 ☐ Yes
0 ☐ No

8. How many months or years have you been going to your same personal doctor or nurse?

1 ☐ Less than 6 months
2 ☐ At least 6 months but less than one year
3 ☐ 1-2 years
4 ☐ More than 2 years but less than 5 years
5 ☐ 5 or more years
0 ☐ I don't have a personal doctor
d ☐ Don't Know

9. Since you joined Medicare, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?

1 ☐ A big problem,
2 ☐ A small problem, or
3 ☐ Not a problem?

10. In the last 6 months, did you get a new doctor or nurse?

1 ☐ Yes
0 ☐ No

11. Are you currently looking for a new doctor or nurse?

1 ☐ Yes
0 ☐ No → **IF NO, GO TO #13**

12. How long have you been looking for a new doctor or nurse?

|__|__| MONTHS

d ☐ Don't Know

13. Are you considering changing to a new doctor in the next 6 months?

1 ☐ Yes
0 ☐ No
2 ☐ Not Sure

14. <u>Specialists</u> are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who concentrate in one area of health care.

In the last 6 months, did you or your doctor think you needed to see a specialist?

1 ☐ Yes
0 ☐ No → **IF NO, GO TO #17**

15. In the last 6 months, how much of a problem, if any, was it to see a specialist that you needed to see?

1 ☐ A big problem
2 ☐ A small problem
3 ☐ Not a problem
4 ☐ I didn't need to see a specialist in the last 6 months → **GO TO #17**

16. Why did you have a problem seeing a specialist?

_____

_____

_____

_____

_____

17. In the last 6 months, did you call a doctor's office or clinic during regular office hours to get help or advice for yourself?

1 ☐ Yes

0 ☐ No → **IF NO, GO TO #19**

18. In the last 6 months, when you called during regular office hours, how often did you get the help or advice you needed?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

5 ☐ I didn't call for help or advice in last 6 months.

19. A <u>health provider</u> could be a general doctor, a specialist doctor, a physician assistant, a nurse, or anyone else you would see for health care.

In the last 6 months, not counting the times you needed health care right away, did you make any appointments with a doctor or other health care provider?

1 ☐ Yes

0 ☐ No → **GO TO #21**

20. In the last 6 months, not counting the times you needed health care right away, how often did you get an appointment for health care as soon as you wanted?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

5 ☐ I didn't need an appointment

21. In the last 6 months, did you have an illness, injury, or condition that needed care <u>right away</u> from a clinic, emergency room, or doctor's office?

1 ☐ Yes

0 ☐ No

2 ☐ I didn't need care right away for an illness, injury or condition in the last 6 months → **GO TO #24**

22. In the last 6 months, when you <u>needed care right away</u> for an illness, injury, or condition, how often did you get care as soon as you wanted?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

23. In the last 6 months, how many times did you go to the emergency room to get help for yourself?

|___|___| TIMES

0 ☐ None

d ☐ Don't Know

24. In the last 6 months (not counting times you went to an emergency room), how many times did you go to a doctor's office or clinic to get care for yourself?

|__|__| TIMES

0 ☐ None → **GO TO #28**

d ☐ Don't Know

25. Wait time in a doctor's office or clinic includes the time you had to wait in the waiting room and exam room.

In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

n ☐ Had No Visits

d ☐ Don't Know → **GO TO #27**

26. For your most recent doctor visit, how long did you have to wait between the day you made the appointment and the day you actually saw the doctor?

|__|__| 1 ☐ Days

|__|__| 2 ☐ Weeks

|__|__| 3 ☐ Months

0 ☐ SAME DAY APPOINTMENT

d ☐ Don't Know

27. In the past year or two, has it gotten harder or easier to see a doctor you want to see, or is it about the same?

1 ☐ Harder

2 ☐ Easier

3 ☐ About the same

28. In the last 6 months, did you or a doctor believe you needed any care, tests, or treatment?

1 ☐ Yes

0 ☐ No → **IF NO, GO TO #30**

29. In the last 6 months, how much of a problem, if any, was it to get the care, tests, or treatment you or your doctor believed necessary?

1 ☐ A big problem

2 ☐ A small problem

3 ☐ Not a problem

4 ☐ I didn't need care, tests or treatment in the last 6 months

30. In the last 6 months, did you have any health condition or problem about which you think you should have seen a doctor or other medical person, but did not?

1 ☐ Yes

0 ☐ No

31. Was there any time in the last 6 months when you put off or postponed getting medical care you thought you needed?

1 ☐ Yes
0 ☐ No

32. In the last 6 months, how would you rate the ease and convenience of getting to a doctor from where you live?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor
6 ☐ Have not gone to the doctor

33. In the last 6 months, how would you rate the availability of care by specialists when you need it?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor
6 ☐ I didn't need specialist care in the last 6 months

34. Some people who are on Medicare also have other insurance to help pay some of the cost of their health care. Do you have any other insurance in addition to Medicare to pay at least some of the cost of your health care?

1 ☐ Yes
0 ☐ No

34a. Do you have Medicaid, also known as State Medical Assistance, which is for some persons with limited incomes or resources?

1 ☐ Yes
0 ☐ No

35. Medicare does not pay for prescription medicine unless you are in the hospital. Do you have insurance in addition to Medicare to pay at least some of the cost of medicines prescribed by doctors and other health providers?

1 ☐ Yes
0 ☐ No

36. In the last 12 months have you been a patient in a hospital overnight or longer?

1 ☐ Yes
0 ☐ No

37. Do you now have any physical or medical conditions that have lasted for at least three months?

1 ☐ Yes
0 ☐ No → **IF NO, GO TO #39**

38. Have you been taking prescription medicine for at least three months for any of these conditions?

1 ☐ Yes
0 ☐ No

39. In the past 6 months, did you leave a Medicare+Choice plan and return to regular Medicare?

1 ☐ Yes
0 ☐ No

40. In general would you say your health is . . .

1 ☐ Excellent,
2 ☐ Very good,
3 ☐ Good
4 ☐ Fair, or
5 ☐ Poor?

41. Compared to one year ago, how would you rate your general health now?

1 ☐ Much better now than one year ago,
2 ☐ Somewhat better now than one year ago,
3 ☐ About the same as one year ago,
4 ☐ Somewhat worse now than one year ago, or
5 ☐ Much worse now than one year ago?

42. Does your health now limit you in doing moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?

1 ☐ Yes
0 ☐ No

43. Does your health now limit you in climbing several flights of stairs?

1 ☐ Yes
0 ☐ No

44. Do you have a physical or medical condition that seriously interferes with your independence, participation in the community or quality of life?

1 ☐ Yes
0 ☐ No

45. Because of any impairment or health problem, do you need help with your routine needs such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

1 ☐ Yes
0 ☐ No

46. Are you of Hispanic or Latino origin or descent?

1 ☐ Yes, Hispanic or Latino
0 ☐ No, not Hispanic or Latino

47. What is your race? Please mark one or more.

1 ☐ White
2 ☐ Black or African American
3 ☐ Asian
4 ☐ Native Hawaiian or other Pacific Islander
5 ☐ American Indian or Alaskan Native

48. Are you . . .

1 ☐ Married,
2 ☐ Living as married,
3 ☐ Widowed,
4 ☐ Divorced,
5 ☐ Separated, or
6 ☐ Have you never been married?

49. What is your annual household income?

1 ☐ $0-$10,999
2 ☐ $11,000-$25,999
3 ☐ $26,000-$35,000
4 ☐ More than $35,000
d ☐ Don't Know

50. How many people does this income support?

|__|__| PERSON/PEOPLE

51. What is your age now?

|__|__| YEARS

52. Are you now in a hospice program?

1 ☐ Yes
0 ☐ No

53. Are you living in a nursing home?

1 ☐ Yes
0 ☐ No

54. Are you the person to whom this questionnaire was mailed? That is, is your name on the envelope?

1 ☐ Yes → **Thank you. Please return your completed survey in the postage-paid envelope.**
0 ☐ No

55. How are you related to the person to whom this questionnaire was mailed?

1 ☐ Spouse
2 ☐ Child
3 ☐ Sibling
4 ☐ Parent
5 ☐ Niece/Nephew
6 ☐ Friend/Other relative
7 ☐ Other *(Specify)*

_____

Thank you for your time. Your answers are very helpful for this study.

Please return your completed survey in the postage paid envelope to:

Targeted Beneficiary Survey
Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

APPENDIX C

ADDITIONAL RESULTS FROM THE 2004 TARGETED BENEFICIARY SURVEY DATA

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

TABLE C.1

PHYSICIAN ACCESS PROBLEMS AMONG MEDICARE BENEFICIARIES
IN 11 TARGETED GEOGRAPHIC SITES, 2004

	Percentage of Medicare FFS Beneficiaries	
How Much of Problem Getting a Personal Doctor since Joining Medicare		
Big problem	3.6	(0.5)
Small problem	4.6	(0.5)
Not a problem	91.8	(0.7)
Needed to See a Specialist in Past Six Months	46.1	(1.2)
How Much of Problem Seeing a Specialist (Among Those Needing One)		
Big problem	4.1	(0.7)
Small problem	4.6	(0.8)
Not a problem	91.4	(1.0)
Made Appointment(s) for Routine Care in Past Six Months (Among Those Making Appointments)	62.2	(1.2)
How Often Got Routine Care Appointment as Soon as Wanted		
Never	1.2	(1.2)
Sometimes	5.4	(0.7)
Usually	14.4	(1.1)
Always	79.1	(1.3)
Had Condition Needing Doctor's Care Right Away in Last Six Months	25.9	(1.1)
How Often Got Care as Soon as Needed		
Never	3.3	(0.9)
Sometimes	3.1	(0.8)
Usually	9.3	(1.4)
Always	84.4	(1.8)
Change in Ease of Seeing a Doctor over Last Year or Two		
Gotten harder	6.9	(0.7)
Gotten easier	3.6	(0.5)
Stayed the same	89.6	(0.8)

Source: 2004 targeted survey of Medicare FFS beneficiaries conducted by MPR for CMS.
Note: Figures in parentheses indicate the standard errors associated with estimates to the left.

TABLE C.2

ADDITIONAL PHYSICIAN ACCESS MEASURES IN 11 TARGETED GEOGRAPHIC SITES, 2004

	Percentage of Medicare FFS Beneficiaries	
Relationship with Primary Care Doctor		
Have One Person Who is Personal Doctor or Nurse	90.4	(0.7)
Had the Same Personal Doctor Before Joining Medicare	47.6	(1.3)
Got a New Personal Doctor in the Past Six Months	11.0	(0.8)
Currently Looking for a New Doctor	4.5	(0.5)
Considering Changing to a New Doctor in Next 6 Months	4.3	(0.5)
Ability to Make Appointments and Access Health Care Services		
Called Doctor's Office in Past Six Months	37.8	(1.2)
How Often Got Help or Advice Needed (Among Those Who Called)?		
Never	2.6	(0.6)
Sometimes	5.4	(0.9)
Usually	13.8	(1.4)
Always	78.3	(1.7)
Needed Care, Tests, or Treatment in the Last 6 Months	55.4	(1.2)
How Much of a Problem to Get Care, Tests, or Treatment Believed Necessary in Last 6 Months (Among Those Needing Care, Tests or Treatment)?		
Big problem	3.5	(0.6)
Small problem	5.3	(0.7)
Not a problem	91.2	(0.9)
Unmet Needs or Delays		
Had Condition not Treated by Doctor in Past Six Months	6.8	(0.6)
Attempted to See Doctor for this Condition (Among Those With Condition)	31.2	(4.9)
Delayed or Put Off Care in Past Six Months	11.4	(0.8)

TABLE C.2 *(Continued)*

	Percentage of Medicare FFS Beneficiaries	
Satisfaction with Physician Access		
Rating of the Ease of Seeing a Primary Care Doctor		
Excellent/very good	68.5	(1.3)
Good	22.8	(1.2)
Fair/poor	8.8	(0.8)
Rating of Availability of Specialist Care		
Excellent/very good	71.0	(1.5)
Good	22.4	(1.3)
Fair/poor	6.6	(0.8)

Source: 2004 targeted survey of Medicare FFS beneficiaries conducted by MPR for CMS.
Note: Figures in parentheses indicate the standard errors associated with estimates to the left.

TABLE C.3

GEOGRAPHIC VARIATION IN ACCESS TO PHYSICIANS AMONG 11 TARGETED SITES, 2004

	Percentage of Medicare FFS Beneficiaries:									
	Currently Have One Person Who is Personal Doctor		Had Same Personal Doctor Before Joining Medicare		Had Problems Getting a Personal Doctor Since Joining Medicare		Needed Specialist in Past Six Months		Had Problems Seeing Specialist in Past Six Months Among Those Needing One	
Alaska (state)	77.2	(3.1)	50.6	(4.2)	15.9	(2.9)	40.3	(3.6)	19.5	(4.7)
Phoenix AZ	91.8	(2.0)	44.8	(4.0)	6.5	(1.9)	47.6	(3.8)	8.6	(3.0)
San Diego, CA	88.6	(2.4)	42.5	(3.9)	5.0	(1.6)	52.4	(3.7)	7.6	(2.9)
San Francisco, CA	94.2	(1.7)	56.9	(3.9)	2.1	(0.9)	48.6	(3.8)	6.6	(2.6)
Denver, CO	90.4	(2.2)	42.5	(4.1)	17.5	(3.0)	50.9	(3.9)	13.6	(4.2)
Tampa, FL	93.2	(2.0)	38.6	(3.9)	7.4	(2.2)	52.3	(4.0)	6.6	(2.7)
Springfield, MO	94.7	(1.7)	42.7	(4.0)	7.9	(2.2)	34.3	(3.7)	8.9	(3.6)
Las Vegas, NV	81.9	(2.8)	42.6	(4.0)	7.0	(1.9)	41.0	(3.6)	8.6	(3.0)
Brooklyn, NY	89.8	(2.4)	64.1	(4.0)	5.7	(1.8)	38.9	(3.9)	7.9	(3.3)
Ft. Worth, TX	91.1	(2.1)	51.8	(4.2)	15.0	(2.9)	43.0	(3.9)	7.1	(3.3)
Seattle WA	90.7	(2.3)	52.9	(4.2)	6.5	(2.0)	49.1	(3.9)	8.6	(3.0)
Median, Among 11 Sites	90.7	-	44.8	-	7.0	-	47.6	-	8.6	-
Lowest	77.2	-	38.6	-	2.1	-	34.3	-	6.6	-
Highest	94.7	-	64.1	-	17.5	-	52.4	-	19.5	-

Source: 2004 targeted survey of Medicare FFS beneficiaries conducted by MPR for CMS

Note: Figures in parentheses indicate the standard errors associated with estimates to the left.

TABLE C.4

GEOGRAPHIC VARIATION IN ABILITY TO GET ROUTINE AND URGENT CARE AND TRENDS IN EASE OF SEEING A DOCTOR AMONG 11 TARGETED SITES, 2004

	Percentage of Medicare FFS Beneficiaries:																	
	Called Doctor's Office in Past Six Months		Didn't Always Get Timely Help or Advice by Phone (Among Those Who Called)		Made Appointment for Routine Care in Past Six Months		Did Not Always Get Timely Routine Care Appointment (Among Those Making Appointments)		Had Condition Needing Urgent Care, Last Six Months		Did Not Always Get Timely Urgent Care (Among Those Needing It)		Seeing a Doctor in the Past Year or Two Has: Gotten Harder		Gotten Easier		Stayed the Same	
Alaska (state)	36.4	(3.6)	23.2	(5.2)	54.0	(3.7)	29.7	(4.7)	26.6	3.3	20.1	(5.8)	10.8	(2.4)	3.5	(1.3)	85.8	(2.7)
Phoenix, AZ	42.0	(3.8)	15.1	(4.0)	60.8	(3.7)	22.9	(4.0)	23.8	3.2	23.8	(6.5)	8.3	(2.1)	2.3	(1.1)	89.5	(2.4)
San Diego, CA	44.9	(3.7)	26.4	(5.1)	69.2	(3.5)	25.6	(4.0)	22.7	3.1	9.7	(4.7)	9.9	(2.4)	3.9	(1.3)	86.3	(2.6)
San Francisco, CA	34.8	(3.6)	21.6	(5.0)	66.4	(3.6)	13.0	(3.0)	30.5	3.5	14.4	(4.8)	3.9	(1.4)	2.2	(1.1)	93.8	(1.7)
Denver, CO	44.9	(3.9)	24.4	(5.1)	68.5	(3.6)	27.5	(4.4)	26.0	3.5	18.1	(6.3)	9.7	(2.5)	4.0	(1.5)	86.3	(2.8)
Tampa, FL	37.7	(3.8)	25.5	(5.6)	63.4	(3.8)	23.8	(4.2)	24.9	3.5	15.7	(5.6)	7.0	(2.2)	2.1	(1.1)	90.9	(2.4)
Springfield, MO	35.9	(3.7)	21.0	(5.4)	50.2	(3.9)	9.5	(3.0)	30.9	3.6	13.6	(4.8)	3.9	(1.5)	3.7	(1.5)	92.4	(2.1)
Las Vegas, NV	32.4	(3.4)	29.8	(5.9)	59.9	(3.6)	22.6	(4.0)	22.9	3.0	19.9	(6.0)	7.5	(2.0)	5.2	(1.7)	87.3	(2.5)
Brooklyn, NY	25.4	(3.5)	19.7	(6.2)	54.9	(4.0)	18.1	(4.1)	26.3	3.5	9.3	(4.4)	4.4	(2.7)	6.6	(2.1)	88.9	(2.6)
Ft. Worth, TX	33.5	(3.7)	24.2	(6.0)	59.6	(3.9)	20.7	(4.2)	24.5	3.4	3.6	(2.5)	8.2	(2.4)	4.6	(1.6)	87.3	(2.8)
Seattle, WA	40.4	(3.9)	17.5	(4.6)	69.7	(3.6)	16.7	(3.5)	29.2	3.6	21.6	(6.0)	3.0	(1.3)	2.5	(1.2)	94.6	(1.8)
Median, Among 11 Sites	36.4	-	23.2	-	60.8	-	22.6	-	26.0	-	15.7	-	7.5	-	3.7	-	88.9	-
Lowest	25.4	-	15.1	-	50.2	-	9.5	-	22.7	-	3.6	-	3.0	-	2.1	-	85.8	-
Highest	44.9	-	29.8	-	69.7	-	29.7	-	30.9	-	23.8	-	10.8	-	6.6	-	94.6	-

Source: 2004 targeted survey of Medicare FFS beneficiaries conducted by MPR for CMS.
Note: Figures in parentheses indicate the standard errors associated with estimates to the left.

TABLE C.5

GEOGRAPHIC VARIATION IN UNMET NEEDS, DELAYS IN CARE, AND SATISFACTION WITH PHYSICIAN ACCESS AMONG 11 SITES, 2004

	Percentage of Medicare FFS Beneficiaries:									
	Had Condition Not Treated by a Doctor in Past Six Months		Tried to See Doctor About Condition		Delayed Seeking Care in Past Six Months		Ease of Seeing Primary Care Physician is "Fair" or "Poor"		Availability of Specialists is "Fair" or "Poor"	
Alaska (state)	8.4	(2.1)	40.5	(15.3)	13.1	(2.5)	9.0	(2.4)	12.9	(3.4)
Phoenix AZ	4.7	(1.5)	37.6	(20.5)	12.1	(2.4)	4.6	(1.6)	6.3	(2.3)
San Diego, CA	7.6	(2.1)	22.7	(17.4)	9.7	(2.3)	12.1	(2.7)	6.9	(2.7)
San Francisco, CA	7.7	(1.9)	44.0	(13.3)	12.0	(2.4)	4.0	(1.6)	6.4	(2.2)
Denver, CO	8.5	(2.2)	46.5	(15.4)	15.2	(2.8)	6.8	(2.2)	7.0	(2.6)
Tampa, FL	5.0	(1.8)	28.9	(16.2)	13.3	(2.8)	5.9	(2.1)	5.1	(2.0)
Springfield, MO	7.6	(2.1)	27.9	(12.5)	8.9	(2.2)	8.2	(2.5)	12.2	(3.7)
Las Vegas, NV	6.5	(1.8)	5.4	(3.1)	10.7	(2.2)	16.1	(3.2)	7.8	(2.5)
Brooklyn, NY	9.2	(2.3)	64.3	(14.7)	13.5	(2.7)	15.6	(3.3)	6.5	(2.6)
Ft. Worth, TX	4.8	(1.6)	21.9	(15.6)	9.0	(2.1)	8.8	(2.4)	5.0	(2.3)
Seattle, WA	8.3	(2.2)	10.6	(8.8)	9.4	(2.3)	9.1	(2.5)	4.7	(2.1)
Median, Among 11 Sites	7.6	-	28.9	-	12.0	-	8.8	-	6.5	-
Lowest	4.7	-	5.4	-	8.9	-	4.0	-	4.7	-
Highest	9.2	-	64.3	-	15.2	-	16.1	-	12.9	-

Source: 2004 targeted survey of Medicare FFS beneficiaries conducted by MPR for CMS.

Note: Figures in parentheses indicate the standard errors associated with estimates to the left.

TABLE C.6

ACCESS TO PHYSICIAN MEASURES, ACCORDING TO BENEFICIARY CHARACTERISTICS IN 11 TARGETED SITES, 2004

	Percentage of Medicare FFS Beneficiaries:									
	Have a Personal Doctor		Had Same Personal Doctor Before Joining Medicare		Problems Finding A Personal Doctor You Are Happy With Since Joining Medicare		Needed Specialist in Past Six Months		Problems Seeing Specialist in Past Six Months (Among Those Needing One)	
Medicare FFS Enrollment Status										
Transitioning FFS Beneficiaries										
Disenrolled from M+C plan in last six months	83.1	(2.2)	18.6	(2.5)	13.0	(2.0)	53.0	(1.6)	15.8	(2.9)
Moved to area in last six months	86.0	(3.2)	42.0	(5.0)	11.3	(3.2)	45.7	(3.1)	9.6	(3.6)
Became eligible for Medicare last six months	85.1	(1.2)	82.4	(1.4)	8.9	(1.0)	42.8	(4.7)	13.6	(1.7)
Other FFS Beneficiaries	90.9	(0.8)	46.1	(1.4)	8.0	(0.7)	46.2	(1.3)	8.2	(1.1)
Health Status										
Health Status										
Excellent/very good/good	90.5	(0.8)	48.0	(1.5)	7.6	(0.8)	44.3	(1.4)	6.0	(1.0)
Fair/poor	91.0	(1.4)	46.6	(2.7)	9.3	(1.5)	52.3	(2.6)	14.9	(2.5)
Limits on Type of Work or Activities										
Yes	89.1	(1.1)	49.0	(2.4)	5.9	(1.5)	40.4	(2.3)	5.1	(2.2)
No	93.4	(1.0)	43.5	(1.7)	11.4	(0.8)	57.8	(1.6)	13.9	(1.2)
Limits on Moderate Activities, Such as Pushing a Vacuum Cleaner										
Yes	92.7	(1.1)	43.8	(2.2)	9.6	(1.3)	53.4	(2.1)	12.7	(1.9)
No	89.3	(0.9)	48.7	(1.7)	7.3	(0.8)	42.7	(1.6)	6.0	(1.2)
Limits on Climbing Several Flights of Stairs										
Yes	92.3	(1.1)	41.9	(2.1)	9.6	(1.2)	52.9	(2.1)	13.6	(1.9)
No	89.3	(0.9)	51.5	(1.7)	7.3	(0.8)	42.3	(1.6)	5.2	(1.1)
Accomplished Less than Desired because of Health										
Yes	93.0	(1.1)	42.9	(2.4)	11.6	(1.5)	59.1	(2.2)	13.7	(2.1)
No	89.6	(1.0)	49.5	(1.8)	5.7	(0.8)	39.8	(1.6)	4.9	(1.2)
Socioeconomic										
Annual Income										
< $10,000	87.1	(2.5)	44.7	(4.0)	10.8	(2.5)	41.5	(3.7)	13.5	(4.2)
$10,000-$25,000	90.2	(1.3)	42.5	(2.5)	9.9	(1.5)	42.4	(2.4)	9.8	(2.1)
> $25,000	92.4	(0.9)	52.0	(1.9)	7.0	(0.9)	51.5	(1.9)	7.2	(1.3)

TABLE C.6 (*continued*)

	Percentage of Medicare FFS Beneficiaries:									
	Have a Personal Doctor		Had Same Personal Doctor Before Joining Medicare		Problems Finding A Personal Doctor You Are Happy With Since Joining Medicare		Needed Specialist in Past Six Months		Problems Seeing Specialist in Past Six Months (Among Those Needing One)	
Highest Grade Completed										
Not high school graduate	88.1	(2.0)	39.8	(3.5)	10.0	(2.1)	35.0	(3.3)	6.9	(2.7)
High school graduate	89.5	(1.4)	45.4	(2.4)	6.8	(1.1)	40.2	(2.2)	6.7	(1.7)
Some college or more	92.2	(1.0)	50.2	(2.0)	7.6	(1.0)	53.9	(1.9)	9.6	(1.6)
Hispanic										
Yes	85.0	(3.6)	42.5	(5.6)	7.2	(2.5)	45.5	(5.4)	5.3	(2.4)
No	90.6	(0.7)	47.9	(1.4)	8.1	(0.7)	46.5	(1.3)	8.7	(1.1)
Race										
White	91.7	(0.7)	47.0	(1.4)	7.7	(0.7)	47.5	(1.4)	7.4	(1.0)
Black	82.0	(3.8)	63.4	(5.4)	8.4	(2.8)	31.1	(4.7)	14.5	(6.2)
Other	84.6	(3.7)	48.3	(5.6)	8.7	(2.6)	43.6	(5.2)	20.4	(6.5)
Health Insurance										
Medicare Supplemental Coverage										
Yes	93.1	(2.7)	47.3	(3.4)	7.7	(1.9)	48.5	(2.9)	7.4	(4.1)
No	77.4	(0.7)	50.0	(1.4)	10.3	(0.7)	34.7	(1.4)	18.0	(1.0)
Demographic										
Gender										
Male	88.3	(1.2)	50.3	(2.0)	7.7	(1.0)	46.4	(1.9)	9.2	(1.6)
Female	92.1	(0.9)	45.5	(1.7)	8.7	(0.9)	46.8	(1.7)	8.2	(1.4)
Age										
Under 65	85.4	(2.6)	59.2	(4.1)	12.8	(2.7)	50.0	(3.8)	32.5	(5.2)
65-69	88.1	(1.4)	71.1	(2.3)	8.6	(1.4)	47.0	(2.3)	9.7	(2.2)
70-74	90.9	(1.5)	48.6	(2.9)	7.4	(1.4)	48.4	(2.7)	4.1	(1.5)
75-79	92.8	(1.5)	36.0	(3.1)	7.7	(1.5)	47.4	(3.1)	2.7	(1.3)
80-84	93.4	(1.7)	31.0	(3.4)	6.7	(1.6)	39.4	(3.4)	5.4	(2.3)
85+	91.5	(2.1)	23.3	(3.3)	7.4	(2.0)	42.9	(3.7)	5.8	(2.7)
Health Care Use										
Hospitalized in Past Year										
Yes	92.8	(1.4)	43.4	(3.1)	9.3	(1.7)	62.6	(2.9)	8.3	(2.0)
No	90.0	(0.8)	48.5	(1.5)	7.8	(0.7)	42.9	(1.4)	8.8	(1.2)
Number of Doctor Visits in Last Six Months										
None	74.3	(2.4)	51.8	(3.3)	8.0	(1.5)	18.7	(2.3)	9.2	(3.5)
One to four	93.9	(0.8)	46.6	(1.7)	7.8	(0.9)	46.4	(1.6)	7.7	(1.3)
Five to nine	96.0	(1.2)	45.8	(3.4)	8.6	(2.0)	65.3	(3.2)	8.8	(2.4)
Ten or more	95.0	(2.1)	41.2	(5.0)	11.3	(3.0)	80.4	(3.8)	14.1	(3.7)

TABLE C.6 (*continued*)

	Percentage of Medicare FFS Beneficiaries:									
	Have a Personal Doctor		Had Same Personal Doctor Before Joining Medicare		Problems Finding A Personal Doctor You Are Happy With Since Joining Medicare		Needed Specialist in Past Six Months		Problems Seeing Specialist in Past Six Months (Among Those Needing One)	
Number of ER Visits in Past Six Months										
None	90.3	(0.8)	48.3	(1.4)	7.4	(0.7)	43.1	(1.3)	7.8	(1.2)
One	94.5	(1.8)	42.1	(4.2)	13.7	(2.9)	62.5	(4.0)	10.1	(3.0)
More than one	84.4	(4.3)	41.6	(6.5)	11.3	(3.8)	72.7	(5.4)	17.5	(5.7)
Combined Characteristics										
Transitioning beneficiaries who are:[a]										
Disabled (age < 65)	86.0	(3.1)	57.8	(4.8)	12.2	(3.2)	49.1	(4.5)	34.4	(6.3)
In poor or fair health	91.5	(1.6)	45.6	(2.9)	8.6	(1.6)	51.8	(2.8)	14.2	(2.7)
Low income (< $10,000)	78.2	(3.2)	57.6	(4.5)	14.4	(2.9)	51.1	(3.9)	16.7	(4.3)
Beneficiaries with no supplemental coverage who are										
In transition	72.0	(2.6)	55.4	(3.3)	14.0	(2.1)	36.5	(2.8)	24.2	(4.2)
Disabled (age < 65)	80.7	(4.5)	52.4	(6.7)	15.0	(4.7)	45.4	(6.1)	27.4	(8.2)
Poor or fair health	76.6	(4.3)	51.7	(5.6)	10.7	(3.2)	45.0	(5.0)	21.2	(6.1)
Low household income (< $10,000)	75.3	(5.2)	51.1	(6.7)	12.3	(4.4)	33.9	(5.6)	17.9	(7.5)
Total	90.4	(0.7)	47.6	(1.3)	8.2	(0.7)	46.1	(1.2)	8.6	(1.0)

Source: 2004 targeted survey of Medicare FFS beneficiaries conducted by MPR for CMS

Note: Figures in parentheses indicate the standard errors associated with estimates to the left.

TABLE C.7

ABILITY TO GET MEDICAL APPOINTMENTS AND ACCESS TO SERVICES
ACCORDING TO BENEFICIARY CHARACTERISTICS IN 11 TARGETED SITES, 2004

	Percentage of Medicare FFS Beneficiaries:													
									Seeing a Doctor in the Past Year or Two Has:					
	Made Appointment for Routine Care in Past Six Months		Did Not Always Get Timely Routine Care Appointment (Among Those Making One)		Had Condition Needing Urgent Care, Last Six Months		Did Not Always Get Timely Urgent Care (Among Those Needing It)		Gotten Harder		Gotten Easier		Stayed the Same	
Medicare FFS Enrollment Status														
Transitioning FFS Beneficiaries														
Disenrolled from M+C Plan in Last Six Months	70.3	(2.7)	25.4	(3.4)	35.4	(3.0)	23.1	(4.7)	7.8	(1.5)	7.1	(1.7)	85.1	(2.2)
Moved to Area in Last Six Months	66.5	(4.3)	31.6	(5.6)	31.5	(4.5)	16.1	(6.6)	6.3	(2.2)	11.5	(3.3)	82.2	(3.7)
Became Eligible for Medicare Last Six Months	59.6	(1.6)	27.2	(1.9)	26.2	(1.4)	21.3	(2.7)	8.0	(0.9)	5.1	(0.7)	87.0	(1.1)
Other FFS Beneficiaries	62.2	(1.3)	20.4	(1.4)	25.6	(1.2)	15.1	(1.9)	6.8	(0.7)	3.3	(0.5)	89.9	(0.8)
Health Status														
Health Status														
Excellent/very good/good	60.5	(1.4)	20.2	(1.5)	22.2	(1.2)	14.7	(2.2)	5.5	(0.7)	3.5	(0.5)	91.0	(0.9)
Fair/poor	67.9	(2.4)	22.1	(2.5)	37.8	(2.5)	17.2	(3.0)	11.3	(1.7)	3.7	(0.9)	65.1	(1.8)
Limits on Types of Work or Activities														
Yes	70.9	(2.1)	24.9	(2.4)	40.1	(2.2)	17.2	(2.7)	11.0	(1.5)	3.3	(0.7)	85.7	(1.6)
No	57.1	(1.6)	15.6	(1.6)	17.2	(1.2)	9.0	(2.2)	4.1	(0.7)	3.9	(0.6)	92.0	(0.9)
Limits on Moderate Activities, Such as Pushing a Vacuum														
Yes	70.4	(2.0)	23.8	(2.1)	37.7	(2.1)	16.9	(2.6)	10.1	(1.4)	3.9	(0.8)	86.0	(1.5)
No	58.1	(1.5)	19.1	(1.6)	19.9	(1.2)	14.7	(2.5)	5.2	(0.7)	3.4	(0.6)	91.4	(0.9)
Limits on Climbing Several Flights of Stairs														
Yes	67.7	(2.0)	25.5	(2.2)	37.1	(2.0)	16.8	(2.6)	10.5	(1.4)	3.2	(0.7)	86.4	(1.5)
No	59.4	(1.6)	17.7	(1.6)	19.4	(1.2)	14.4	(2.5)	4.8	(0.7)	3.8	(0.6)	91.5	(0.9)
Accomplished Less than Desired Because of Health														
Yes	71.2	(2.1)	26.2	(2.4)	38.0	(2.2)	19.0	(2.9)	10.9	(1.5)	2.6	(0.6)	86.5	(1.6)
No	56.6	(1.7)	14.5	(1.6)	17.9	(1.3)	7.9	(2.0)	4.1	(0.7)	4.1	(0.7)	91.8	(0.9)

TABLE C.7 (*continued*)

	Percentage of Medicare FFS Beneficiaries:													
									Seeing a Doctor in the Past Year or Two Has:					
	Made Appointment for Routine Care in Past Six Months		Did Not Always Get Timely Routine Care Appointment (Among Those Making One)		Had Condition Needing Urgent Care, Last Six Months		Did Not Always Get Timely Urgent Care (Among Those Needing It)		Gotten Harder		Gotten Easier		Stayed the Same	
Socioeconomic														
Annual Income														
< $10,000	54.9	(3.8)	24.5	(4.5)	21.7	(3.4)	20.5	(6.0)	7.1	(2.2)	4.0	(1.4)	88.9	(2.5)
$10,000-$25,000	58.4	(2.4)	21.6	(2.7)	29.6	(2.2)	17.7	(3.5)	9.3	(1.5)	3.2	(0.8)	87.5	(1.6)
> $25,000	68.9	(1.7)	20.5	(1.7)	25.6	(1.6)	13.3	(2.4)	5.4	(0.9)	3.2	(0.6)	91.4	(1.0)
Highest Grade Completed														
Not high school graduate	51.6	(3.4)	12.0	(2.9)	26.7	(3.0)	12.6	(4.4)	3.9	(1.2)	4.6	(1.3)	91.5	(1.8)
High school graduate	54.2	(2.3)	15.5	(2.2)	22.8	(1.9)	12.4	(3.1)	5.2	(1.0)	4.1	(0.8)	90.7	(1.3)
Some college or more	70.1	(1.7)	23.0	(1.9)	25.4	(1.6)	15.1	(2.7)	7.6	(1.0)	3.1	(0.7)	89.3	(1.2)
Hispanic														
Yes	55.6	(5.4)	11.2	(4.0)	29.2	(4.9)	7.2	(3.7)	5.0	(2.1)	9.3	(3.1)	86.7	(3.6)
No	62.9	(1.3)	21.1	(1.3)	25.7	(1.1)	16.2	(1.9)	6.9	(0.7)	3.3	(0.5)	89.8	(0.8)
Race														
White	63.1	(1.3)	20.4	(1.4)	25.1	(1.2)	15.8	(2.0)	6.3	(0.7)	3.2	(0.5)	90.5	(0.8)
Black	45.9	(5.0)	27.5	(6.6)	31.5	(4.7)	12.1	(5.1)	9.8	(2.9)	2.8	(1.7)	87.4	(3.3)
Other	67.4	(4.7)	21.7	(4.9)	30.8	(4.9)	19.4	(7.1)	7.3	(2.8)	4.7	(2.1)	88.0	(3.4)
Health Insurance														
Medicare Supplemental Coverage														
Yes	64.3	(1.3)	21.2	(1.4)	26.8	(1.2)	15.3	(1.9)	6.1	(0.7)	3.0	(0.5)	90.9	(0.8)
No	51.1	(3.0)	18.1	(3.2)	21.0	(2.4)	18.5	(4.7)	10.6	(2.1)	6.4	(1.5)	83.1	(2.5)
Demographic														
Gender														
Male	59.8	(1.8)	20.2	(1.9)	23.7	(1.6)	14.1	(2.5)	5.8	(0.9)	3.7	(0.7)	90.5	(1.1)
Female	64.0	(1.6)	21.7	(1.7)	27.6	(1.5)	16.4	(2.4)	7.7	(0.9)	3.5	(0.6)	88.8	(1.1)

TABLE C.7 (*continued*)

	Percentage of Medicare FFS Beneficiaries:													
	Made Appointment for Routine Care in Past Six Months		Did Not Always Get Timely Routine Care Appointment (Among Those Making One)		Had Condition Needing Urgent Care, Last Six Months		Did Not Always Get Timely Urgent Care (Among Those Needing It)		Seeing a Doctor in the Past Year or Two Has:					
									Gotten Harder		Gotten Easier		Stayed the Same	
Age														
Under 65	65.0	(3.6)	27.9	(4.2)	37.5	(3.7)	30.5	(5.4)	19.3	(3.3)	6.3	(1.9)	74.4	(3.6)
65-69	64.8	(2.2)	23.9	(2.5)	22.9	(1.9)	16.0	(4.0)	6.7	(1.1)	3.1	(0.9)	89.2	(1.4)
70-74	63.5	(2.6)	21.4	(2.9)	25.3	(2.4)	16.1	(4.4)	3.9	(1.1)	4.0	(1.1)	92.2	(1.5)
75-79	62.8	(3.0)	19.2	(3.0)	20.4	(2.4)	11.9	(4.4)	6.7	(1.7)	2.0	(0.8)	91.4	(1.8)
80-84	51.6	(3.5)	17.7	(3.6)	26.3	(3.0)	5.5	(3.0)	5.4	(1.6)	1.4	(0.7)	93.3	(1.7)
85+	63.2	(3.7)	13.3	(3.4)	31.5	(3.6)	13.1	(4.7)	4.2	(1.6)	4.4	(1.4)	91.4	(2.1)
Health Care Use														
Hospitalized in Past Year														
Yes	75.7	(2.6)	22.9	(2.9)	54.9	(3.0)	9.2	(2.1)	8.7	(1.8)	4.1	(1.0)	87.2	(2.0)
No	59.4	(1.4)	20.0	(1.4)	20.0	(1.1)	19.2	(2.5)	6.5	(0.7)	3.4	(0.5)	90.1	(0.8)
Number of Doctor Visits in Last Six Months														
None	17.8	(2.2)	20.5	(5.5)	7.8	(1.5)	23.0	(9.4)	4.1	(1.2)	1.7	(0.7)	94.2	(1.4)
One to four	69.6	(1.5)	19.2	(1.6)	25.1	(1.4)	14.5	(2.3)	6.3	(0.8)	3.8	(0.6)	89.9	(1.0)
Five to nine	81.1	(2.7)	22.6	(3.1)	36.0	(3.2)	15.9	(4.1)	8.8	(1.9)	5.6	(1.6)	85.6	(2.4)
Ten or more	84.4	(3.6)	32.7	(5.0)	49.6	(4.9)	15.0	(4.7)	12.6	(3.2)	2.6	(1.0)	84.9	(3.4)
Number of ER Visits in Past Six Months														
None	60.2	(1.3)	20.8	(1.4)	NA	-	15.2	(2.6)	6.3	(0.8)	3.3	(0.5)	90.4	(0.8)
One	73.6	(3.6)	20.3	(3.7)	NA	-	15.2	(3.0)	11.2	(3.2)	6.0	(1.8)	82.9	(3.2)
More than one	79.3	(5.1)	28.9	(6.0)	NA	-	16.1	(4.3)	9.6	(3.7)	2.9	(1.7)	87.5	(3.7)
Combined Characteristics														
Transitioning Beneficiaries Who Are:[a]														
Disabled (age < 65)	65.1	(4.3)	26.7	(5.0)	36.6	(4.3)	29.5	(6.5)	21.0	(4.0)	6.1	(2.2)	73.0	(4.2)
In poor or fair health	67.6	(2.7)	20.9	(2.7)	37.0	(2.7)	15.7	(3.3)	11.1	(1.8)	3.2	(0.9)	85.7	(2.0)
Low income (< $10,000)	56.9	(3.8)	23.2	(4.3)	37.8	(3.9)	19.6	(5.4)	3.5	(1.3)	6.4	(1.9)	90.1	(2.2)

TABLE C.7 (*continued*)

	Percentage of Medicare FFS Beneficiaries:													
									Seeing a Doctor in the Past Year or Two Has:					
	Made Appointment for Routine Care in Past Six Months		Did Not Always Get Timely Routine Care Appointment (Among Those Making One)		Had Condition Needing Urgent Care, Last Six Months		Did Not Always Get Timely Urgent Care (Among Those Needing It)		Gotten Harder		Gotten Easier		Stayed the Same	
Beneficiaries With No Supplemental Coverage Who Are														
In transition	49.3	(2.3)	23.0	(3.6)	26.4	(2.5)	29.0	(5.3)	8.3	(1.6)	7.3	(1.4)	84.4	(2.1)
Disabled (age < 65)	58.5	(5.9)	21.9	(6.5)	33.2	(5.7)	33.0	(9.2)	17.0	(5.2)	9.8	(3.6)	73.2	(5.8)
Poor or fair health	58.5	(5.0)	13.3	(3.7)	30.0	(4.5)	19.2	(5.9)	13.6	(3.7)	6.6	(2.4)	79.8	(4.2)
Low household income (< $10,000)	44.1	(5.9)	29.9	(8.2)	23.6	(5.1)	14.8	(7.8)	7.0	(3.9)	7.0	(3.0)	86.0	(4.7)
Total	**62.2**	**(1.2)**	**21.0**	**(1.3)**	**25.9**	**(1.1)**	**15.6**	**(1.8)**	**6.9**	**(2.1)**	**3.6**	**(1.8)**	**89.6**	**(2.0)**

Source: 2004 targeted survey of Medicare FFS beneficiaries conducted by MPR for CMS.

Note: Figures in parentheses indicate the standard errors associated with estimates to the left.

TABLE C.8

UNMET NEEDS, DELAYS IN CARE, AND SATISFACTION WITH PHYSICIAN ACCESS
ACCORDING TO BENEFICIARY CHARACTERISTICS IN 11 TARGETED SITES, 2004

	Percentage of Medicare FFS beneficiaries:											
	Got a New Doctor in the Past Six Months		Had condition Not Treated by a Doctor in Past Six Months		Tried to See Doctor About Condition (Among Those With a Condition)		Delayed Seeking Care in Past Six Months		Ease of Seeing Primary Care Physician is "Fair" or "Poor"		Availability of Specialists is "Fair" or "Poor"	
Medicare FFS Enrollment Status												
Transitioning FFS beneficiaries												
Disenrolled from M+C plan in last six months	36.5	(3.0)	11.0	(2.0)	30.4	(10.0)	14.7	(2.3)	12.0	(2.4)	7.2	(1.2)
Moved to area in last six months	20.8	(3.8)	10.9	(2.9)	27.7	(11.8)	11.6	(3.0)	8.9	(2.9)	13.0	(2.0)
Became eligible for Medicare last six months	12.0	(1.1)	8.7	(0.9)	40.8	(5.8)	13.7	(1.1)	10.3	(1.1)	8.9	(3.5)
Other FFS beneficiaries	10.4	(0.8)	6.6	(0.7)	30.7	(6.5)	11.2	(0.8)	8.6	(0.8)	6.4	(0.9)
Health Status												
Health Status												
Excellent/very good/good	13.4	(0.9)	4.2	(0.5)	23.7	(5.9)	8.5	(0.8)	6.8	(0.9)	4.3	(0.8)
Fair/poor	10.2	(1.6)	15.7	(1.9)	38.4	(7.5)	20.4	(2.1)	14.8	(1.9)	12.6	(2.1)
Limits on Type of Work or Activities												
Yes	12.8	(1.4)	9.7	(1.3)	40.4	(7.0)	18.5	(1.8)	14.8	(1.7)	10.9	(1.8)
No	9.5	(1.0)	3.9	(0.6)	20.1	(6.1)	6.0	(0.7)	5.4	(0.8)	3.6	(0.8)
Limits on Moderate Activities, Such as Pushing a Vacuum Cleaner												
Yes	13.1	(1.4)	10.8	(1.3)	32.9	(6.8)	19.0	(1.7)	12.0	(1.5)	11.1	(1.7)
No	9.8	(0.9)	4.9	(0.7)	29.2	(6.8)	7.6	(0.8)	6.9	(0.9)	4.1	(0.8)
Limits on Climbing Several Flights of Stairs												
Yes	13.6	(1.4)	10.1	(1.2)	34.7	(7.1)	17.2	(1.6)	11.4	(1.4)	10.9	(1.6)
No	9.3	(0.9)	4.9	(0.6)	24.7	(6.4)	8.1	(0.8)	7.2	(0.9)	4.0	(0.8)

TABLE C.8 (*continued*)

	Percentage of Medicare FFS beneficiaries:											
	Got a New Doctor in the Past Six Months		Had condition Not Treated by a Doctor in Past Six Months		Tried to See Doctor About Condition (Among Those With a Condition)		Delayed Seeking Care in Past Six Months		Ease of Seeing Primary Care Physician is "Fair" or "Poor"		Availability of Specialists is "Fair" or "Poor"	
Accomplished Less Than Desired Because of Health												
Yes	12.1	(1.4)	10.0	(1.3)	37.4	(6.7)	18.9	(1.8)	14.6	(1.7)	10.9	(1.8)
No	9.4	(1.0)	3.7	(0.6)	22.8	(6.5)	5.6	(0.7)	5.1	(0.8)	3.7	(0.8)
Socioeconomic												
Annual Income												
< $10,000	11.7	(2.3)	11.4	(2.4)	24.8	(10.2)	14.6	(2.6)	15.0	(3.0)	13.1	(3.2)
$10,000-$25,000	12.6	(1.6)	9.3	(1.4)	39.5	(8.7)	16.3	(1.8)	12.8	(1.8)	8.9	(1.8)
> $25,000	10.4	(1.1)	5.2	(0.8)	22.4	(7.6)	9.2	(1.0)	5.3	(0.9)	4.0	(0.9)
Highest Grade Completed												
Not high school graduate	10.6	(2.1)	6.3	(1.5)	31.9	(11.4)	10.6	(2.1)	12.1	(2.4)	6.7	(2.1)
High school graduate	9.6	(1.3)	6.3	(1.1)	24.2	(7.7)	8.3	(1.3)	6.9	(1.2)	4.5	(1.2)
Some college or more	11.2	(1.2)	5.1	(0.8)	36.4	(7.5)	11.3	(1.2)	8.5	(1.1)	7.0	(1.9)
Hispanic												
Yes	10.6	(3.6)	7.1	(0.7)	30.4	(11.8)	11.7	(2.6)	8.5	(3.5)	6.5	(3.4)
No	16.0	(0.8)	2.8	(0.7)	44.1	(5.0)	8.1	(0.8)	8.8	(0.8)	7.6	(0.8)
Race												
White	10.7	(0.8)	6.3	(0.6)	25.6	(5.3)	11.7	(0.9)	8.1	(0.8)	5.8	(0.8)
Black	8.8	(3.0)	12.3	(3.2)	49.8	(14.9)	9.5	(2.7)	12.7	(3.5)	10.1	(3.6)
Other	14.2	(3.6)	6.8	(2.3)	36.4	(18.3)	9.9	(2.8)	11.4	(3.5)	15.0	4.6)
Health insurance												
Medicare Supplemental Coverage												
Yes	10.6	(0.8)	5.8	(0.6)	34.7	(6.1)	10.7	(0.8)	8.4	(0.8)	5.8	(0.8)
No	12.8	(2.0)	12.5	(2.0)	23.0	(7.0)	15.4	(2.2)	10.2	(2.2)	11.4	(2.7)

TABLE C.8 (*continued*)

	Percentage of Medicare FFS beneficiaries:											
	Got a New Doctor in the Past Six Months		Had condition Not Treated by a Doctor in Past Six Months		Tried to See Doctor About Condition (Among Those With a Condition)		Delayed Seeking Care in Past Six Months		Ease of Seeing Primary Care Physician is "Fair" or "Poor"		Availability of Specialists is "Fair" or "Poor"	
Demographic												
Gender												
Male	10.1	(1.3)	6.5	(0.9)	27.6	7.2	9.9	(1.1)	8.0	(1.1)	4.8	(1.0)
Female	11.5	(1.0)	7.1	(0.8)	33.7	6.5	12.7	(1.1)	9.5	(1.1)	8.1	(1.2)
Age												
Under 65	12.5	(2.4)	20.7	(3.1)	49.5	(9.9)	24.7	(3.3)	19.2	(4.2)	19.5	(3.9)
65-69	11.0	(1.4)	6.8	(1.1)	23.9	(7.7)	9.4	(1.3)	6.9	(2.3)	2.6	(0.7)
70-74	10.0	(1.6)	4.3	(1.0)	10.8	(5.9)	9.4	(1.6)	7.6	(2.8)	7.3	(1.8)
75-79	12.2	(2.0)	5.6	(1.4)	32.6	(16.2)	13.2	(2.2)	5.1	(3.0)	5.3	(1.7)
80-84	8.4	(1.9)	4.4	(1.4)	39.0	(15.7)	7.6	(1.7)	12.4	(3.7)	6.0	(2.1)
85+	12.5	(2.6)	4.5	(1.6)	1.0	(1.1)	10.1	(2.3)	9.1	(3.8)	6.6	(2.8)
Health care use												
Hospitalized in Past Year	13.6	(1.9)	6.9	(1.5)	21.8	(9.5)	14.2	(2.1)	13.1	(2.1)	9.4	(2.0)
Number of Doctor Visits in Last Six Months												
None	4.7	(1.1)	6.6	(1.3)	13.2	(7.9)	5.7	(1.3)	-		-	
One to four	10.8	(1.0)	6.4	(0.8)	30.8	(6.8)	11.3	(1.0)	7.8	(0.9)	(6.5)	(1.0)
Five to nine	15.8	(2.4)	8.7	(1.8)	55.3	(11.2)	16.4	(2.6)	12.0	(2.1)	(6.4)	(1.6)
Ten or more	21.9	(4.1)	4.5	(1.8)	17.4	(10.6)	15.8	(3.5)	11.0	(2.9)	(8.4)	(2.7)
Number of ER Visits in past Six Months												
None	10.3	(0.8)	6.0	(0.6)	28.6	(5.5)	10.7	(0.8)	8.3	(0.8)	(5.2)	(0.8)
One	14.5	(2.9)	8.9	(2.3)	28.0	(12.1)	11.5	(2.7)	10.4	(2.6)	(9.9)	(3.1)
More than one	16.5	(4.4)	16.8	(4.5)	63.2	(16.7)	18.4	(4.5)	15.4	(4.3)	(23.1)	(6.2)

TABLE C.8 (*continued*)

	Percentage of Medicare FFS beneficiaries:											
	Got a New Doctor in the Past Six Months		Had condition Not Treated by a Doctor in Past Six Months		Tried to See Doctor About Condition (Among Those With a Condition)		Delayed Seeking Care in Past Six Months		Ease of Seeing Primary Care Physician is "Fair" or "Poor"		Availability of Specialists is "Fair" or "Poor"	
Combined Characteristics												
Transitioning beneficiaries who are												
Disabled (age < 65)	11.2	(2.8)	21.2	(3.7)	51.1	(11.8)	24.7	(3.9)	18.2	(3.9)	20.1	(4.7)
In poor or fair health	12.3	(1.8)	15.2	(2.1)	37.8	(8.6)	20.2	(2.3)	14.2	(2.0)	12.2	(2.2)
Low income (< $10,000)	20.9	(3.3)	15.7	(2.8)	41.8	(10.9)	22.9	(3.4)	16.7	(3.3)	15.0	(3.8)
Beneficiaries with no supplemental coverage who are												
In transition	20.4	(2.4)	15.4	(2.0)	30.5	(6.8)	18.2	(2.2)	16.1	(2.5)	11.7	(2.5)
Disabled (age < 65)	13.9	(4.2)	22.0	(4.8)	14.5	(7.4)	30.0	(5.6)	18.3	(5.4)	13.1	(5.3)
Poor or fair health	17.0	(3.7)	23.6	(4.2)	21.4	(8.7)	25.4	(4.5)	14.0	(3.7)	16.5	(4.9)
Low household income (< $10,000)	12.2	(3.5)	14.3	(4.3)	15.4	(11.1)	15.9	(4.6)	17.0	(5.7)	10.1	(4.2)
Total	11.0	(0.8)	6.1	(0.6)	31.2	(4.9)	11.4	(0.8)	8.8	(1.3)	6.6	1.4)

Source: 2004 targeted survey of Medicare FFS beneficiaries conducted by MPR for CMS

Note: Figures in parentheses indicate the standard errors associated with estimates to the left.

TABLE C.9

REASONS FOR PHYSICIAN ACCESS PROBLEMS IN 11 TARGETED GEOGRAPHIC SITES, 2004

	Percentage of Medicare FFS Beneficiaries	
Access to Primary Care and Specialists		
Percentage Without a Personal Doctor	9.6	(0.7)
Reasons For Not Having a Personal Doctor (Among Those Without One)		
Medicare physician participation reasons		
Doctor stopped taking Medicare	1.3	(0.7)
Doctor does not accept Medicare assignment	2.1	(1.0)
New to Medicare and previous doctor doesn't participate	0.5	(0.3)
Other reasons		
Have more than one doctor or nurse	21.1	(3.3)
Doctor died/moved from area/retired	9.6	(2.2)
Didn't like doctor	11.8	(2.5)
New to the area	8.1	(2.0)
Had difficulty getting appointment with old doctor	2.9	(1.4)
Left Medicare HMO and couldn't keep doctor	0.1	(0.1)
Healthy/Don’t need a doctor	29.0	(3.6)
Go to VA hosp./Military Clinic	0.0	(0.0)
Other[a]	15.1	(2.7)
Percentage who got a new doctor in past 6 months	11.0	(0.8)
Reasons For Getting a New Doctor (Among Those Who Got One)		
Medicare physician participation reasons		
Doctor charged more than Medicare would pay	1.5	(0.9)
New to Medicare and previous doctor wouldn't participate	1.8	(0.9)
Old doctor stopped taking Medicare	0.1	(0.1)
Other reasons		
Old doctor died/moved from area/retired	23.9	(3.5)
New to area	12.9	(2.3)
Didn't like doctor	10.0	(2.4)
Old doctor was not conveniently located	8.0	(2.1)
Had difficulty getting appointment with old doctor	1.9	(0.9)
Left Medicare HMO and couldn't keep doctor	2.4	(1.3)
Needed a specialist	25.6	(3.6)
Other[a]	20.7	(3.2)

TABLE C.9 (*continued*)

	Percentage of Medicare FFS Beneficiaries	
Percentage with Problems Getting Doctor Since Joining Medicare	8.2	(0.7)
Reasons for Problems Getting a Doctor Since Joining Medicare		
Medicare physician participation reasons		
Could not find doctor accepting Medicare at all	21.3	(3.9)
Could not find doctor taking new Medicare patients	14.9	(3.3)
Could not find doctor accepting Medicare assignment	6.4	(2.3)
Other reasons		
Couldn't get a good recommendation or referral	13.6	(3.3)
Could not find doctor taking any new patients	6.1	(2.1)
Wasn't sure where to look	6.0	(2.3)
There were very few doctors in my area	16.6	(3.8)
Could not afford what doctor wanted to charge	8.8	(3.1)
Found doctor(s), but appointments too hard to get	11.2	(3.0)
Other[a]	25.9	(4.1)
Percentage Currently Looking for a New Doctor	4.5	(0.5)
Reasons Unable to Find a New Doctor (Among Those Currently Looking)		
Medicare physician participation reasons		
Doctor wasn't taking new Medicare patients	5.7	(2.6)
Could not find doctor accepting Medicare at all	8.1	(3.0)
Could not find doctor accepting Medicare assignment	2.5	(2.2)
Other reasons		
Just started looking	45.5	(5.9)
Not sure where to look	16.4	(4.3)
Can't get a good recommendation	12.5	(4.0)
Cannot afford what doctors charge	4.8	(2.6)
There are few doctors in my area	8.1	(3.0)
Doctor wasn't taking any new patients	0.3	(0.2)
Found doctor(s), but appointments too hard to get	3.8	(2.6)
Other[a]	16.8	(4.3)
Percentage Considering Changing Doctor in Next 6 Months	4.3	(0.5)
Reasons for Considering a Change in Doctors (Among Those Considering A Change)		
Medicare physician participation reasons		
My doctor is dropping Medicare	0.3	(0.2)
My doctor charges more than Medicare pays	3.9	(3.1)
Other reasons		
My doctor is too far away or inconvenient	19.7	(5.4)
Dissatisfied with the care received	26.9	(6.1)
Current doctor is planning to retire or leave the area	31.8	(6.9)
Difficult to get appointment with my doctor	2.9	(2.5)
Respondent is moving	8.1	(4.2)
Other[a]	12.2	(3.9)

TABLE C.9 (*continued*)

	Percentage of Medicare FFS Beneficiaries	
Percentage with Problem Seeing a Specialist in Last 6 Months (Among Those Needing One)	8.6	(1.0)
Reasons for Problems Seeing a Specialist (Among Those With Problems)		
Medicare physician participation reasons		
Couldn't find a doctor taking new Medicare patients	11.9	(3.8)
Couldn't find a doctor accepting Medicare at all	19.2	(5.0)
Couldn't find a doctor accepting Medicare assignment	3.7	(1.9)
Other reasons		
Found doctor, but appointments were too hard to get	44.6	(6.3)
Couldn't find a doctor taking any new patients	1.4	(0.7)
Can't get a good recommendation or referral	10.1	(3.7)
Couldn't afford what the doctor wanted to charge	7.6	(3.2)
Not sure where/how to look	2.3	(2.0)
Few doctors in my area	13.3	(4.0)
Other[a]	18.0	(4.6)
Ability to Get Appointments and Access to Services		
Percentage Not Always Getting Timely Routine Care Appointments in Last 6 Months (Among Those Making Appointments)	20.1	(1.3)
Reasons Not Always Getting Timely Routine Care (Among Those With Problems)		
Doctor did not have appointment available	64.9	(3.8)
Doctor had an appointment but not at a convenient time	31.3	(3.7)
Doctor I wanted to see was away/out of town	4.0	(1.6)
Did not have/could not get transportation	1.1	(1.1)
Could not reach doctor by phone	2.6	(2.6)
Could not leave other family member	0.0	(0.0)
Did not have time	3.0	(3.0)
Thought it would cost too much	0.3	(0.3)
Other[a]	10.9	(2.4)
Percentage not Always Getting Timely Urgent Care in Last 6 Months (Among Those Needing Urgent Care)	15.6	(1.8)
Reasons for Not Always Getting Timely Urgent Care		
Other reasons		
Doctor did not have appointment available	39.2	(7.1)
Doctor had an appointment but not at a convenient time	34.4	(6.9)
Could not reach doctor by phone	9.0	(3.8)
Did not have/could not get transportation	1.2	(0.8)
Did not have the time	3.8	(3.2)
Doctor I wanted to see was away/out of town	9.7	(0.7)
Thought it would cost too much	1.1	(0.6)
Could not leave other family member	0.0	(0.0)
Other[a]	22.3	(5.6)

TABLE C.9 (*continued*)

	Percentage of Medicare FFS Beneficiaries	
Percentage Saying Ease of Seeing Doctor is Getting Harder in Past Year or Two	6.9	(0.7)
Reasons Seeing Doctor is Harder		
Medicare physician participation reasons		
Doctor I want to see is not accepting Medicare at all	7.8	(2.6)
Doctor I wanted to see is not accepting new Medicare patients	4.4	(2.0)
Doctor I want to see is not accepting Medicare assignment	2.5	(1.5)
Other reasons		
Have more difficulty getting appointment	65.0	(5.1)
Doctor died/moved away/retired	3.0	(1.7)
Doctor I want to see is not taking any new patients	1.0	(0.5)
Spend too much time waiting in doctor's office	15.4	(4.0)
Transportation is not available	2.3	(1.4)
I moved further from doctor	0.5	(0.2)
I am older/frailer	0.0	(0.0)
Do not like doctor	1.8	(1.2)
Doctor moved further from me	1.3	(0.6)
Other[a]	12.1	(3.6)
Percentage Rating Ease of Seeing Personal Doctor as Less than "Excellent" or "Very Good"	31.6	(1.3)
Reasons for Less than "excellent" or "very good" rating		
Medicare physician participation		
Available doctors do not take new Medicare patients	0.2	(0.1)
Available doctors do not take Medicare patients at all	0.3	(0.2)
Other reasons		
Have to travel too far/hard to get to	90.5	(2.8)
Can't get appointment	1.9	(1.4)
Wait too long for appointment	2.2	(1.4)
No doctor available	4.7	(1.9)
Don't like available doctors	1.5	(1.1)
Couldn't leave other family member	0.9	(0.8)
Available doctors charge too much	2.0	(2.0)
Other[a]	9.7	(2.8)
Percentage Rating Availability of Specialists as Less than "Excellent" or "Very Good"	21.4	(1.3)
Reasons for Less than "Excellent" or "Very Good" Rating		
Medicare physician participation reasons		
Available doctors do not take Medicare patients at all	4.9	(2.0)
Available doctors do not take new Medicare patients	1.5	(0.8)
Available doctors do not accept Medicare assignment	1.0	(0.5)

TABLE C.9 (*continued*)

	Percentage of Medicare FFS Beneficiaries	
Other reasons		
Wait too long for appointment	38.2	(7.7)
Have to travel too far/hard to get to	23.7	(5.8)
Can't get appointment	20.0	(5.2)
Don't like available doctors	16.2	(5.1)
No doctor available	11.8	(4.1)
Available doctors charge too much	2.4	(1.6)
Doctor requires upfront payment	0.3	(0.2)
Couldn't leave other family member	0.1	(0.1)
Available doctors do not take any new patients	0.4	(0.3)
Other[a]	11.7	(4.8)

Source: 2004 targeted survey of Medicare FFS beneficiaries conducted by MPR for CMS

Note: All items represented in this table were posed as open-ended questions. Respondents were prompted to give as many reasons as applicable. Interviewers coded responses in all applicable categories. Figures in parentheses indicate the standard errors associated with estimates to the left.

[a]This category includes verbatim responses that could not be categorized in precoded categories and were coded by research staff into categories that represented less than 3 percent of all respondents answering this particular question.

TABLE C.10

MEDICARE FFS BENEFICIARY CHARACTERISTICS
FOR ALL 11 GEOGRAPHIC AREAS, 2004

	All 11 Sites	Alaska (state)	Phoenix, AZ	San Diego, CA	San Francisco, CA	Denver, CO	Tampa, FL	Springfield, MO	Las Vegas, NV	Brooklyn, NY	Ft. Worth, TX	Seattle, WA
Respondent Type												
Self	94.5	93.4	95.5	95.4	93.7	94.8	95.0	94.1	96.3	89.9	93.4	95.6
Proxy	5.5	6.6	4.5	4.7	6.4	5.2	5.0	5.9	3.7	10.1	6.6	4.4
Survey Mode												
Telephone	87.7	89.3	84.7	87.7	86.2	86.6	87.7	93.0	83.0	87.0	95.5	86.4
Mail	12.3	10.8	15.3	12.3	13.9	13.4	12.3	7.1	17.0	13.0	4.6	13.6
Enrollment Status												
Eligible for Medicare in Past Six Months	5.5	6.5	5.7	5.5	5.3	5.6	4.8	4.5	6.9	5.7	5.7	5.3
Disenrolled from Medicare + Choice in Past Six Months	1.7	1.6	2.7	1.1	0.7	1.3	2.7	1.2	3.4	0.4	1.4	0.9
Moved to Area in Past Six Months	0.7	0.1	0.9	1.2	0.5	0.8	0.3	0.3	0.8	1.0	0.5	0.7
Other FFS Beneficiaries	92.1	91.9	90.7	92.2	93.5	92.3	92.2	93.6	89.0	92.9	92.4	93.2

TABLE C.10 (*continued*)

	All 11 Sites	Alaska (state)	Phoenix, AZ	San Diego, CA	San Francisco, CA	Denver, CO	Tampa, FL	Springfield, MO	Las Vegas, NV	Brooklyn, NY	Ft. Worth, TX	Seattle, WA
Health Insurance Coverage												
Types of Supplemental Coverage												
Medigap	44.5	27.7	48.2	31.3	48.5	36.8	57.0	52.3	40.2	38.3	40.1	53.3
Retiree coverage	39.6	43.2	50.4	33.9	47.2	51.7	39.3	22.5	44.9	31.4	38.4	34.5
Veteran's	11.4	11.6	16.5	10.2	8.3	8.3	13.4	8.4	15.5	2.8	12.7	12.5
Military retiree	9.7	7.9	10.7	27.4	5.2	10.0	7.8	5.6	12.1	1.4	8.6	4.5
Number of Different Types of Coverage												
None	20.1	30.2	12.0	22.6	17.0	17.6	18.0	19.7	14.6	36.8	27.5	16.3
One	53.0	49.2	52.8	52.2	59.3	56.3	46.8	61.7	55.1	47.3	48.2	57.0
More than one	26.9	20.7	35.2	25.3	23.7	26.1	35.2	18.6	30.3	16.0	24.3	26.7
Demographic												
Gender												
Male	45.1	48.2	45.4	46.6	41.3	44.5	45.1	45.5	49.0	41.9	43.4	45.6
Female	54.9	51.8	54.6	53.4	58.7	55.6	54.8	54.5	51.0	58.1	56.6	54.4
Age												
Under 65	9.7	11.4	5.4	11.3	8.3	12.2	8.4	12.0	10.8	17.2	10.6	5.7
65-69	25.6	34.0	26.7	26.3	21.3	23.9	21.9	22.9	32.9	21.6	26.8	26.8
70-74	21.2	19.9	21.9	19.0	22.5	20.4	24.8	21.2	22.3	14.5	24.6	21.0
75-79	17.9	15.4	22.2	13.0	18.5	19.2	17.8	20.5	17.3	17.9	14.5	17.0
80-84	13.7	12.1	12.1	17.6	16.4	13.6	14.0	11.6	9.7	14.0	13.2	15.5
85+	12.0	7.1	11.7	12.9	13.0	10.6	13.1	11.9	7.0	14.9	10.4	14.0

TABLE C.10 (*continued*)

	All 11 Sites	Alaska (state)	Phoenix, AZ	San Diego, CA	San Francisco, CA	Denver, CO	Tampa, FL	Springfield, MO	Las Vegas, NV	Brooklyn, NY	Ft. Worth, TX	Seattle, WA
Time Living at Current Address												
< 6 months	2.7	1.4	3.1	1.4	0.1	1.7	4.1	4.5	3.0	3.0	3.8	1.6
6 months to less than 1 year	3.5	5.0	4.3	2.9	2.3	2.9	3.7	4.3	7.5	2.2	3.5	1.6
1 year to less than 5 years	17.7	12.8	19.5	15.2	5.2	23.3	28.4	9.2	29.7	5.5	19.8	17.6
5 years to less than 10 years	14.3	14.0	23.0	16.5	8.8	10.2	18.1	6.6	20.8	9.3	10.4	10.5
10 years or more	61.8	66.7	50.1	64.0	83.6	61.9	45.8	75.5	39.1	80.1	62.6	68.7
Marital Status												
Married	59.2	61.5	62.7	67.5	53.0	59.1	65.2	65.5	60.3	37.5	56.3	56.8
Widowed	27.5	22.9	25.4	22.3	29.2	24.3	26.2	24.8	19.8	36.4	35.0	32.5
Divorced	8.1	9.7	9.6	6.8	10.0	10.2	6.2	5.0	11.4	10.7	4.3	7.7
Separated	1.3	1.8	0.2	1.8	0.9	0.2	0.7	0.7	3.0	5.7	0.9	0.6
Never married	3.9	4.1	2.1	1.6	6.9	6.3	1.7	4.0	5.5	9.6	3.6	2.4
Socioeconomic												
Highest Grade Completed												
8th grade or less	7.5	7.2	4.3	6.9	3.2	6.1	6.3	9.8	3.3	21.3	8.6	6.6
Some high school	7.2	10.3	6.0	2.3	7.3	4.8	10.6	11.3	7.2	9.3	10.1	3.8
High school graduate	35.4	41.4	32.6	33.2	20.0	31.6	43.1	47.3	36.2	44.7	32.7	29.5
Some college/2 year degree	24.7	27.1	27.1	23.3	36.2	26.8	21.0	21.7	27.7	11.3	24.3	28.5
4 year college graduate	14.1	9.2	20.0	13.5	17.2	18.0	9.7	5.8	12.0	9.7	16.2	16.4
More than college graduate	11.2	4.8	10.0	20.9	16.1	12.6	9.3	4.1	13.7	3.7	8.1	15.3
Annual Household Income												
More than $25,000	12.1	11.8	6.2	7.2	9.2	8.3	16.1	19.5	10.4	29.3	14.6	7.6
10,000 to 25,000	32.3	25.1	29.0	22.9	25.3	32.7	28.4	47.3	32.8	41.5	36.4	33.4
Less than 10,000	55.6	63.1	64.8	69.9	65.1	59.0	55.6	33.2	56.8	29.2	49.0	59.0

TABLE C.10 (*continued*)

	All 11 Sites	Alaska (state)	Phoenix, AZ	San Diego, CA	San Francisco, CA	Denver, CO	Tampa, FL	Springfield, MO	Las Vegas, NV	Brooklyn, NY	Ft. Worth, TX	Seattle, WA
Race												
White	89.1	85.6	94.0	89.5	73.9	93.5	96.0	94.8	86.6	70.6	90.7	90.9
Black	5.9	1.9	3.2	3.5	9.0	4.0	2.5	0.0	5.8	27.6	6.6	3.0
Other	5.1	12.5	2.8	7.0	17.1	2.5	1.6	5.2	7.7	1.8	2.7	6.2
Hispanic												
Yes												
No	95.3	99.2	97.2	93.2	91.4	95.3	94.7	99.9	93.8	90.0	95.3	97.7
Health Status												
Rating of Health Status												
Excellent	14.6	16.4	18.8	19.4	17.2	10.4	11.3	15.6	14.2	6.6	14.8	12.9
Very good	27.8	27.4	29.7	28.0	29.1	27.9	27.4	30.4	27.2	16.2	33.2	27.3
Good	33.8	31.2	33.5	31.5	35.4	40.2	35.0	31.1	39.2	31.3	27.5	36.4
Fair	17.7	17.6	13.5	17.2	15.5	15.0	20.5	12.6	14.1	33.3	21.1	15.8
Poor	6.2	7.7	4.5	4.0	2.8	6.6	5.8	10.2	5.3	12.6	3.4	7.6
Limits on Activities of Daily Living												
Limits on moderate activities, such as vacuuming	34.5	32.9	30.9	35.5	31.1	33.0	36.5	33.5	33.2	50.8	39.8	26.3
Difficulty climbing several flights of stairs	37.2	32.7	37.8	36.6	25.1	32.7	38.8	38.2	32.5	52.8	44.6	30.5
Accomplished less than desired because of health	34.5	41.4	28.1	34.5	28.4	36.7	38.6	36.8	28.8	42.7	30.9	38.3
Limits on the kind of work or other daily activities	33.2	39.8	27.0	35.6	27.3	33.3	34.2	35.3	24.4	42.8	37.1	33.0
Have Medical Condition That	26.2	29.5	21.7	24.9	21.8	23.6	28.6	28.3	25.6	38.0	28.4	23.0

TABLE C.10 (*continued*)

	All 11 Sites	Alaska (state)	Phoenix, AZ	San Diego, CA	San Francisco, CA	Denver, CO	Tampa, FL	Springfield, MO	Las Vegas, NV	Brooklyn, NY	Ft. Worth, TX	Seattle, WA
Seriously Interferes with Independence												
Have a Current Medical Condition That Has Lasted at Least 3 Months	60.8	59.0	61.0	63.5	56.4	59.4	64.7	55.1	58.0	62.2	60.3	66.3
Hospitalized for One or More days in Past 12 Months	17.0	16.2	13.2	18.0	15.7	15.9	19.0	15.6	14.6	20.3	22.2	16.8

Source: 2004 targeted survey of Medicare FFS beneficiaries conducted by MPR for CMS.

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

APPENDIX D

ADDITIONAL REGRESSION RESULTS USING POOLED 2003-2004 TARGETED BENEFICIARY SURVEY DATA

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

TABLE D.1

LOGISTIC REGRESSION MODELS PREDICTING ANY ACCESS PROBLEMS
AND PROBLEMS DUE TO MEDICARE PHYSICIAN PARTICIPATION
BY TRANSITIONING VS. NON-TRANSITIONING STATUS, 2003-2004 POOLED DATA

	Dependent Variables for Three Logistic Regressions:					
	Any Access Problem (Odds Ratio)		Any Problem Due to Medicare Physician Participation (Odds Ratio)		Any Problem Due to Medicare Physician Participation or Other Physician Availability Issues (Odds Ratio)	
	Transitioning	Non-Transitioning	Transitioning	Non-Transitioning	Transitioning	Non-Transitioning
Independent Variables[a]						
Age						
65-69	0.72[b]	0.45[b]	0.96	0.43	0.91	0.49[b]
70-74	0.90	0.37[b]	0.64	0.38[b]	1.18	0.29[b]
75-79	0.79	0.41[b]	0.41	0.44	1.11	0.38[b]
80-84	0.72	0.37[b]	0.61	0.13[b]	0.81	0.25[b]
85+	0.98	0.27[b]	1.21	0.15[b]	1.22	0.21[b]
Poor/Fair Health Status	2.42[b]	1.94[b]	2.19	1.21	2.21[b]	1.72[b]
No Supplemental Coverage	0.98	1.06	0.81	1.76	0.86	1.37
Income						
$10,000-$25,000	0.76	1.20	0.86	0.59	0.71	0.88
>$25,000	0.60[b]	0.79	0.85	0.84	0.64[b]	0.83
Hispanic	1.13	0.97	1.65	0.39	1.22	0.46
Race						
Black	1.24	0.74	1.18	0.41	1.32	0.67
Other	1.33	0.99	1.12	1.03	1.41	1.01
Female	1.21	1.30[b]	1.16	1.41	1.08	1.32

Source: 2003 and 2004 targeted surveys of Medicare FFS beneficiaries conducted by MPR for CMS.

Note: A set of dummy variables indicating the 11 targeted geographic sites (not shown here) were also included in the regressions to control for differences in geographic location.

[a]Omitted reference group includes beneficiaries who are age <65 (disabled), are in excellent/very good/good health, have supplemental coverage, have incomes <$10,000, are non-Hispanic, white, and male.

[b]Odds ratio is statistically significant ($p < 0.05$).

TABLE D.2

LOGISTIC REGRESSION MODELS PREDICTING ANY ACCESS PROBLEMS AND PROBLEMS DUE TO MEDICARE PHYSICIAN PARTICIPATION AMONG BENEFICIARIES WITH VS. WITH OUT SUPPLEMENTAL COVERAGE, 2003-2004 POOLED DATA

	Dependent Variables for Three Logistic Regressions:					
	Any Access Problem (Odds Ratio)		Any Problem Due to Medicare Physician Participation (Odds Ratio)		Any Problem Due to Medicare Physician Participation or Other Physician Availability Issues (Odds Ratio)	
	No Supplemental Coverage	Supplemental Coverage	No Supplemental Coverage	Supplemental Coverage	No Supplemental Coverage	Supplemental Coverage
Independent Variables[a]						
Transitioning Status	0.99	1.07	0.72	1.57[b]	0.81	1.24
Age						
65-69	0.47[b]	0.54[b]	0.63	0.48	0.78	0.44[b]
70-74	0.39[b]	0.47[b]	0.28	0.46	0.56	0.25[b]
75-79	0.37[b]	0.51[b]	0.55	0.48	0.36	0.37[b]
80-84	0.38[b]	0.46[b]	0.02[b]	0.18[b]	0.10[b]	0.28[b]
85+	0.15[b]	0.37[b]	0.07[b]	0.22[b]	0.07[b]	0.24[b]
Poor/Fair Health Status	2.90[b]	1.86[b]	1.22	1.28	2.11[b]	1.68[b]
Income						
$10,000-$25,000	1.19	1.09	0.83	0.48	0.87	0.89
>$25,000	0.81	0.73	1.27	0.70	0.85	0.82
Hispanic	0.69	1.16	0.56	0.78	0.59	0.66
Race						
Black	0.45[b]	0.98	0.81	0.21[b]	0.90	0.45
Other	0.43[b]	1.25	0.77	1.21	0.63	1.27
Female	1.49	1.25[b]	0.96	1.57	1.33	1.28

Source: 2003 and 2004 targeted surveys of Medicare FFS beneficiaries conducted by MPR for CMS.

Note: A set of dummy variables indicating the 11 targeted geographic sites (not shown here) were also included in the regressions to control for differences in geographic location.

[a]Omitted reference group includes beneficiaries who are not in transition, age <65 (disabled), are in excellent/very good/good health, have supplemental coverage, have incomes <$10,000, are non-Hispanic, white, and male.

[b]Odds ratio is statistically significant ($p < 0.05$).

TABLE D.3

LOGISTIC REGRESSION MODELS PREDICTING ANY ACCESS PROBLEMS AND PROBLEMS DUE TO MEDICARE PHYSICIAN PARTICIPATION AMONG BENEFICIARIES UNDER AGE 65 (DISABLED) VS. AGE 65 AND OLDER, 2003-2004 POOLED DATA

	Dependent Variables for Three Logistic Regressions:					
	Any Access Problem (Odds Ratio)		Any Problem Due to Medicare Physician Participation (Odds Ratio)		Any Problem Due to Medicare Physician Participation or Other Physician Availability Issues (Odds Ratio)	
	Disabled	Aged	Disabled	Aged	Disabled	Aged
Independent Variables[a]						
Transitioning Status	0.74	1.23[b]	0.88	1.60[b]	0.75	1.57[b]
Poor/Fair Health Status	1.80[b]	2.02[b]	1.10	1.37[b]	1.73	1.68[b]
No Supplemental Coverage	1.24	0.92	1.48	1.56	1.10	1.55[b]
Income						
$10,000-$25,000	2.47[b]	0.91	1.61	0.44	1.01	0.79
>$25,000	0.98	0.69	1.02	0.83	0.93	0.76
Hispanic	0.70	1.18	0.31	0.81	0.28[b]	0.85
Race						
Black	0.99	0.96	0.86	0.56	0.63	0.82
Other	1.50	0.95	0.81	1.18	1.56	0.90
Female	1.36	1.39[b]	1.02	1.46	0.88	1.47

Source: 2003 and 2004 targeted surveys of Medicare FFS beneficiaries conducted by MPR for CMS.

Note: A set of dummy variables indicating the 11 targeted geographic sites (not shown here) were also included in the regressions to control for differences in geographic location.

[a]Omitted reference group includes beneficiaries who are not in transition, in excellent/very good/good health, have supplemental coverage, have incomes <$10,000, are non-Hispanic, white, and male.

[b]Odds ratio is statistically significant ($p < 0.05$).