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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

January 5, 1979

HUMAN RESOURCES
DIVISION

See form #103 for title

RESTRICTED

Mr. Leonard Schaeffer
Administrator
Health Care Financing
Administration

RELEASED

Dear Mr. Schaeffer:

We conducted a study designed to determine where Medicaid recipients received their medical care and what problems, if any, they had in obtaining care. Our review encompassed a city, a rural county with a relatively large number of physicians, and a rural county with few physicians in Colorado, Hawaii, Missouri, New Mexico, New York, and Virginia. Although other types of providers were included, we concentrated on the use of physicians because the physician is the normal entry point into the health delivery system.

In addition, we wanted to develop data on the extent of provider participation in Medicaid and the primary reasons for any lack of physician participation.

Although this report contains no recommendations, we are providing the results of our study to you in light of HCFA's Research, Demonstration and Evaluation program priority areas for 1980 which include (1) studies to determine the effectiveness of HCFA's programs in removing barriers that prevent beneficiaries' access to health care services and (2) demonstration projects designed to increase physician participation in the Medicaid program.

SUMMARY OF STUDY FINDINGS

We interviewed 750 randomly selected Medicaid recipients who headed households containing 2,268 people eligible for Medicaid in the six States. Most interviews were conducted during the first 6 months of 1976. They told us that they were generally able to obtain medical services when needed. They also said they were generally satisfied with the care they received. The only problem raised frequently was that obtaining transportation to and from providers was difficult.

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Group III report restrict

Our analysis of Medicaid data showed that a relatively few providers received most of the payments for services, particularly in the cities. Hospitals were a major source of ambulatory care in the cities and their cost of care was often higher than that provided in a physician's office. We also noted that the high volume Medicaid providers were located in or near urban poverty areas but other providers with similar locations received little or no Medicaid payments.

To increase physician participation in Medicaid and thereby reduce overall Medicaid costs for physician services by shifting recipients from higher cost hospital sources of physician services, disincentives toward participation must be overcome. The Congress and HEW have taken actions designed to reduce two of the three major disincentives--paperwork and delays in payments. The third disincentive--payment rates below the level of health insurance programs--will be harder to overcome.

Additional information on the scope of this study and the related findings are as follows.

HOW GEOGRAPHIC AREAS AND RECIPIENTS WERE SELECTED

We selected the six States we studied to provide a cross section of the various regions of the Country and because these States provide a wide range in the scope of services provided and types of individuals covered under Medicaid. For example, New York provides 17 different optional services under Medicaid while Missouri provides 7. Colorado, Missouri, and New Mexico cover only the categorically needy while Hawaii, New York, and Virginia also cover the medically needy.

For each selected State, we studied a city, a rural county with a relatively large population, and a low population rural county. These areas were chosen because:

--Cities usually have large numbers of providers including both private practice and facility based practitioners. Cities also normally have fairly good public transportation systems.

--Rural counties with a relatively large town usually have a fairly large number of physicians and, therefore, have a low ratio of population per physician.

While such counties often have minimal public transportation systems, the travel distances to providers are often short. We refer to these counties as low ratio counties.

--Small town rural counties normally have few, if any, physicians and, therefore, have a high ratio of population per physician. Also, these counties often have no public transportation systems and travel distances to providers can be great. We refer to these counties as high ratio counties.

Other factors we used in selecting counties were the number of Medicaid recipients in the county and the number of providers in surrounding counties. For the later factor, we attempted to select counties which were surrounded by counties with few providers in order to minimize recipient spillover into those counties when they seek medical care. The following table presents for each State and locality reviewed its population, number of physicians, ratio of population per physician, number and percent of physicians who received Medicaid payments, and number of aid to families with dependent children (AFDC) recipients. AFDC recipients generally comprise about 75 percent of the Medicaid eligibles.

State/ locality	Population (note a)	Number of physicians (note b)	Population per physician	Physicians receiving Medicaid payments (note c) Number	Percent	Number of AFDC recipients (note d)
Colorado	2,207,300	4,488	490	2,347	52	99,500
Denver	514,700	3,359	150	985	29	37,700
La Plata Co.	19,200	36	530	36	100	800
Bent Co.	6,500	3	2,160	2	67	400
Hawaii	770,000	1,412	540	952	67	54,500
Honolulu	324,900	1,203	270	786	65	41,800
Kauai Island	29,800	47	630	46	98	1,800
Molokai Island	5,300	3	1,750	3	100	1,200
Missouri	4,677,400	6,741	690	note e/	note e/	275,000
Kansas City	507,300	2,207	230	627	28	49,500
Butler Co.	33,500	50	670	49	98	3,200
Dallas Co.	10,000	0	-	0	-	500
New Mexico	1,016,000	1,401	720	779	56	59,900
Albuquerque	243,800	817	300	342	42	18,200
San Miguel Co.	22,000	25	880	15	60	2,400
Guadalupe Co.	5,000	0	-	0	-	400
New York	18,241,300	45,026	400	note e/	note e/	1,226,300
Syracuse	197,300	1,277	150	427	33	20,500
Franklin Co.	43,900	61	720	40	66	2,500
Lewis Co.	23,600	12	1,970	10	83	600
Virginia	4,648,500	6,846	680	4,026	59	179,400
Richmond	249,400	1,367	180	336	25	24,100
Tazwell Co.	39,800	40	1,000	28	70	1,300
Cumberland Co.	6,200	2	3,090	0	-	400

a/Taken from the 1970 census rounded to hundreds.
b/Taken from Physician Distribution and Medical Licenses in the U.S., 1974, published by the Center for Health Service Research and Development, American Medical Association.
c/Data is for calendar year 1975.
d/Data is for February 1976, rounded to hundreds.
e/Not available.

After selecting the localities to be reviewed, we randomly selected from the Medicaid eligibility roles 50 recipients in each city (total of 300), 50 in each low ratio county (total of 300), and 25 in each high ratio county (total of 150). We interviewed the head of the household containing these 750 people about their household's ability to obtain medical services, where they obtained services, and their satisfaction with the services received. The households contained 2,268 persons eligible for Medicaid. The questions asked related to all the members of the household.

RESULTS OF RECIPIENT INTERVIEWS

We asked the recipienits where they went to see a physician. A majority said they normally went to a physician's office with the second largest response being an outpatient department of a hospital. There were substantial differences, however, among the three types of localities we reviewed as shown in the following table.

Place where physician is seen	Percent of recipients giving response			
	Overall	In cities	In low ratio counties	In high ratio counties
Physician's office	67	51	84	74
Hospital emergency room/ outpatient department	16	29	2	11
Public clinic a/	12	15	8	11
Other	5	5	6	4

a/These are clinics established by or funded through Government agencies. For example, county health department clinics, maternal and child health clinics, and comprehensive neighborhood health centers.

As shown by the table, hospitals and public clinics were a major source of health care for recipients residing in cities while they were a relatively minor source for recipients in rural areas. Another indicator of the importance of hospitals for providing physician services to Medicaid recipients is the percent of total physician visits made to hospital outpatient departments. Nationwide, this percentage is about 32 percent or almost one hospital outpatient physician visit for every two physician office visits.

We asked recipients in Hawaii, Missouri, New Mexico, and New York why they went where they did for physicians services. Their responses are summarized in the following table.

Why place of service was used	Percent of Recipients Responding			
	Overall	In cities	In low ratio counties	In high ratio counties
Only available source	10	4	5	32
Personal preference	54	59	58	34
Convenience	18	15	17	24
Was told to	8	10	8	4
Other or no response	10	12	12	6

We also asked recipients where they received dental care and why they went there. The responses were quite similar to those for physician services. For example, almost half of the recipients went to a dentist's office and did so because of personal preference. One significant difference in the responses was that about 30 percent of the recipients said that they did not receive dental care. This is explained by the fact that dental care coverage, especially adult dental care, is a very limited service under Medicaid in most States.

We also asked whether the recipient was satisfied with the care received under Medicaid. About 96 percent of those interviewed said they were. Of the remaining 4 percent, 2 percent questioned the quality of or the specific type of care recieved, 1 percent cited problems which would be faced by all patients whether or not eligible for Medicaid, and 1 percent gave no explanation.

Problems in Obtaining Transportation to Providers

The problem most frequently raised by the recipients we interviewed related to their ability to obtain transportation to and from providers. Many Medicaid recipients do not own automobiles and depend on public transportation, relatives, or neighbors for transportation. Of the recipients interviewed, 23 percent said that obtaining transportation to physicians was a problem. Fifteen percent of the recipients residing in cities cited this problem while 23 percent of

those in high ratio counties and 31 percent of those in low ratio counties did. When we asked if transportation problems had ever kept the recipients from going to a physician, 17 percent responded that they had--20 percent in high ratio counties, 17 percent in low ratio counties and 15 percent in cities. These statistics indicate that obtaining transportation to providers can raise an impediment to receiving services under the Medicaid program.

Recipients Billed for Covered Services

Providers who participate in Medicaid are required by law to accept as payment in full the amount Medicaid reimburses them. Providers cannot bill the recipient for covered services. HEW requires the State to include such a provision in their provider agreements.

In all the States studied except Virginia, we asked the recipients if they had ever paid or been billed for services which should have been paid by Medicaid. Twenty-six percent said that they had. In most cases there was insignificant evidence available for us to conclude whether the recipients had been billed improperly for covered services. We turned cases of alleged improper billing over to the State Medicaid agencies for whatever action they deemed appropriate.

MINORITY OF PHYSICIANS AND DENTISTS RECEIVED MAJORITY OF PAYMENTS

To determine how extensively providers participated in the Medicaid program, we analyzed Medicaid payment data for all of the localities we reviewed. This analysis showed that participation was quite extensive for many types of providers including pharmacies, hospitals, laboratories, and nursing homes. However, provider participation was much more limited for physicians and dentists who are the normal entry point into the health delivery system. The following table lists various indicators of the extent of physician and dentist participation in Medicaid in the cities and low ratio counties we reviewed. Data is not presented for the high ratio counties because of the low number of providers in these counties.

	Physicians		Dentists	
	Cities	Low ratio counties	Cities	Low ratio counties
Number of providers	9,355	260	1,827	65
Percent of providers receiving Medicaid payments	41.6%	83.8%	39.9%	75.4%
Percent of total providers receiving 25 percent of Medicaid payments	1.0%	6.5%	1.0%	10.8%
Percent of total providers receiving 50 percent of Medicaid payments	3.6%	17.7%	3.2%	18.5%
Percent of total providers receiving 75 percent of Medicaid payments	8.7%	33.8%	7.8%	29.2%
Percent of total providers receiving less than $5,000 in Medicaid payments	93.2%	56.2%	90.4%	60.0%
Percent of total providers receiving more than $25,000 in Medicaid payments	0.6%	4.2%	1.2%	3.1%
Percent of Medicaid payments received by top 5 providers	12.3%	38.9%	31.4%	81.2%

High Use of More Costly Hospital Outpatient Departments and Emergency Rooms

As noted on page 5, 29 percent of the recipients residing in cities that we interviewed said they normally went to a hospital outpatient department or emergency room when they needed to see a physician. Two percent of the recipients in low ratio counties and 11 percent of those in high ratio counties gave the same response. Because these hospital departments normally have higher costs and receive higher payments than physicians in private practice, it can increase overall Medicaid costs if recipients use hospitals as their source of physician services. Comparisons of costs for services from these two sources of physician services in the States we visited follow.

In Colorado and New Mexico payments to hospital outpatient departments and emergency rooms would almost always exceed those made to physicians for the same services. This occurs because these States paid the physician who treated the patient at the hospital at the same rates as would be paid to physicians in private practice. In addition, the hospital was reimbursed its reasonable costs for the use of the facility such as utilities, depreciation, and overhead. Therefore, unless the hospital-based physician chose to charge little or nothing, payments for services provided at the hospital would exceed payments to private-practice physicians for the same services.

Missouri's payments to hospital outpatient departments and emergency rooms were similar to that in Colorado and New Mexico. The hospital-based physician was paid the same rates as a private-practice physician. In addition, the hospital was paid a flat fee of $8 per visit for the use of its services. Thus, payments for physicians' services provided in a hospital would normally exceed payments to a private-practice physician by $8. In fiscal year 1975, there were about 587,000 Medicaid services provided in hospital outpatient departments and emergency rooms in Missouri.

Hawaii and New York paid hospital outpatient departments and emergency rooms a flat fee per visit. In 1975 Hawaii's flat fee was $8.50 for most services to all its hospitals while New York paid all inclusive rates which varied among hospitals from a low of $7.18 to a high of $133.40. Most of New York's hospitals were paid in the $25 to $40 range.

Because of these payment methods, it depends on the service or services received by a recipient during a visit whether payments would be higher to a hospital or a physician. However, for routine-type visits, which constitute a significant percent of total Medicaid physician visits, payments would normally be higher to the hospital.

Virginia paid hospital outpatient departments and emergency rooms on the basis of their actual reasonable costs. Because these hospital departments have relatively high costs, payments to them would normally be higher than payments to private-practice physicians for the same services. During December 1975, the average payment per physician visit was $12.15 while the average payment per outpatient/emergency room visit was $23.57, almost twice as much.

The extent of the use of hospital outpatient departments by Medicaid is illustrated in the following table, both nationally and in the State we reviewed, for fiscal year 1976.

States	Number of recipients obtaining physican services	Number of recipients obtaining outpatient hospital services	Payments to physicians (millions)	Payments to outpatient hospital departments (note a) (millions)
Nationwide	15,922,537	7,447,801	$1,338.6	$556.3
Colorado	166,679	132,180	11.0	6.5
Hawaii	90,784	34,446	8.8	2.3
Missouri	274,027	147,825	18.0	4.3
New Mexico	60,983	29,032	5.1	1.5
New York	1,630,985	370,998	162.6	82.0
Virginia	214,010	131,472	19.4	9.8

a/ Does not necessarily include payments made to physicians who work in the outpatient departments.

Our interviews with Medicaid recipients showed that many of those who went to hospital outpatient departments or emergency rooms to see physicians did so because of convenience (closest provider, located on a bus route, etc.) or personal preference (have always gone there, I like the doctor there, my friends go there, etc.). However, about a third of them went because it was the only source of physician services available to them.

DISINCENTIVES TO PARTICIPATION AS PERCEIVED BY PROVIDERS

We met with representatives of State medical, osteopathic, and hospital associations to obtain their comments on what they believed to be the disincentives toward provider participation in Medicaid and the problems the associations' members had with Medicaid. Representatives of these associations generally cited three major factors which they believed to be disincentives toward participation and/or problems with participation

--low Medicaid payment rates,
--paperwork necessary to obtain payment, and
--long delays between filing claims and receiving payments.

Especially troublesome in the paperwork area was that different coding systems and claim forms are used by Medicaid, Medicare, and other health insurance programs.

Several of the State associations suggested that we prepare a questionnaire to elicit information on disincentives toward participation and problems with Medicaid from their members and said the association would distribute the questionnaire for us. We prepared questionnaires which were distributed by the State hospital associations in Colorado, Hawaii, Missouri, New Mexico, New York, and Virginia; the State medical associations in Colorado, Hawaii, Missouri, and New Mexico; and the State osteopathic associations in Colorado, Missouri, and New Mexico. The questionnaires were sent to 721 hospitals of which 405 or 56 percent responded and 11,060 physicians (doctors of medicine or osteopathy) of which 1,795 or 16 percent responded. Because of the low response rate by physicians the data gathered from the questionnaire cannot be projected to all physicians in the States studied. The physicians who returned the questionnaire were probably those who had strong feelings about

Medicaid. Therefore, the results may not be indicative of the general provider population. Conversely, because the respondents probably did have strong feelings about Medicaid, their responses are likely to present the major problem areas physicians have with Medicaid.

The responses to the questionnaire tend to confirm the statements by the State associations that the major problems with Medicaid from the provider's prospective were low payments, paperwork, and delays in payment. The following table presents the physicians' responses to questions about the extent of problems created by Medicaid paperwork requirements and delays in payments and about the comparability of Medicaid payment rates to the rates of other insurance programs.

PERCEIVED PROBLEMS WITH MEDICAID PAPERWORK, TIMELINESS OF PAYMENT, AND AMOUNT OF PAYMENT

Extent of problem/ comparability of payment	Physician Responses					
	Paperwork		Time to get paid		Payment rates	
	Number	Percent	Number	Percent	Number	Percent
Paperwork-time no problem/ Payments much higher	139	8	106	6	5	-
Paperwork-time minor problem/ Payments somewhat higher	219	12	202	11	17	1
Paperwork-time moderate problem/ Payments about average	336	19	339	19	121	7
Paperwork-time substantial problem/ Payments somewhat lower	358	20	352	29	435	24
Paperwork-time great problem/ Payments much lower	492	27	546	30	997	56
Other (note a)	251	14	250	14	220	12

a/No response, do not know, not applicable.

About half of the responding physicians thought that Medicaid paperwork requirements and payment delays caused them great or substantial problems while only about a fifth of the physicians perceived these requirements as causing only minor or no problems. Also, 80 percent thought Medicaid payment rates were at best somewhat lower than those of insurance programs while only 8 percent believed that Medicaid payments were at least as good.

Our discussions with provider organizations and selected providers indicated that one of the primary problems with paperwork was that Medicare, Medicaid, and private insurance companies often use different claims forms and coding systems. This required the provider and/or his staff to be familiar with many different billing systems which increased provider costs and billing errors.

We asked the hospitals the same questions about paperwork and payment delays. Fifty-seven percent said paperwork requirements and 51 percent said payment delays caused substantial or great problems. Only 19 percent said that these 2 factors caused minor or no problems.

We asked physicians whether they intended to continue participating in the Medicaid program. The following table presents their responses to this question related to the extent the physicians said they participated in the program.

Intent of Participating Physicians Toward Continuing Participation

Extent of participation	Physicians (note a)		Percent of physicians by intent to continue participation (note b)			
	Number	Percent	Yes	No	Only if payments increase and/or the paper work decreases	Other (note c)
Very large	147	9%	46%	1%	39%	14%
Substantial	320	20	46	2	36	16
Moderate	500	32	40	1	38	21
Some	621	39	22	8	43	27
Total	1,588	100	35	4	39	22

a/In addition, 192 physicians responded that they did not participate in Medicaid and 15 physicians who responded to the questionnaire did not respond to this question.

b/Represents percent of physicians participating to the indicated extent who gave the response related to continuing participation.

c/Includes such responses as, do not know, only if there is no other way to receive payment, etc.

As shown in the table, about a third of the responding physicians intended to continue participating even if no improvements in payment rates or reductions in paperwork occurred. A higher percentage of physicians whose involvement with the program was more extensive intended to continue participation than those with little involvement.

REDUCING MEDICAID PAPERWORK PROBLEMS AND PAYMENT DELAYS

Regarding Medicaid paperwork, HEW is currently trying to design a claim form that could be used by both Medicaid and Medicare as well as by other Government and private health insurance plans. We believe the successful culmination of this effort would deminish the perceived paperwork disincentive toward Medicaid participation. Also, we have previously recommended 1/ that HEW develop a uniform identification numbering system for Medicaid and Medicare providers and recipients and adopt standard coding systems for medical procedures, diagnoses, drugs, and medical supplies for use by the Medicaid and Medicare programs. Implementation of this recommendation should also decrease any paperwork disincentive toward Medicaid participation.

Public Law 95-142 contained a provision requiring the States to pay most Medicaid claims within 30 days of receipt. Implementation of this provision should help eliminate the delay in payment disincentive toward Medicaid participation.

In addition, over the last several years many States have upgraded the quality of their claims payment systems. This has enabled States to make more timely Medicaid payments. Of course, some claims will continue to take a relatively long time to pay such as those with questions relating to recipient eligibility and those which require some form of utilization review before payment can be authorized.

PAYMENT RATES

The last major disincentive toward physician participation in Medicaid is more complex and harder to overcome than the previously discussed disincentives. As a rule, Medicaid payments are less than those of health insurance programs including Medicare payment rates. Medicaid payment rates are established by the States. Thus, the ability to increase

1/ Attainable Benefits of the Medicaid Management Information System Are Not Being Realized, HRD-78-151, September 26, 1978.

Medicaid payment rates depends on the ability of States to obtain tax moneys necessary for possible increases in Medicaid expenditures. Also, any increase in State Medicaid expenditures increases Federal Medicaid expenditures.

An increase in Medicaid physician payment rates could be offset, at least in part, by reductions in payments to hospital outpatient departments and emergency rooms. If more physicians did participate and more recipients used office-based physicians, utilization of outpatient departments and clinics would decrease. Since the cost of services provided by outpatient departments and emergency rooms is usually higher, more utilization of office-based physicians would tend to lower overall Medicaid costs for physician services.

By law, Federal sharing in Medicaid physician reimbursements is limited to the amount Medicare pays for the same service. Physicians appear to be generally unwilling to accept Medicare payments as payment in full. This is demonstrated by the fact that only about 50 percent of Medicare physician claims are paid directly to physicians in which case the physician agrees to accept Medicare's determination of this reasonable charge. This rate is even lower if claims relating to persons eligible for both Medicare and Medicaid are not considered because for such claims physicians are required to accept Medicare's determination. Therefore, it is questionable what impact increasing Medicaid payments to the legally authorized upper limit--Medicare payment rates--would have on physician participation in Medicaid. It would appear that some form of incentive besides increased Medicaid payments would be necessary in order to overcome the disincentive toward participation presented by Medicaid's comparatively low payment rates.

This report requires no action by the agency; however, we would be pleased to make additional details of this study available to your staff if they so desire. Also, we plan to make this report available to various Congressional Committees that have expressed an interest in the issues of the availability of services under Medicaid and the extent of physician participation in the program.

Sincerely yours,

Robert E. Iffert

Robert E. Iffert, Jr.
Assistant Director