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Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians

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Objective: Sixteen million people will gain Medicaid under health reform. This study compares primary care physicians (PCPs) on reported acceptance of new Medicaid patients and practice characteristics.

Data and Methods: Sample of 1,460 PCPs in outpatient settings was drawn from a 2008 nationally representative survey of physicians. PCPs were classified into four categories based on distribution of practice revenue from Medicaid and Medicare and acceptance of new Medicaid patients. Fifteen in-depth telephone interviews supplemented analysis.

Findings: Most high- and moderate-share Medicaid PCPs report accepting “all” or “most” new Medicaid patients. High-share Medicaid PCPs were more likely than others to work in hospital-based practices (20%) and health centers (18%). About 30% of high- and moderate-share Medicaid PCPs worked in practices with a hospital ownership interest. Health IT use was similar between these two groups and high-share Medicare PCPs, but more high- and moderate-share Medicaid PCPs provided interpreters and non-physician staff for patient education. Over 40% of high- and moderate-share Medicaid PCPs reported inadequate patient time as a major problem. Low- and no-share Medicaid PCPs practiced in higher-income areas than high-share Medicaid PCPs. In interviews, difficulty arranging specialist care, reimbursement, and administrative hassles emerged as reasons for limiting Medicaid patients.

Policy Implications: PCPs already serving Medicaid are positioned to expand capacity but also face constraints. Targeted efforts to increase their capacity could help. Acceptance of new Medicaid patients under health reform will hinge on multiple factors, not payment alone. Trends toward hospital ownership could increase practices’ capacity and willingness to serve Medicaid.

Keywords: Medicaid, health reform, physician supply

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Introduction

The Patient Protection and Affordable Care Act (ACA) includes two major provisions with implications for the adequacy of the supply of primary care physicians (PCP) serving Medicaid beneficiaries. The new law extends Medicaid eligibility to nearly everyone under age 65 up to 133% of the federal poverty level (FPL).¹ The Congressional Budget Office estimated that 16 million people, mostly adults, will gain Medicaid coverage as a result (Congressional Budget Office, 2010). In addition, the ACA temporarily (in 2013 and 2014) raises Medicaid payment rates to Medicare payment levels for primary care services delivered by PCPs. Low Medicaid payment rates are considered to be the chief reason that fewer physicians are willing to treat Medicaid patients compared to patients with other coverage (Cunningham & Nichols, 2005; Coburn, Long, & Marquis, 1999), although many physicians also cite other reasons (Cunningham & O'Malley, 2009; Cunningham & May, 2006).

The Medicaid expansion is large enough—a 25% increase in enrollment—that both the market impact and health needs of newly eligible adults could have a greater effect on how physicians view Medicaid than factors considered important today. We can expect that adults who become newly eligible for Medicaid will have very different health needs than currently eligible adults, who are primarily pregnant women, young parents, the disabled, and seniors. Research to date is sparse, but indicates that half the adults who will gain eligibility in 2014 are very poor (income below 50%FPL), a third have a diagnosed chronic condition, and many are likely to have pent-up needs for care. (Kaiser Family Foundation, 2010a, 2010b). They will also include many relatively healthy adults (Somers, Hamblin, Verdier, & Byrd, 2010).

How PCPs will respond to the Medicaid expansion is difficult to project, because people who gain private coverage as the result of federal reform and those newly eligible for Medicaid will compete for physician services. Expanded benefits for preventive services under the ACA will also spur demand for primary care. New pressures on the system are gathering amid rising concern that population growth and aging could, by themselves, strain the nation's primary care resources (Colwill, Cultice, & Kruse, 2008). As competition for primary care resources intensifies, an assessment of the potential additional PCP capacity available to meet new Medicaid demands for primary care can help to inform planning for the Medicaid expansion.

This study classified PCPs by their level of Medicaid participation and compared them on their reported acceptance of new Medicaid patients and on measures of capacity. This is the first study to examine physician willingness to see Medicaid patients in relation to physician capacity. Descriptive analysis used data from a national survey of physicians and was supplemented by in-depth physician interviews.

Data

Data Sources

Data for the quantitative analysis are drawn from the 2008 Center for Studying Health System Change (HSC) Health Tracking Physician Survey, a nationally representative survey of U.S. physicians. The sampling frame was all physicians listed in the AMA Masterfile (which includes both AMA members and nonmembers) as of July 2007. The sample used a stratified random sampling design with proportional allocation to 20 strata based on ten regions, and physician classification as a PCP or specialist according to specialty codes from the AMA file. Implicit stratification procedures were applied to achieve proportional representation by gender, age, practice type, and ZIP Code of the physician's preferred address. The self-administered mail questionnaire was fielded in 2008. A total of 4,720 physicians replied to the mail survey for a weighted response rate of 61.9%. Weighting adjusts for probability of selection and differential survey nonresponse. The Westat IRB approved all survey data collection materials and procedures. Detailed survey methods are documented elsewhere (Strouse et al., 2009).

Sample Eligibility

Physicians eligible for the sampling frame must have completed their medical training, practiced within the 50 states and the District of Columbia, and provided direct patient care for at least 20 hours per week. This analysis limited sample to physicians in primary care, defined as a primary specialty in internal medicine, family medicine, or general practice medicine, and excluded pediatricians since the study is concerned with the expansion of Medicaid to more adults and the PCPs who would treat them (n=1,460).² Some physicians in the sample may treat both children and adults. Specialty classification was updated from the AMA data file based on physician self-report.

Ranking by Level of Participation in Medicaid

PCPs were classified into four groups based on level of Medicaid participation as measured by self-reported distribution of practice revenue and acceptance of new patients. High-share Medicaid PCPs reported 26% or more of their practice revenue from Medicaid—a disproportionate share relative to other PCPs. Moderate-share Medicaid PCPs reported 6% to 25% of their practice revenue from Medicaid and excluded PCPs accepting no new Medicaid patients. High-share Medicare PCPs reported 26% or more of their practice revenue from Medicare and accepting new Medicare patients, and reported non-zero Medicaid revenue; they did not meet the criteria for either high- or moderate-share Medicaid PCPs.³ Low- and no-share Medicaid PCPs represent the remaining PCPs in the sample, who did not satisfy any of the criteria above.

Methods

PCP subgroups were compared on reported acceptance of new Medicaid patients and capacity measures available from the survey report, including physician and practice characteristics, health information technology (IT), non-physician patient supports, and reported problems limiting physician's ability to provide high-quality care. Analysis was conducted in SAS v9.2. Differences were tested for statistical significance using t-tests in SUDAAN that accounted for the complex survey design. All results presented in the text were significant at $p < .05$.

Qualitative Analysis

In-depth telephone interviews were conducted with 15 PCPs in July and September, 2010, to gain insights into PCPs' willingness to accept Medicaid patients now and after health reform, factors that discourage Medicaid participation, and practice resources that affect their readiness to manage increased demand. Interviewees were recruited from the first three PCP subgroups defined and were stratified by practice size, type, and region. PCPs were recruited across subgroups until 15 interviews were completed. Participants included five high-share Medicaid PCPs (two hospital-based, one solo practice, two group practices), four moderate-share Medicaid PCPs (one solo practice, three group practices), and six high-share Medicare PCPs (three medium-sized group practices, three solo/two-physician practices), representing all four regions of the country and various markets as self-reported (low-income urban, small town, suburban middle-income).

Results

Level of Medicaid Participation

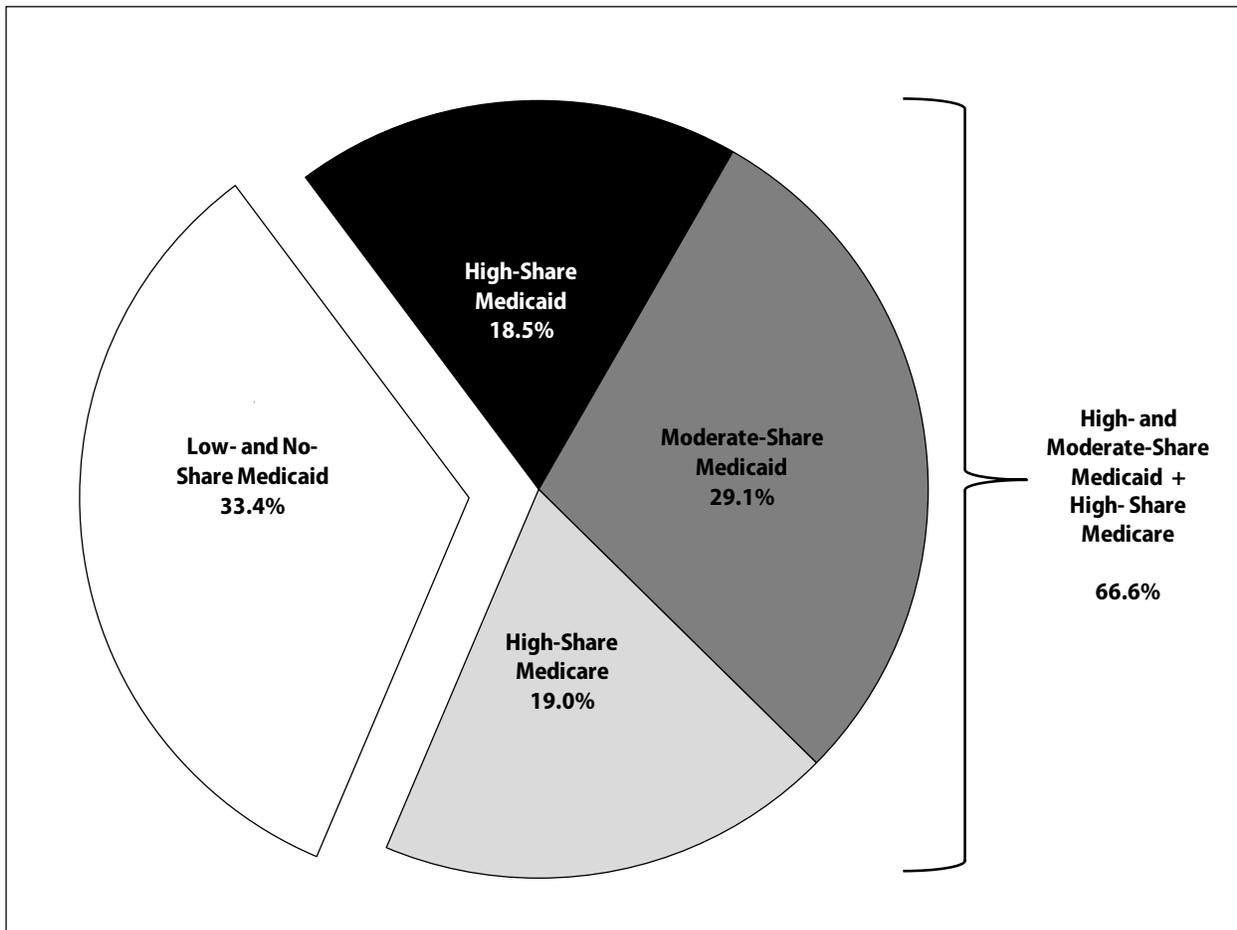
High-share Medicaid PCPs accounted for 18.5% of all PCPs nationally (Figure 1). Moderate-share Medicaid PCPs accounted for 29.1% and high-share Medicare PCPs accounted for 19.0%. Together, these physicians comprised two-thirds of PCPs nationally, while low and no-share Medicaid PCPs accounted for one-third.

High-share Medicaid PCPs are the most willing of all PCPs to see new Medicaid patients. Almost all (83.6%) reported accepting "all" or "most" new Medicaid patients (Figure 2). Many of these PCPs (86.7%) also reported accepting "all" or "most" new Medicare patients (Appendix Table 1). Among moderate-share Medicaid PCPs, 68.4% reported accepting "all" or "most" new Medicaid patients. Only 20.1% of high-share Medicare PCPs reported accepting "all" or "most" new Medicaid patients.

Eight in ten (80.4%) low- and no-share Medicaid PCPs reported that they accept no new Medicaid patients, while 11.3% reported accepting "some," and 8.3% "all" or "most." Notably, low- and no-share Medicaid PCPs also limit their participation in Medicare and private insurance—more than one-quarter (29.1%) reported accepting no new Medicare patients and

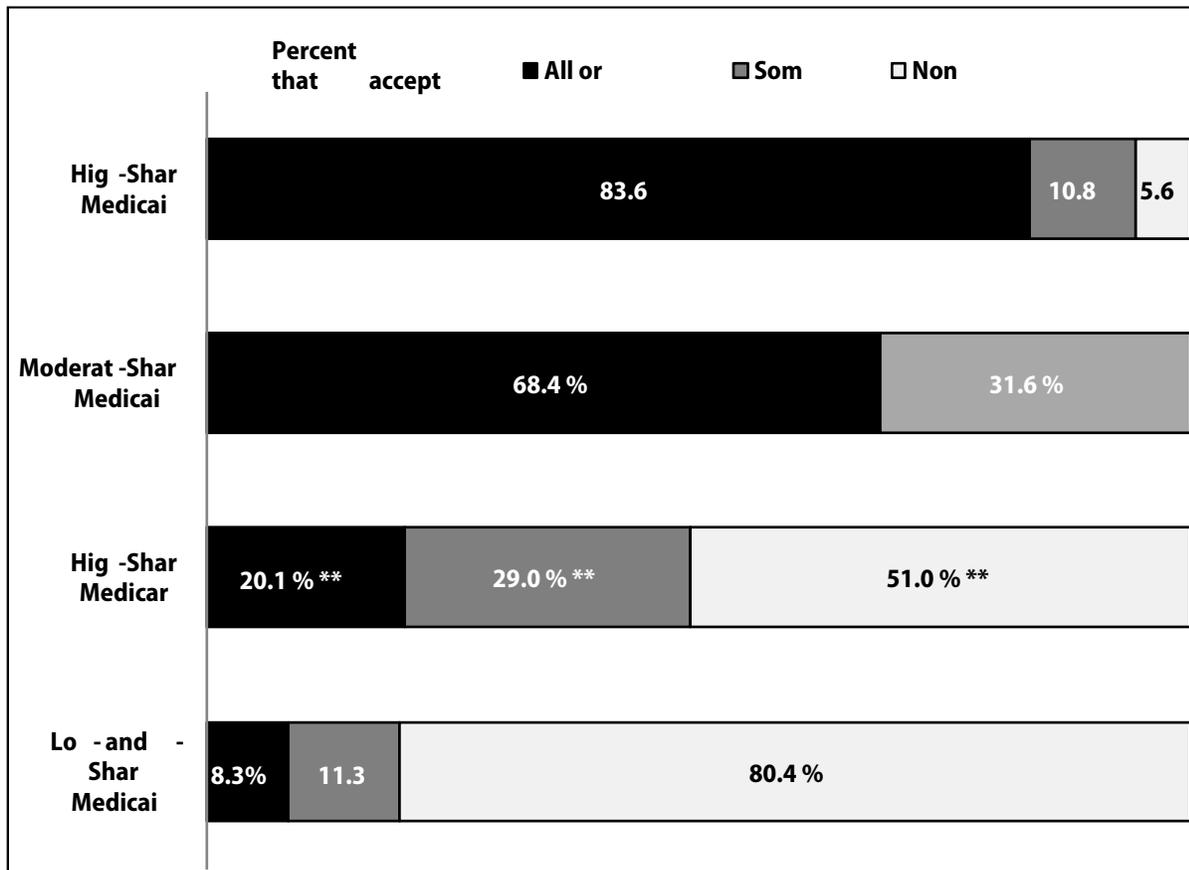
about one-quarter accept just “some” (15.4%) or no (9.4%) new privately insured patients (Appendix Table 1). Fully 93% of low- and no-share Medicaid PCPs reported that 5% or less of their practice revenue is from Medicaid (Appendix Table 2). About one-half (51.5%) of these PCPs, practicing predominantly in the private market, receive 25% or less of their revenue from public sources. PCPs overall report a more balanced mix of public and private revenue—60% receive between one-third and 80% of their revenue from public sources (data not shown). These, along with other results (data not shown), suggest that low- and no-share Medicaid PCPs may offer less promise for expanding the Medicaid PCP workforce. In particular, they practice in the highest-income ZIP Code areas and are less likely than other PCPs to use health IT and to offer patient education for people with major chronic conditions. For brevity, these PCPs are omitted from further discussion, but results are available from the authors.

Figure 1. Percent Distribution of Primary Care Physicians by Level of Medicaid Participation, 2008



NOTE, Sample excludes pediatricians and physicians who work most hours on hospital staff or in emergency room.
 SOURCE: 2008 HSC Health Tracking Physician Survey

Figure 2. Acceptance of New Medicaid Patients by Primary Care Physicians¹ by Level of Medicaid Participation, 2008



¹Sample excludes pediatricians and physicians who work most hours on hospital staff or in emergency room.

Difference from high-share Medicaid PCPs is statistically significant at *p<.05 and **p<.01.

Difference between moderate-share Medicaid and high-share Medicare PCPs is statistically significant at †p<.05 and ‡p<.01.

SOURCE: 2008 HSC Health Tracking Physician Survey

Setting Limits on Seeing Medicaid Patients

The in-depth telephone interviews with PCPs provided new insights into how physicians set limits on Medicaid participation and considerations underlying these decisions. At the time of interviews, in 2010, seven participants said they accepted “all” or “most” new Medicaid patients, and eight said they accepted “some” or “none.” PCPs interviewed in-depth described adopting one of two business strategies if they accepted any new Medicaid patients. Some PCPs accepted “all” or “most” new Medicaid patients, explaining that their practices set no limits on how many Medicaid patients they see. Most of these were high-share Medicaid PCPs located in lower-income areas. However, two PCPs with low practice revenue from Medicaid also took this approach; these physicians described their service area as “middle income” and likely faced lower Medicaid demand.

Other PCPs interviewed, who were accepting “some” new Medicaid patients described different approaches to limiting the number of Medicaid patients seen, stemming from hospital

affiliation, ownership structure, and physician agreements for compensation within group practices. In three practices, each with more than two physicians, decisions were made, respectively, by a CEO of a multispecialty group, the hospital partner of a practice, and an individual PCP in a mid-sized group practice who chose to take a few severely disabled individuals referred by the state. One PCP in a large (>50) multispecialty practice described an agreement among her colleagues to limit Medicaid to 10% of each physician's panel, because they shared equally in overhead costs. Another practice contracted with one of the state's two Medicaid plans, and still another contracted with the Medicaid managed care plan that paid the highest rate.

Factors That Discourage Medicaid Participation

Among PCPs responding on the mail survey that they accepted only "some" new Medicaid patients or "none," the vast majority (90.5%) cited more than one reason as a very or moderately important factor in their decision (Table 1). The most common reason cited was inadequate reimbursement (89.4%), but three-fourths also cited "delayed reimbursement" and "billing requirements." The "high clinical burden" of Medicaid patients was cited less often, but still by a majority of PCPs.

Table 1. Reasons for Primary Care Physicians' Decisions to Accept "Some" or No New Medicaid Patients

| | Physicians ¹ reporting reason as very or moderately important (%) |
|---|--|
| Inadequate reimbursement | 89.4 |
| Delayed reimbursement | 75.7 |
| Billing requirements | 76.2 |
| Practice already has enough Medicaid patients | 56.0 |
| High clinical burden | 60.1 |
| More than one of these reasons | 90.5 |

¹Sample excludes pediatricians, and physicians who work most hours on hospital staff or in emergency room.

SOURCE: 2008 HSC Health Tracking Physician Survey

In interviews, too, PCPs accepting only "some" or no new Medicaid patients identified Medicaid payment levels as very important in their participation decision, but low reimbursement was often mentioned in conjunction with the burden that physicians faced from various program and patient-related tasks. The issue most often cited after payment levels was the time-intensive burden of finding specialists to see Medicaid patients, which made it difficult to care adequately for Medicaid patients. (This concern was not among the response options offered for the question posed in the mail survey.) Other reasons cited included prior authorization, restrictions

on prescriptions, and the illness burden and psycho-social needs of the Medicaid population, but PCPs were not uniform in their perspectives on these points. Several did not view Medicaid patients as being any sicker than others they see, noted that Medicare patients are much sicker, or thought the Medicare program was a bigger hassle.

Capacity to Treat More Medicaid Patients

Physician Characteristics

High-share Medicaid PCPs are just as likely as PCPs in the other two groups to be board-certified in their specialty (Table 2). High- and moderate-share Medicaid PCPs were similar across most other personal characteristics. High-share Medicare PCPs were slightly older and had practiced longer on average. A larger percentage of high-share Medicaid PCPs reported compensation based on fixed salary (42.8%), while moderate-share Medicaid and high-share Medicare PCPs were more likely to receive other types of compensation, such as salary adjusted for performance and share-of-practice billing or workload.

Table 2. Personal Characteristics of Primary Care Physicians, by Physician's Level of Medicaid Participation

| | High- Share Medicaid | Moderate-Share Medicaid ² | High-Share Medicare ^{2,3} |
|-------------------------------------|-------------------------|---|---------------------------------------|
| Physician Demographics ¹ | | | |
| Years in practice (mean) | 15.1 | 16.9 * | 19.3 ** † |
| Physician age (mean) | 48.5 | 49.2 | 51.2 ** † |
| Board-certified in specialty (%) | 85.6 | 88.7 | 90.0 |
| Medical training in US/Canada (%) | 60.7 | 72.5 ** | 74.1 ** ‡ |
| Primary Specialty (%) | | | |
| Internal medicine | 36.7 | 43.0 | 63.4 ** ‡ |
| Family/general practice | 63.3 | 57.0 | 36.6 ** ‡ |
| Basic Compensation Method (%) | | | |
| Fixed Salary | 42.8 | 25.4 ** | 20.4 ** |

¹Sample excludes pediatricians and physicians working most hours on hospital staff or in emergency room.

²Difference from high-share Medicaid PCPs is statistically significant at *p<.05 and **p<.01.

³Difference between moderate-share Medicaid and high-share Medicare PCPs is statistically significant at † p<.05 and ‡ p<.01.

SOURCE: 2008 HSC Health Tracking Physician Survey

Practice Characteristics.

High-share Medicaid PCPs practice in different settings than other PCPs (Table 3). Almost four in ten high-share Medicaid PCPs work in hospital-based practices⁴ (19.8%) or community health centers (18.2%). Moderate-share Medicaid PCPs are less likely to work in these settings, and more likely to work in small and mid-sized group practices and group/staff-model health maintenance organizations (HMOs). However, close to 30% of both high- and moderate-share

Medicaid PCPs work in practices where a hospital has an ownership interest. High-share Medicare PCPs are less likely to work in such practices (18.6%); they are also more likely to work in solo/two-physician practices. Finally, high-share Medicare PCPs practice in ZIP Code areas with higher median household income than high-share Medicaid PCPs, suggesting that they practice farther away from the lower-income communities where Medicaid patients are likely to live.

Table 3. Practice Characteristics of Primary Care Physicians¹ by Physician's Level of Medicaid Participation, 2008

| | High-Share Medicaid | Moderate-Share Medicaid ² | High-Share Medicare ^{2,3} |
|--|------------------------|---|---------------------------------------|
| Ownership of practice (%) | | | |
| Hospital has an ownership interest | 28.7 | 30.9 | 18.6 ** ‡ |
| Type of practice (%) | | | |
| Solo/2 physician | 26.3 | 31.9 | 43.8 ** ‡ |
| Group 3-10 physicians | 13.4 | 20.2 * | 24.2 ** † |
| Group 11-50 physicians | 6.0 | 10.3 * | 10.1 † |
| Large Group 50+ physicians | 7.0 | 9.7 | 9.1 |
| Group or staff model HMO | 1.7 | 5.7 ** | 4.3 ‡ |
| Hospital-based practice | 19.8 | 12.9 * | 5.6 ** ‡ |
| Community health center | 18.2 | 3.8 ** | 0.3 ** ‡ |
| Other | 7.7 | 5.5 | 2.6 ** |
| Geographic Characteristic of Main Practice | | | |
| Median income of ZIP Code (average) | \$52,987 | \$55,460 | \$58,495 ** |

¹Sample excludes pediatricians and physicians working most hours on hospital staff or in emergency room.

²Difference from high-share Medicaid PCPs is statistically significant at *p<.05 and **p<.01.

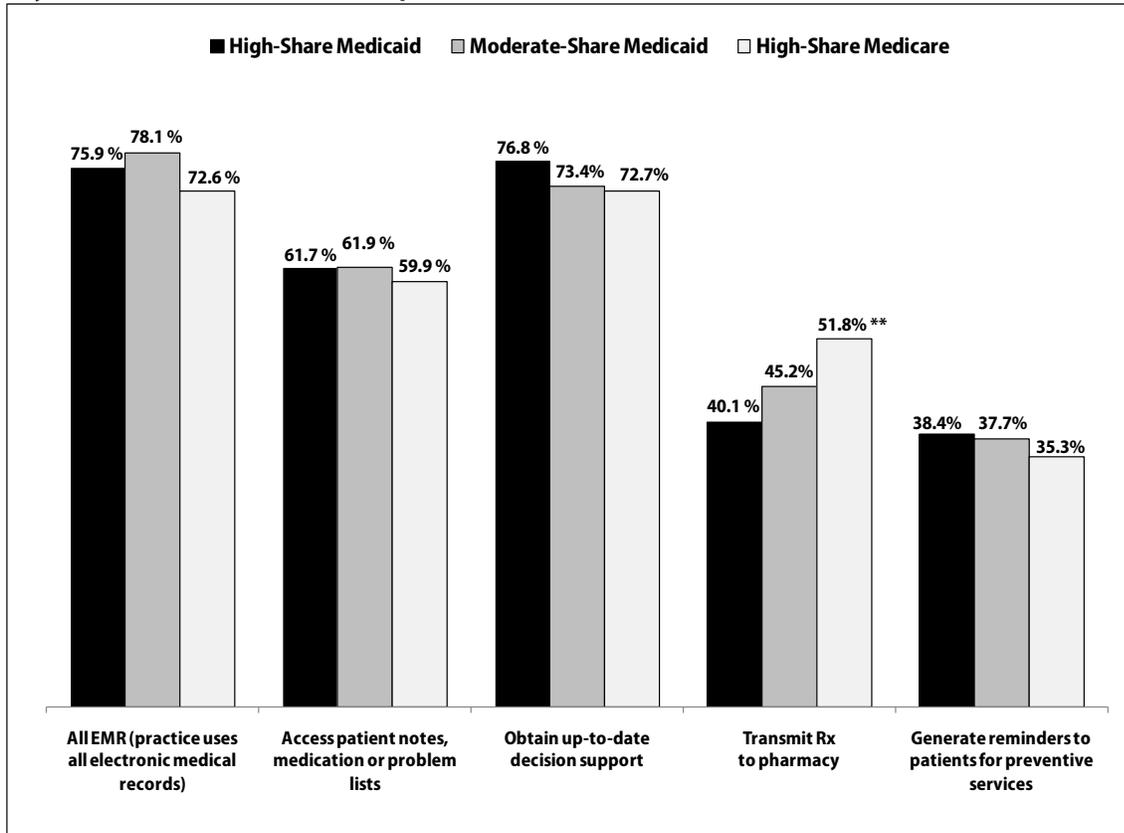
³Difference between moderate-share Medicaid and high-share Medicare PCPs is statistically significant at † p<.05 and ‡ p<.01.

SOURCE: 2008 HSC Health Tracking Physician Survey

Resources at Physician's Main Practice.

There were no differences across the three PCP subgroups in the availability of health IT at the PCP's main practice to support patient care. The most commonly reported IT resources were the use of all electronic medical records (EMR), IT to obtain up-to-date decision support, and IT to access patient notes, medications or problem lists (Figure 3). Close to three-quarters of PCPs in all three groups reported use of all EMR and IT to obtain up-to-date decision support. The only IT resource that high-share Medicare PCPs reported more often than high-share Medicaid PCPs was the capacity to transmit prescriptions electronically to pharmacies.

Figure 3. Use of Health Information Technology (IT) at Primary Care Physician's¹ Main Practice by Physician's Level of Medicaid Participation, 2008



¹Sample excludes pediatricians and physicians who work most hours on hospital staff or in emergency room.

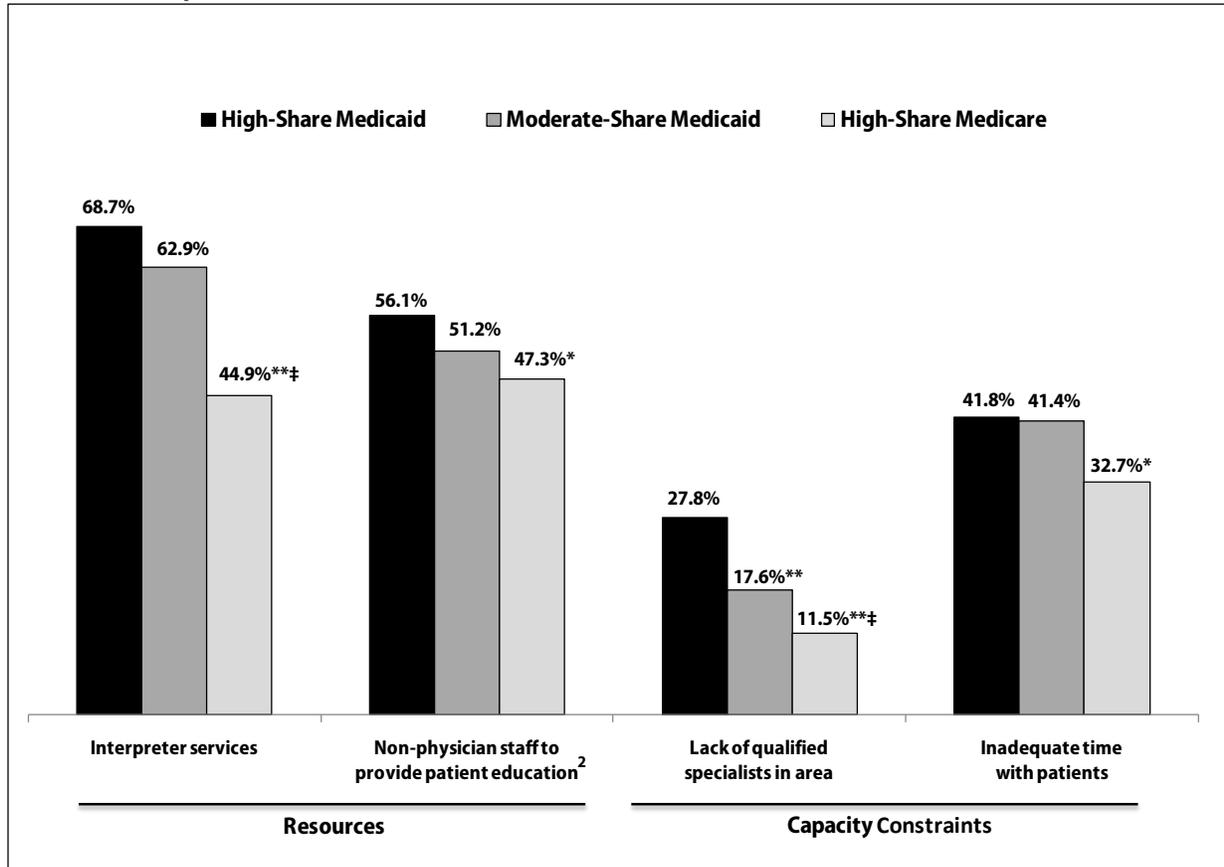
Difference from high-share Medicaid PCPs is statistically significant at *p<.05 and **p<.01.

Difference between moderate-share Medicaid and high-share Medicare PCPs is statistically significant at †p<.05 and ‡p<.01.

SOURCE: 2008 HSC Health Tracking Physician Survey

High-share Medicaid PCPs are more likely than high-share Medicare PCPs to provide interpreter services at their main practice (68.7% versus 44.9%) and to use non-physician staff to provide patient education to patients with at least one of four chronic conditions (56.1% versus 47.3% [Figure 4]). There were no statistically significant differences on these measures between high- and moderate-share Medicaid PCPs.

Figure 4. Resources and Capacity Constraints at Primary Care Physician's¹ Main Practice by Physician's Level of Medicaid Participation, 2008



¹Sample excludes pediatricians, and physicians working most hours on hospital staff or in emergency room.

²Reported to be used for patients with any of four conditions: asthma, diabetes, depression, congestive heart failure.

Difference from high-share Medicaid PCPs is statistically significant at * $p < .05$ and ** $p < .01$.

Difference between moderate-share Medicaid and high-share Medicare PCPs is statistically significant at † $p < .05$ and ‡ $p < .01$.

SOURCE: 2008 HSC Health Tracking Physician Survey

Problems Limiting Ability to Provide High-Quality Care.

On the survey, physicians were presented with a list of problems, including a “lack of qualified specialists in your area” and “inadequate time with patients during office visits,” that may limit ability to provide high-quality care, and they were asked to indicate if each was a major or minor problem or not a problem. More than a quarter (27.8%) of high-share Medicaid PCPs reported a lack of qualified specialists in the area as a major problem, compared to 17.6% of moderate-share Medicaid and 11.5% of high-share Medicare PCPs. Difficulty finding specialists may reflect problems accessing specialists who accept Medicaid patients, specialist shortages in the practice area, or limitations of the PCP’s own network of specialists.

A greater percentage of both high- and moderate-share Medicaid PCPs also reported inadequate time during office visits as a major problem (41.8% and 41.4%), compared to high-share Medicare PCPs (32.7%). Having inadequate time with patients may indicate that physician resources are strained, affecting the quality of care for all patients in the practice. Alternatively,

physicians might only limit time with Medicaid patients to account for the lower marginal revenue received from Medicaid.

High-share Medicare PCPs reported spending more time on average in direct patient care (43.8 hours in a typical week) compared to high-share Medicaid (40.7 hours) and moderate-share Medicaid PCPs (41.5 hours [data not shown]). This result could reflect that high-share Medicare PCPs have larger patient panels, work longer hours, or allocate their time differently between patient care and other tasks.

Physician Perspectives on Willingness and Capacity after Health Reform

In in-depth interviews, PCPs were asked how their perspective on accepting more Medicaid patients might change when Medicaid fees are raised. The practice's capacity to serve more Medicaid patients based on its current infrastructure and recent or planned investments, as well as staff cutbacks that could diminish short-term capacity, were discussed.

Willingness

PCPs in practices that currently limit their Medicaid patient panel (moderate-share Medicaid and high-share Medicare PCPs) said they expected that they or their practice's leadership would revisit their Medicaid participation levels, possibly raising caps on Medicaid to a higher percentage of panel representation, from 20% to 25%, for example. However, most cited at least one issue besides payment that they would factor in before accepting more Medicaid patients. These issues were often the same ones that discouraged their participation now, including difficulty finding specialists, paperwork hassles, and the burden of addressing non-medical needs of Medicaid patients.

Several PCPs explained that the decision would depend on the illness burden of new patients. One high-share Medicare PCP said that unless the new Medicaid patients were eligible because of disability, they would be no different from his regular patients. Another PCP indicated that she would reconsider seeing more patients like the relatively healthy Medicaid patients she sees now if she received higher reimbursement, but that she would not reconsider if the new patients were more like her current Medicare patients, who are sicker and need a lot of services. One PCP in solo practice was simply unwilling to see new Medicaid patients.

High-share Medicaid PCPs generally indicated that they would continue to take as many new Medicaid patients as they could and were limited only by the hours they can work. One PCP at a hospital-based clinic noted that, because the clinic already serves a large number of patients who are uninsured now, but will likely gain Medicaid coverage in 2014, it did not expect to face much increase in demand under health reform. Other high-share Medicaid PCPs were willing to see more Medicaid patients, but said that doing so would require working very long hours or would increase patient wait times for an appointment.

Short-term Capacity

Both moderate-share Medicaid and high-share Medicare PCPs in varied practice settings described having some infrastructure in place to accept more Medicaid patients in the short-term, or indicated that they would consider hiring a physician assistant or nurse practitioner to accommodate more demand from Medicaid. PCPs in group practices of all sizes who were interviewed reported recent investments by their practices. All had either established EMRs or were now implementing them. Other activities underway or planned included a merger with a local hospital, building satellite clinics, adding evening and weekend hours, and seeking certification as a patient-centered medical home. None of the solo/two-physician practices interviewed had either adopted an EMR or reported recent or planned investments.

Recent Cutbacks in Capacity.

Virtually all respondents reported that patients had cut back on office visits as a result of higher unemployment and loss of health insurance experienced in their service areas.⁵ However, only two practices had stopped hiring or cut clinical staffing levels. Other practice changes were minor. We interpret statements about available capacity cautiously, because they were offered during a recession when physicians were observing lower overall utilization.

Study Limitations

Data on Medicaid participation drawn from 2008 surveyance may not be predictive of how physicians will behave under health reform. This study did not quantify the relationship between available PCP resources and projected demand from 16 million additional Medicaid beneficiaries, and so cannot assess the adequacy of the PCP workforce to meet this new demand. To do so will require better measures of physician capacity, as well as data on the geographic access of newly eligible Medicaid beneficiaries to providers who are willing to see them. We lacked data on the size of physicians' patient panels, number of staff employed by the practice, and certain organizational features, such as the availability of after-hours care, that could affect overall capacity.

Discussion

Under health reform, Medicaid enrollment is expected to grow by over 25% by 2019. To help boost the supply of primary care in Medicaid, the health reform law increases Medicaid payment rates for PCPs temporarily. Additional reforms that may benefit Medicaid include investments in primary care workforce development and in community health centers and the National Health Service Corps.

This study does not project future capacity to absorb increased Medicaid demand for primary care, but it adds to other studies (Doty, Abrams, Hernandez, Stremikis, Beal, 2010) indicating that the settings that may offer the most potential new capacity are those where many

Medicaid patients currently seek care. PCPs already serving many Medicaid patients (high- and moderate-share Medicaid PCPs) practice in lower-income areas. They are just as likely as others to report resources such as the use of health IT for core patient care purposes, and more likely to offer interpreter services and patient education—key supports for many Medicaid patients. High-share Medicare PCPs are less likely to have these supports and they practice in higher-income areas, both factors that might limit their capacity to see more Medicaid patients even if they were willing.

Nearly four in ten (38%) high-share Medicaid PCPs work in hospital-based practices and community health centers, settings that may have the capacity to expand their Medicaid service. However, there are also indications that some PCPs who currently serve Medicaid actively could face constraints in their capacity to serve more Medicaid patients. Specifically, over a quarter of high- and moderate-share Medicaid PCPs are in solo or two-physician practices; their capacity to see more patients is probably commensurate with the small number of additional hours they could work. Further, the 40% of PCPs in these two groups, who currently report inadequate time with patients as a major problem limiting their ability to provide high-quality care, will likely face additional difficulty treating more patients and maintaining the same quality of care. Thus, meeting future Medicaid demand for primary care will require recruiting additional Medicaid providers.

PCPs who currently accept few or no new Medicaid patients cite Medicaid payment levels as one of several reasons, but their acceptance of new Medicaid patients in the future will likely hinge on multiple factors, not payment alone. Indeed, other research shows that higher reimbursement is associated with only a small marginal increase in the share of PCPs participating in Medicaid (Cunningham, 2011). PCPs are more likely to respond positively if other problems, such as payment delays and prior authorization burden, are addressed, too. Also, payment adjusted for patient complexity could alleviate physician concerns about the uncertain and pent-up health needs of adults newly eligible for Medicaid. In interviews, difficulty finding specialists to see Medicaid patients emerged as a major reason for limiting participation for some PCPs. Thus, low specialist participation in Medicaid may indirectly discourage PCP participation as well.

Another factor likely to influence whether PCPs see more Medicaid patients is the practice ownership arrangement. Hospital ownership of a practice can bring enhanced resources (resident staffing) and efficiencies (centralized billing) that can subsidize provision of primary care and potentially increase capacity to accept new Medicaid patients. If more practices are acquired by hospitals, participation dynamics could change and more practices could enter the Medicaid market. Ongoing studies show an emerging trend toward hospital acquisition of primary care and multispecialty group practices (Katz et al., 2010; O'Malley et al., 2011). It is worth monitoring whether this phenomenon expands beyond a few local markets to gauge its implications for PCP participation in Medicaid.

Finally, a broader primary care workforce could help expand the supply of providers seeing Medicaid patients. The ACA includes provisions to expand the supply and role of nurse practitioners and other health professionals, including new funding for nurse-managed health clinics. Interviews with PCPs in this study suggest that some practices would consider hiring nurse practitioners and physician assistants to expand capacity if it made economic sense, but with the general decline in demand for physician services due to the recession, such action is unlikely in advance of the Medicaid expansion.

This study provides new information regarding PCPs' willingness and capacity to see more Medicaid patients. The finding that PCPs who already serve Medicaid substantially are better-positioned than others, in terms of location and practice resources, to expand their Medicaid service, suggests that targeted efforts to increase Medicaid participation in these practices could be more fruitful than efforts to secure broad-based PCP participation in Medicaid. At the same time, it is possible that a period of higher Medicaid payment rates for primary care, along with a much larger Medicaid market, will motivate increased interest in Medicaid among PCPs who have, until now, declined to participate much, if at all, in the program. In any case, it is safe to say that the expansion of Medicaid coverage presents both new challenges and opportunities for PCPs and others in the primary care workforce as the demand for their services continues to grow.

Endnotes

¹A special deduction to income equal to five percentage points of the poverty level raises the effective eligibility level to 138% FPL for non-elderly non-disabled adults.

²We further excluded physicians from the sample who reported working in a hospital or medical school and spent most of their time seeing patients in the emergency room or on hospital staff.

³Interviews with high-share Medicare PCPs suggest that some who report little or no revenue from Medicaid nonetheless may be treating patients covered by Medicaid, because they described their patients as including disabled or elderly individuals dually eligible for Medicare and Medicaid. PCPs could receive reimbursement from Medicare as primary payer for these patients and may not participate in Medicaid as a result.

⁴These physicians identified the place where they worked as a hospital, and in a follow-up question, described the setting as an "office practice owned by the hospital" or "a hospital or medical school clinic." Elsewhere in the report this setting is described as a "hospital-based practice."

⁵This recent trend has been observed in national data and in most sectors of health care services (Boorady, Giacobbe, & Santangelo, 2010).

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