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Changes in
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findings brief

Who Decides: Do Individual Physicians in Group Practices Have Discretion Over Acceptance of New Medicaid Patients?

Medicaid's ability to make high quality medical care accessible to low-income Americans depends, in part, on physician willingness to participate in the program. State restrictions, payment rates, market structure, geography, and the race and ethnicity of prospective patients reflect the range of factors that may influence physicians' decisions to participate.[1] Since Medicaid is administered by states within the context of broad federal guidelines, variation in program design creates natural experiments for determining how both policy and the organization of care effects physicians' choices to treat Medicaid patients.

New research examines the extent to which physicians' have discretion over their acceptance of new Medicaid patients and the affect that this discretion has on the extent of Medicaid participation. The study was led by Phillip R. Kletke, Ph.D., formerly of the Health Research and Educational Trust. Other members of the research team include the late Janet D. Perloff, Ph.D. of the State University of New York at Albany, James W. Fossett, Ph.D. of the Rockefeller Institute of Government, Jon Gabel of Health System Change, David W. Emmons, Ph.D. of the American Medical Association, and Gregory D. Wozniak, Ph.D. of the BlueCross BlueShield Association.

Background

Historically, physician practices have been arranged in a solo-practice model, with the locus of control for both administrative and medical decisions resting squarely with individual physicians. A shift in the organizational landscape of care began in the 1980s as physician offices moved toward larger independent practices organized by groups of "employee" rather than, "manager" physicians. This trend expanded exponentially in the 1990s with the advent of managed care and the resulting decline of solo-practices. According to Kletke, "prevailing models of physicians' Medicaid participation tacitly assume individual physicians have discretion about whether they accept Medicaid patients. However, this generally is no longer the case." Kletke explains that changes in the way decisions are made in physician offices have the potential to substantially affect Medicaid patients. "The reason we wanted to do this study was because there was good reason to think that physician discretion over the amount of Medicaid patients had changed, because practice arrangements had changed."[2]

Traditionally, analysis of physician discretion is based on a two-market model developed by Sloan, Cromwell, and

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Mitchell. The two-market model locates physician decisions to participate in Medicaid within a dynamic interplay of multiple variables; specifically, (1) physician payment; (2) demand for medical services in the non-Medicaid market; (3) size of the Medicaid population; (4) physician and practice characteristics; (5) community characteristics; and (6) time available to physicians.

While research has been conducted on a range of these factors, few studies have assessed how the locus of decision-making about whether to accept of new Medicaid patients affects physicians' Medicaid participation. Kletke et al. attempt to fill in this gap.

Data and Methods

Examining the period between 1996-1998, the researchers used the American Medical Association's Socioeconomic Monitoring System (SMS) as their primary source of data. The SMS is a series of physician telephone surveys conducted annually between 1983 and 1998. Information collected comes from random samples of approximately 4,000 non-federal patient care physicians drawn from the AMA master file. The SMS collected data on the socioeconomic characteristics of physician practices—including type of practice, income, work hours, and Medicaid participation. It consistently receives response rates between 50 and 70 percent.[3] The study population for this analysis includes 2,328 physicians in group practices and excludes physicians practicing in hospitals or other institutions, physicians in hospital-based specialties, and physicians in practices with a single physician owner.

Between 1996 and 1998 physicians were asked: "At this time, do you accept all new Medicaid patients who come to you, only some, or none?" Then, they were asked, "Who made the final decision to accept (all/some/no) new patients." Response options to this question were: (1) physicians individually (2) physicians in the practice collectively (3) an administrative body (4) some other process.

Once the research team collected the results, they conducted a multivariate analysis of the data to determine whether physicians participate in Medicaid and if so, the extent of their participation (i.e., the percent of their patients covered by Medicaid). Then, the researchers used both descriptive statistics and multivariate analyses to examine who has discretion over the acceptance of new Medicaid patients and how this discretion varies with the following:

- Physician characteristics (specialty, years of medical practice);
- Practice characteristics (number of physicians in the practice, employee vs. owner); and
- Market characteristics (community, size, census region).

Results and Policy Implications

According to the study, when determining whether to accept Medicaid patients

- 28 percent of physicians have individual discretion;
- 56 percent make their decision collectively with other physicians;
- 14 percent have a decision made by board or another administrative body; and
- 2 percent make decisions made in another, unspecified way.

The descriptive analysis showed that physicians with an ownership interest in their practice were more likely to have individual discretion over their Medicaid participation than were employees. Employee physicians (who did not have an ownership interest in their practice) were significantly more likely to have their Medicaid participation determined administratively. The likelihood of Medicaid participation decisions being made collectively decreased with the number of physicians in the practice. In large practices, participation decisions were more likely to be made administratively or by physicians individually.

Discretion over Medicaid participation also varied significantly by specialty. Physicians in psychiatry, general internal medicine, and family/general practice were especially likely to have individual discretion over the acceptance of Medicaid patients. However, discretion over Medicaid participation did not vary significantly with the number of years of experience.

Although discretion over Medicaid participation decisions varies systematically among physicians in group practices, the multivariate analysis indicates that it does not appear to have a strong effect on the extent to which physicians participate. In short, while the locus of decision-making changed the actual decisions did not. The proportion of Medicaid participation decisions made administratively is likely to increase in the future as the proportion of physicians who are employees or in large group practices continues to rise. However, the findings from this study indicate that this shift in the locus of decision-making will not have a large effect on overall Medicaid participation, since the participation decisions made administratively closely resemble those made by individual physicians or made collectively by the physicians in the group.

Endnotes

1 Greene, J. et. al. "Race, Segregation and Physicians' Participation in Medicaid," *the Milbank Quarterly*, Vol 84, Nov. 2, 2006 pp.239-272.

2 Phone Interview with Phillip Kletke, Ph.D., June 9, 2006.

3 The data for the study was weighted to correct for nonresponse bias.