

RUPRI Center for Rural Health Policy Analysis

Rural Policy Brief

Brief No. 2011-1

January 2011

www.public-health.uiowa.edu/rupri/

Medicare Beneficiary Access to Primary Care Physicians – Better in Rural, but Still Worrisome

A. Clinton MacKinney, MD, MS

Liyan Xu, MD, MS

Keith J. Mueller, PhD

Primary care is the foundation of the rural U.S. health care system. Thus, the willingness of rural primary care physicians to accept new Medicare patients is critically important to the Medicare program and to rural America's elderly. But universally consistent access to primary care physicians for Medicare beneficiaries may be in jeopardy. The American Academy of Family Physicians (AAFP) reports that the percentage of family physicians accepting new Medicare patients declined from 84% in 2000 to 73% in 2008. Urban family physicians accepted new Medicare patients at a lower rate (70%) than did rural family physicians (83%).¹ In this policy brief, we use results from a large national physician survey to assess U.S. primary care physician and general surgeon willingness to accept Medicare patients. We also assess physician-reported reasons for not accepting Medicare patients.

Key Findings

- *Rural physicians in our analysis were more likely than urban physicians to accept all new Medicare patients.*
- *Among rural physicians in our analysis, "have enough patients" was most often reported as a very important reason to not accept new Medicare patients.*
- *Among urban physicians in our analysis, "inadequate reimbursement" was most often reported as a very important reason to not accept new Medicare patients.*



Funded by the Federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services (Grant #U1C RH20419)

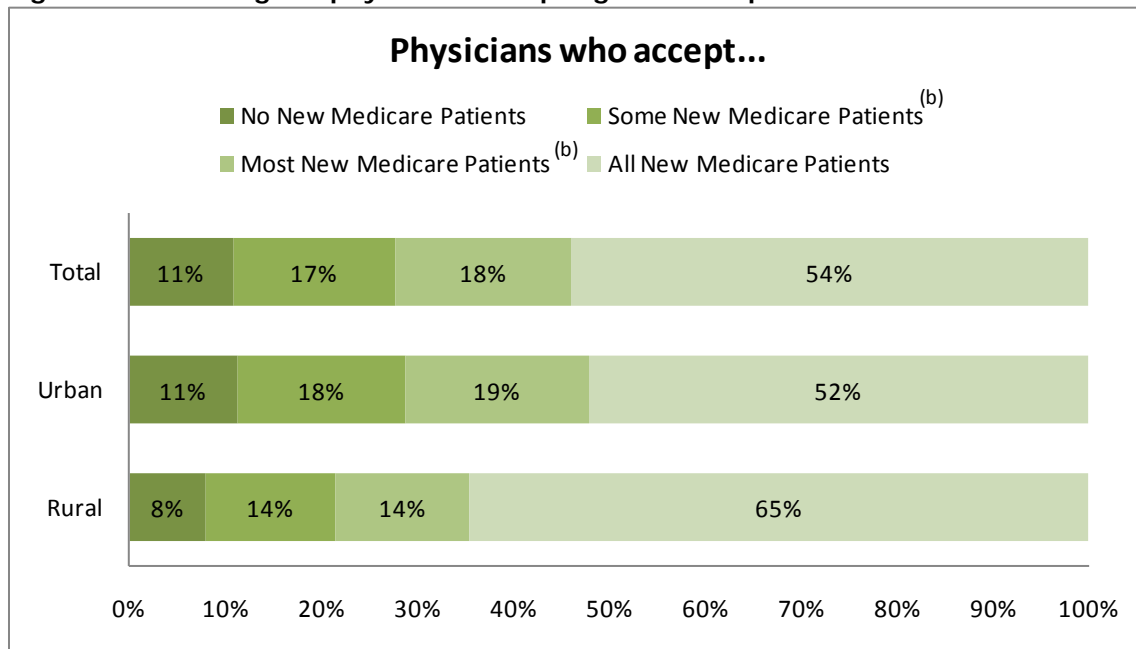
RUPRI Center for Rural Health Policy Analysis, University of Iowa College of Public Health, Department of Health Management and Policy, 200 Hawkins Dr., Iowa City, IA 52242, (319) 384-5122, <http://www.public-health.uiowa.edu/rupri>

Methods and Results

To evaluate physician willingness to accept Medicare patients, we analyzed responses to the Center for Studying Health System Change 2008 Health Tracking Physician Survey (HTPS). The survey includes information from more than 4,700 physicians and was conducted by mail by Westat. All data herein are derived from the survey responses. Because of changes in survey administration, results from the 2008 HTPS cannot be compared to findings from earlier Community Tracking Study physician surveys.² Since most physicians practicing in rural areas are primary care physicians, we assessed responses from only certain physician specialties. We included 1,937 responses from the specialties of family medicine, general practice, general internal medicine, obstetrics/gynecology, and geriatric medicine. We also included general surgery due to the specialty's importance to rural communities. General pediatrics was excluded because very few Medicare beneficiaries are less than 19 years old.³

In 2008, approximately 11% (95% confidence interval: 10% to 12%) of all physicians in our analysis accepted no new Medicare patients. Conversely, only 54% (95% confidence interval: 52% to 56%) of all physicians accepted all new Medicare patients. After parsing the responses by practice location, we found that urban physicians in our analysis were more likely than rural physicians to accept no new Medicare patients (11% for urban versus 8% for rural, $p < 0.01$). And as therefore might be expected, rural physicians in our analysis were more likely than urban physicians to accept all new Medicare patients (65% for rural versus 52% for urban, $p < 0.01$) (Figure 1).

Figure 1: Percentage of physicians accepting Medicare patients^(a)



Source: Center for Studying Health System Change 2008 Health Tracking Physician Survey.

^(a)Based on 2003 Urban Influence Codes. Large metropolitan areas (1 million+ population) and small metropolitan areas (<1 million population) are coded as urban counties. All other areas are coded as rural counties.

^(b)The survey question did not give respondents a percentage or a range of percentages for the categories "some new Medicare patients" or "most new Medicare patients." The survey question was "Is the practice accepting all, most, some, or no new patients who are insured through Medicare, including Medicare managed care patients?"

Among all physicians in our analysis who accept no new Medicare patients, plus those who accept only some new Medicare patients, the following reasons were described as “very important” for that decision:

- Inadequate reimbursement, reported by 62% of all physicians;
- Billing requirements, reported by 43% of all physicians;
- Having enough patients, reported by 39% of all physicians;
- High clinical burden, reported by 30% of all physicians; and
- Concern about audit, reported by 14% of all physicians.

We also parsed these data by practice location, and we found crucial differences between rural and urban physicians. “Having enough patients” was the most frequently reported (51%) very important reason for accepting no, or some, new Medicare patients among rural physicians, while “inadequate reimbursement” was the most frequently reported (64%) very important reason among urban physicians. For both rural and urban physicians, “concern about an audit” was the least frequently reported very important reason to accept no, or some, new Medicare patients. Importantly, the hierarchy of very important reasons to accept no, or some, new Medicare patients was different for rural and urban physicians in our analysis (Table 1).

Table 1: Very important reasons to accept no, or some, new Medicare patients, in descending order of frequency reported

All	Rural	Urban
Inadequate reimb. – 62%	Have enough patients – 51%	Inadequate reimb. – 64%
Billing requirements – 43%	Inadequate reimb. – 46%	Billing requirements – 46%
Have enough patients – 39%	High clinical burden – 28%	Have enough patients – 38%
High clinical burden – 30%	Billing requirements – 24%	High clinical burden – 31%
Concern about audit – 14%	Concern about an audit – 7%	Concern about an audit – 15%

Source: Center for Studying Health System Change 2008 Health Tracking Physician Survey.

Note: Respondents could select more than one reason as “very important.”

Only 10% of physicians in our analysis reported that inadequate reimbursement was not at all an important reason to accept no, or some, new Medicare patients (data not shown). Thus, inadequate reimbursement was of at least some importance to 90% of physicians. These physicians have already limited their practice, but what about those physicians who have *considered* limiting acceptance of Medicare patients? In response to a recent AAFP survey regarding likely practice change if a scheduled 23% Medicare physician payment cut were implemented, 13% of respondents would consider no longer seeing any patients, 62% said they may be forced to stop accepting new Medicare patients, and more than 73% said they would have to limit the number of Medicare appointments.⁴ Admittedly, physician behavior (accepting or not accepting Medicare patients) is a more reliable assessment of policy impact than a possible response to a hypothetical policy. Nonetheless, the AAFP survey responses, combined with physician behaviors documented in our analysis, may portend worsening access for Medicare beneficiaries if Medicare physician payment decreases.

Discussion

Physician willingness to accept new Medicare patients can impact Medicare beneficiary access to physician services. We hypothesize that rural primary care physicians and general surgeons are more likely to accept new Medicare patients because fewer physician options exist in rural areas. As one physician previously told us, “If I don’t see Medicare patients in the office, they’ll present to the ER even more sick.”⁵ Rural physicians may feel a stronger sense of commitment to community, or alternately, may be more sensitive to negative community perceptions associated with a practice closed to new Medicare patients. Patients in a small rural community practice may tend to be “lifelong” patients. When they age in place and become Medicare beneficiaries, their physician may be less likely to turn them away. This phenomenon may explain the higher percentage (65%) of rural physicians in our analysis who accept all new Medicare patients compared to urban physicians (52%).

The data analyzed in this report present a *comparatively* positive picture for rural Medicare beneficiary access to physician care, but the finding that 8% of rural physicians and 11% of urban physicians will accept no new Medicare patients signals a willingness to close a practice to Medicare patients. Those percentages could increase if payments decline. Furthermore, significant Medicare beneficiary access-to-physician problems may not be completely described by these data. In a previous policy brief, the authors described “pockets” in the United States where Medicare beneficiary access to physician services is particularly problematic.⁵ Thus, there are likely regions where physician acceptance of new Medicare patients is low, yet these regions are not captured in a national assessment.

Although rural physicians expressed relatively less concern than urban physicians about inadequate Medicare reimbursement, 46% of rural physicians who have chosen to see no, or some, new Medicare patients reported “inadequate reimbursement” as a very important reason to limit their practice. At the time of this writing, Congress voted to delay a scheduled 23% Medicare physician pay cut for one year. Therefore, policy makers will wrestle with this recurring issue in 2011. Based on our analysis, rural Medicare beneficiary access to physician services will depend, in part, on the outcome of this debate.

Physician reasons to accept no new Medicare patients are consistent with a long understood rural reality: the supply of physicians is inadequate in much of rural America. Therefore, the most frequently mentioned very important reason to accept no new Medicare patients is more a consequence of practices at capacity than of payment inadequacy. Congress will have the dual challenge of setting a payment rate that makes treating Medicare patients economically viable for physicians and the program, while concurrently enacting policies to make practice in rural places as attractive as possible.

¹Facts about Family Medicine. <http://www.aafp.org/online/en/home/aboutus/specialty/facts.html>.

²Center for Studying Health System Change. <http://www.hschange.com/index.cgi?data=04>.

³United States: Distribution of Medicare Enrollees by Age. <http://www.statehealthfacts.org/profileind.jsp?ind=294&cat=6&rgn=1>.

⁴Where Will Seniors Get Health Care? More Than One in 10 Family Medicine Practices Consider Closing with Continued Threats to Medicare Payment. http://www.aafp.org/online/en/home/media/releases/2010b/medicare-cuts-2010_printerview.html.

⁵Mueller KJ, MacKinney AC, McBride TD, et al. Rural Physicians’ Acceptance of New Medicare Patients. <http://www.public-health.uiowa.edu/rupri/publications/policybriefs/2004/PB2004-5.pdf>.