Key Findings from the Ohio State Medical Association’s Primary Care Reimbursement Increase Survey

Ohio Physician Feedback about Medicaid’s Enhanced Primary Care Rates in 2013-2014
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EXECUTIVE SUMMARY

Conducted between June 16 and July 18, 2014, the Ohio State Medical Association's (OSMA's) Enhance Medicaid Primary Care Reimbursement Survey questioned a sample of Ohio physicians about their experiences in 2013-2014 with Medicaid's enhanced primary care rates. Survey questions were designed to gain an understanding for how the enhanced payments affected physicians, their patients, and their practices.

The survey was sent to over 7,000 physicians who attested to receive Medicaid's enhanced primary care payment rates in 2013-2014. Overall, the survey's response rate was nearly 8 percent. Survey respondents were very similar to the entire population of physicians who attested in terms of specialty and geography.

The OSMA, the Ohio Osteopathic Association, the Ohio Academy of Family Physicians, and the Ohio Chapter of the American Academy of Pediatrics disseminated the survey to their members.

Among the survey's key findings:

- Over 90 percent of survey respondents accepted Medicaid patients prior to the primary care rate increase (PCRI).
- Nearly 40 percent of physicians who already accepted Medicaid patients prior to the PCRI indicated they accepted more Medicaid patients after the rate increase.
- Of those who did not accept Medicaid patients prior to the PCRI, over 40 percent indicated they began accepting Medicaid patients because of the rate increase.
- Almost 40 percent of physicians indicated that they plan to accept fewer Medicaid patients or that they plan to discontinue accepting Medicaid patients when the PCRI expires at the end of 2014.
- When asked how they would react to a more permanent Medicaid primary care rate increase, 60 percent of physicians said they would make business decisions involving Medicaid patients. Specifically,
  - Almost 60 percent would accept a greater number of Medicaid patients
  - Approximately one-third would add staff to meet new Medicaid patient demand
  - Over 15 percent would provide better care coordination for Medicaid patients
  - Nearly 13 percent would extend hours to accommodate more Medicaid patients

Overall, these survey results strongly indicate that maintaining an enhanced primary care reimbursement rate will be necessary to ensure Medicaid patients' access to care. The survey also suggests that increasing Medicaid physician payment has real potential to result in better coordinated, higher quality care for individuals receiving Medicaid benefits.
INTRODUCTION

In 2012, state Medicaid programs reimbursed physicians at an average rate of just 59 percent of Medicare fees. Ohio’s rates fell near the national average: physicians were paid just 59 percent of Medicare for primary care services, 65 percent for obstetric care, and 61 percent on average for all services.

The 2010 federal health reform law established a Medicaid Primary Care Rate Increase (PCRI) for specific primary care services furnished by certain qualified primary care providers. The increase will result in payment of primary care services at the Medicare rate to qualified Medicaid providers from January 1, 2013 through December 31, 2014.

Late in 2012, the Centers for Medicare and Medicaid Services (CMS) released a final rule to implement the PCRI. This rule clarified the reasoning behind increasing Medicaid rates for primary care:

“Primary care for any population is critical to ensuring continuity of care, as well as to providing necessary preventive care, which improves overall health and can reduce health care costs. The availability of primary care is particularly important for Medicaid beneficiaries, to establish a regular source of care and to provide services to a group that is more prone to chronic health conditions that can be appropriately managed by primary care physicians. Primary care physicians provide services that are considered to be a core part of a state’s Medicaid benefit package. Additionally, these physicians can perform the vital function of coordinating care, including specialty care.”

Through this rule, CMS stated that the rate increase would only be available for specific groups of physicians who perform specific procedures.

- To qualify for the PCRI, physicians must practice in the designated primary care specialties of Family Medicine, General Internal Medicine or Pediatric Medicine and must provide services to Medicaid managed care and fee for service beneficiaries.
- Qualifying physicians can only be reimbursed at the enhanced rate for two sets of procedure codes: those for evaluation and management of patients (99201-99499), and those for vaccine administration (90460, 90471, 90472, 90473 & 90474).

In order to begin receiving enhanced rates in 2013, physicians were required to self-attest to practicing in primary care. In Ohio, physicians did this through a form administered by the Ohio Department of Medicaid.

The Ohio State Medical Association (OSMA) conducted a survey to assess the effects of the PCRI on physicians across the state of Ohio.

2 Ibid.
SURVEY METHODOLOGY

Survey Development

The OSMA developed a brief 11-question survey tool to be distributed electronically to physicians. This survey was reviewed by officials from the Department of Medicaid before it was sent to physicians.

Survey Distribution

In May 2014, the OSMA accessed a list of all Ohio physicians who attested to receive Medicaid’s enhanced primary care rates from the Ohio Department of Medicaid website. As of February 2014, a total of 10,023 physicians were included on this attestation list.

The OSMA was able to identify e-mail addresses for 7,241 of these physicians. A link to complete a survey about the PCRI was sent to each physician’s email address via online survey administration software and through the OSMA’s internal e-mail system. The survey was also promoted in the OSMA’s weekly e-mail newsletter. Overall, 443 physicians responded to the OSMA’s solicitations to take the survey.

Three other physician organizations also distributed a link to take the survey to their memberships:

- Ohio Osteopathic Association – 45 respondents
- Ohio Academy of Family Physicians – 59 respondents
- Ohio Chapter of the American Academy of Pediatrics – 12 respondents

In total, 559 physicians completed the survey.

Survey Limitations and Sample Applicability

The survey process was designed to sample physicians who actually represent the total population of physicians delivering primary care services to Medicaid patients. This survey may have been affected by sampling error since data was collected only from a sample of physicians who attested to receive the PCRI. It is also possible that the survey was affected sampling bias if the physicians who responded to the survey are systematically different from the total population. Similarly, the survey results could have non-response bias if the answers given by the physicians who did respond to the survey differ greatly from the potential answers of physicians who did not respond.

Roughly 5.6 percent of all Ohio physicians who attested to receive enhanced Medicaid rates participated in the PCRI survey (559 of 10,023 physicians). Assuming the sample population of physicians who took the survey accurately represents the total population of physicians who attested, there is a 95 percent chance that the survey results reflect the views of all physicians who attested to receive the PCRI within a range of plus or minus 4.03 percent.

The OSMA used information stored in its statewide physician database to compare the demographics of the sample population with those of the total attestation population.

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3 Ohio Department of Medicaid, *PCRI Approved Provider* (Columbus, OH: Ohio Department of Medicaid, February 14, 2014), http://medicaid.ohio.gov/Portals/0/Providers/PCRIApprovedProviders.pdf.
The following demographic comparisons were made:

**Specialty**, as divided into primary care (family medicine + internal medicine), pediatrics, and other.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Population</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>60%</td>
<td>64%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>22%</td>
<td>25%</td>
</tr>
<tr>
<td>Others</td>
<td>17%</td>
<td>11%</td>
</tr>
</tbody>
</table>

**Geographic region of the state**, as divided the regions listed below.

<table>
<thead>
<tr>
<th>Region</th>
<th>Population</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southwest</td>
<td>15%</td>
<td>17%</td>
</tr>
<tr>
<td>Northwest</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>Northeast</td>
<td>28%</td>
<td>22%</td>
</tr>
<tr>
<td>Southeast</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>West Central</td>
<td>9%</td>
<td>13%</td>
</tr>
<tr>
<td>Central</td>
<td>19%</td>
<td>18%</td>
</tr>
</tbody>
</table>

**Age**, as measured by year and grouped into decades.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Population</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>30s</td>
<td>23%</td>
<td>13%</td>
</tr>
<tr>
<td>40s</td>
<td>31%</td>
<td>22%</td>
</tr>
<tr>
<td>50s</td>
<td>27%</td>
<td>37%</td>
</tr>
<tr>
<td>60s</td>
<td>15%</td>
<td>24%</td>
</tr>
<tr>
<td>70s</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Practice setting**, as divided into employed practice, independent practice, and no response.

<table>
<thead>
<tr>
<th>Practice Setting</th>
<th>Population</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>55%</td>
<td>35%</td>
</tr>
<tr>
<td>Independent</td>
<td>37%</td>
<td>61%</td>
</tr>
<tr>
<td>Unassigned</td>
<td>9%</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Practice size**, as divided into the groups listed below.

<table>
<thead>
<tr>
<th>Practice Size</th>
<th>Population</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-9</td>
<td>48%</td>
<td>70%</td>
</tr>
<tr>
<td>10-100</td>
<td>27%</td>
<td>19%</td>
</tr>
<tr>
<td>101-500</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>501+</td>
<td>7%</td>
<td>3%</td>
</tr>
<tr>
<td>Unassigned</td>
<td>9%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Sample physicians were found to very closely resemble the total population in terms of specialty and geographic location. Sample physicians were more likely than the total population to work in independent settings, to be over the age of 50, and to work in small practices.

Overall, the sample best represents independent physicians who work in smaller practices, regardless of their reported specialty or geographic location.
Data Analysis

For each question, categorical variables were proportionally calculated in terms of the total number of responses.

Where relevant, a qualitative coding analysis was performed on free-text comments. Text was coded by a single interpreter, and the prevalence of each code was calculated. In these situations, key quotes were identified in order to preserve the richness of survey respondents’ comments.
PART 1: RESPONDENTS’ SELF-REPORTED DEMOGRAPHICS

Respondents were asked a few questions about their practice setting and location, about their Medicaid case-mix, and about the types of Medicaid payment that they accept.

FIGURE 1: RESPONDENTS’ ANSWERS TO:
"DO YOU CONSIDER YOUR PRACTICE LOCATION TO BE..."

This question was available to all respondents, and 499 responses were collected. Answer options included: “Rural”, “Urban”, “Suburban”, “Underserved”, and “Other (please explain in comments)”. Respondents were able to select multiple answers and had the option to leave text comments.

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suburban</td>
<td>41.9%</td>
</tr>
<tr>
<td>Urban</td>
<td>33.2%</td>
</tr>
<tr>
<td>Rural</td>
<td>26.8%</td>
</tr>
<tr>
<td>Underserved</td>
<td>18.3%</td>
</tr>
<tr>
<td>Other</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

FIGURE 2: RESPONDENTS’ ANSWERS TO:
“WHERE DO YOU PRIMARILY PRACTICE?”

This question was available to all respondents, and 502 responses were collected. Answer options included: “Private practice”, “Employed practice”, “Affiliated Practice”, and “Other”. Respondents were able to select multiple answers and had the option to leave text comments.

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private practice</td>
<td>57.6%</td>
</tr>
<tr>
<td>Employed practice</td>
<td>31.3%</td>
</tr>
<tr>
<td>Affiliated practice</td>
<td>6.0%</td>
</tr>
<tr>
<td>Other</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

It is noteworthy that this data matches well with the sample demographic data obtained from the OSMA’s physician database.
FIGURE 3: RESPONDANTS’ ANSWERS TO:
"APPROXIMATELY WHAT PERCENTAGE OF YOUR PRACTICE PANEL IS
COMPOSED OF PATIENTS WHO PAY WITH MEDICAID?"

This question was available to all respondents, and 346 responses were collected. Answer options included: “<5%”, “5-10%”, “10-15%”, and “15-20%”, “20-25%”, “25-30%”, “30-35”, “35-40%”, and “>40%”. Respondents were able to a single answer and had the option to leave text comments.

While just over 20% of practices reported a greater than 40% Medicaid case-mix, nearly 50% reported a case mix of under 20% Medicaid patients. A number of respondents left text comments saying their case-mix is over 60% Medicaid.

![Bar chart showing distribution of respondents' answers to the question on the percentage of their practice panel composed of patients who pay with Medicaid.]

FIGURE 4: RESPONDENTS’ ANSWERS TO:
"WHAT TYPE(S) OF MEDICAID REIMBURSEMENT DOES YOUR PRACTICE ACCEPT?"

This question was available to all respondents. Answer options included: “Medicaid-Fee-for-Service Only”, “Medicaid Managed Care Only”, and “Both Medicaid Fee-For-Service and Medicaid Managed Care”. Respondents were able to select a single answer and had the option to leave text comments.

The data shows that almost all surveyed physicians accept both fee-for-service and managed care payment from Medicaid.
This question was only available to respondents who indicated they accepted payment from Medicaid managed care plans. This question received 395 responses. Answer options included: “Prior to December 31, 2014”, “January 2014”, “February 2014”, “March 2014”, “April 2014”, and “Have not yet received enhanced payment”. Respondents were able to select a single answer and had the option to leave text comments.

The data shows that while just over a third of physicians received PCRI payments from Medicaid MCOs in 2013, nearly two thirds of physicians waited at least a year to receive PCRI payment from MCOs or still have not yet received payment.

This analysis shows a clear correlation between physicians’ employed practice status and a response of “have not yet received payment” to the question, “When did you first receive your enhanced reimbursement payment for primary care from the Medicaid Managed Care Plans that you accept?”

This may mean that employed physicians are not aware that their employers have taken in PCRI payments. This also may indicate that employed physicians are not aware that their employers are required by the ACA to pass on PCRI payment to the physicians who delivered PCRI services.
Respondents were asked questions about how the PCRI has affected their practice and their patients thus far. Questions were also asked to determine if respondents would be likely to make business decisions in the future based upon the continuation of primary care rate increases.

**FIGURE 7: RESPONDENTS’ ANSWERS TO:**
“DID YOU ACCEPT PAYMENT FROM MEDICAID PRIOR TO THE 2013-2014 ENHANCED PRIMARY CARE REIMBURSEMENT FOR MEDICAID PATIENTS?”

This question was available to all respondents, and it received 549 responses. Answer options included “Yes” and “No”. Respondents were able to select a single answer and had the option to leave text comments.

The data shows that nearly all survey respondents accepted Medicaid payment prior to the PCRI.

**FIGURE 8: RESPONDENTS’ ANSWERS TO:**
“DID THE ENHANCED REIMBURSEMENT RATE CAUSE YOU TO BEGIN ACCEPTING A GREATER NUMBER OF PATIENTS WHO HAVE MEDICAID?”

This question was only available to those who answered “Yes” to the question that read, “Did you accept payment from Medicaid prior to the 2013-2014 enhanced primary care reimbursement for Medicaid patients?” This question received 515 responses. Answer options were “Yes” and “No”, with an option to leave text comments.

In the comments section, some respondents said they accepted Medicaid-paying patients before 2013, but that they did not accept any new Medicaid patients prior to the rate increase.
FIGURE 9: RESPONDENTS’ ANSWERS TO:
“DID THE ENHANCED REIMBURSEMENT RATE FACTOR INTO YOUR DECISION TO BEGIN ACCEPTING MEDICAID PATIENTS INTO YOUR PRACTICE?”

This question was only available to those who answered “No” to the question that read, “Did you accept payment from Medicaid prior to the 2013-2014 enhanced primary care reimbursement for Medicaid patients?” This question received 34 responses. Answer options were “Yes” and “No”, with an option to leave text comments.

Since the sample size for this question was small, it is difficult to draw strong conclusions from this data.

FIGURE 10: RESPONDENTS’ ANSWERS TO:
“HAS MEDICAID’S ENHANCED REIMBURSEMENT RATE CAUSED YOUR PRACTICE TO MAKE BUSINESS DECISIONS ABOUT ANY OF THE FOLLOWING?”

This question was available to all respondents, and it received 511 responses. Answer options included: “Hired new staff (please explain how many / roles in comments)”, “Extended hours of business”, “Other (please explain in comments)”, and “No changes have been made”. Respondents were able to select multiple answers and had the option to leave text comments.

Interestingly, nearly 30% of physicians made business decisions, including the hiring of new staff and extension of hours, even though they knew the PCRI would only last for two years. It is likely that the remaining 69% of physicians were not willing to make business decisions based upon the PCRI’s short length.
112 Respondents left free-text comments about the business changes they made as a result of the PCRI. These comments were qualitatively analyzed into the categories listed below. Some respondents’ answers were placed into multiple categories.

This data shows that many practices were able to use PCRI funds to enhance their practices by adding staff, accepting more patients paying with Medicaid and accepting current patients paying with Medicaid, improving their ability to coordinate care, and upgrading their information technology systems.

**Key comments about changes include:**

- “[The PCRI] has helped significantly in supporting an enhanced staffing model being used in our PCMH practice that provides care to a large Medicaid population.”
- “[We hired an] MA and an NP [and we are] eliminating many referrals and ER visits.”
- “Hired a care coordinator (part-time), hired more primary care providers (NP, pediatrician), [and] bought equipment.”
- “Hired a new nurse [and] old staff are now giving more time to patient education - especially asthma education.”
- “We are using funds to enhance our medical home.”
- “Since our main source of patients is Medicaid (we are a urban Urgent Care in downtown Dayton) this allows us to be more financially stable.”
- “Prior to ACA, we were considering the need to STOP accepting Medicaid from any new patients.”
- “I did not decrease my Medicaid numbers, which I contemplated due to the low reimbursement.”
FIGURE 12: RESPONDENTS’ ANSWERS TO:
“CURRENTLY, MEDICAID’S ENHANCED PRIMARY CARE REIMBURSEMENT RATE IS SET TO EXPIRE AT THE END OF 2014. AFTER 2014, DO YOU PLAN TO…”

This question was available to all respondents, and it received 530 responses. Answer options included: “Continue to accept the same proportion of patients paying with Medicaid as you accepted in 2013 and 2014”, “Reduce the proportion of patients paying with Medicaid from the number you accepted in 2013 and 2014”, “Discontinue accepting Medicaid payment from patients”, “Other (please explain in comments)”. Respondents were able to select multiple answers and had the option to leave text comments.

This data shows that nearly all physicians who began accepting Medicaid patients as well as those who began accepting more Medicaid patients because of the PCRI anticipate going back to their old practice patterns when the PCRI ends.

FIGURE 13: RESPONDENTS’ COMMENTS ABOUT TAKING STEPS AFTER THE PCRI EXPIRATION 2015:

Respondents’ comments in the free-text area from the previous question were qualitatively analyzed into the categories listed below. Respondents’ answers were placed into a single category.
**FIGURE 14: RESPONDENTS’ ANSWERS TO:**
“IF YOU KNEW THAT MEDICAID’S ENHANCED PRIMARY CARE REIMBURSEMENT RATE WOULD CONTINUE IN PERPETUITY, WOULD YOU CHANGE YOUR PRACTICE PATTERNS (I.E. ACCEPT AN EVEN GREATER NUMBER OF MEDICAID PATIENTS, HIRE ADDITIONAL STAFF, EXTEND BUSINESS HOURS, ETC.)?"  

This question was available to all respondents, and it received 513 responses. Answer options were “Yes” and “No” with an option to leave text comments.

This data shows that the majority of physicians would make changes if they were guaranteed better reimbursement rates in the future.

![Yes 60.0% No 40.0%](image)

**FIGURE 15: RESPONDENTS’ ANSWERS TO:**
“HOW WOULD YOU PLAN TO CHANGE YOUR PRACTICE PATTERNS BECAUSE OF A LONG-TERM ENHANCED RATE?”

This question was available to all respondents. Respondents were asked to leave free-text answers. The 310 text responses were qualitatively analyzed into the categories listed below. Some respondents’ answers were placed into multiple categories.

The most common responses mentioned accepting a greater number of patients paying with Medicaid and mentioned providing patients with better care coordination.
FIGURE 16: RESPONDENTS’ WHO COMMENTED ABOUT ADDING STAFF - SPECIFIC MENTION OF ADDING STAFF IN THE FOLLOWING CATEGORIES:

The 98 comments from the previous question that mentioned adding staff were qualitatively analyzed into the categories listed below. Some respondents’ answers were placed into multiple categories.

This data shows that most staff additions would provide clinical care to Medicaid patients.

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Staff</td>
<td>33%</td>
</tr>
<tr>
<td>Physician Staff</td>
<td>11%</td>
</tr>
<tr>
<td>Non-Clinical Staff</td>
<td>10%</td>
</tr>
</tbody>
</table>

KEY COMMENTS FROM FREE-TEXT RESPONSES TO “HOW WOULD YOU PLAN TO CHANGE YOUR PRACTICE PATTERNS BECAUSE OF A LONG-TERM ENHANCED RATE?”

*Care coordination comments:*

- “I could set up a model that could truly help our office take care of this population: mental health staff, social services, beef up our care coordination, more outreach to community agencies.”
- “Provide walk-in facility that would avoid unnecessary ER visits saving costs.”
- “Provide greater hours of service and include more patient education in treatment.”
- “It would allow me the capital I need to hire and utilize a care coordinator to help better care for an increased Medicaid population.”
- “Expand services offered at our office: part-time social worker, part-time dietitian.”
- “Hire staff, extend hours, update computers, more network printers, [hire a] Care Manager, integrate behavioral health, [hire] FT Social Worker, FT Dietician, FT Pharmacist.”
- “Expand our PCMH program and provide even better resources for patient self management programs and form a patient advocacy group.”
- “We have hired 7 RN case managers to work with our most complicated (socially, medically) cases. If we knew the Medicaid enhanced rates would continue we could make a business case to hire more (perhaps 2-3) in the coming year to work in our resident continuity clinic which specifically serves a large percent of Medicaid patients (this approaches 30-35% of their practice). Our East side clinic also has a very large Medicaid population and they too would hire an additional Nurse Case Manager and probably one additional social worker and a mental health specialist.”
Access-related comments:

- “Would accept new patients and continue to provide immunization through VFC program. “
- “It would allow us to accept Medicaid with no restriction on panel size. Medicaid has historically paid us so low, we have not allowed the panel size to be in excess of 10% of our payer mix as we could not economically sustain a heavier load. The enhanced reimbursement removes this barrier.
- “Allow me provide services to new patients that would not be able to pay anything, especially to my current and future addiction service clients.”
- “I am about to retire. Extension of Medicaid payment would definitely influence that decision.”
CONCLUSIONS

The number of individuals receiving Medicaid benefits in Ohio is growing. By the end of July 2014, the state’s expansion program had enrolled 338,769 individuals to receive extended Medicaid services. This expansion population is just beginning to seek medical services from Ohio physicians, and their demand for care is likely to greatly increase over the coming years.

Prior to Medicaid expansion, the Government Accountability Office found that 38 states had trouble ensuring sufficient provider participation to meet Medicaid patient needs, and nearly all of these states cited low Medicaid payment rates as a factor that affects providers’ willingness to accept patients with Medicaid. Continuing to reimburse Ohio physicians at a fraction of Medicare rates will almost certainly guarantee that new and existing Medicaid patients will be denied access to care.

The results of the OSMA’s survey provide strong evidence that primary care physicians in Ohio who already accepted Medicaid patients are now accepting more patients who have both Medicaid fee-for-service and managed care benefits. A small number of physicians began accepting Medicaid patients because of the PCRI, and it is likely that many other physicians chose to avoid Medicaid payment altogether because they knew the enhanced rate was only slated to last for two years.

Many physicians who responded to the survey are committed to serving patients who pay with Medicaid, but these providers face frequent financial instability because of Medicaid’s low reimbursement rates. The results of this survey indicate that most physicians who began seeing Medicaid patients under the PCRI as well as those who increased their Medicaid case mixes under the PCRI will have to reduce the services they provide to Medicaid patients when the enhanced rate expires at the end of this year.

Results from this survey suggest that maintaining the PCRI (or creating a similar program to increase primary care physician payment in Ohio’s Medicaid program) would have very positive results for individuals with Medicaid benefits. In particular, parity between Medicaid and Medicare payment rates would increase Medicaid patients’ access to care and would significantly improve the quality of care that these patients receive. Physicians frequently wrote about their desire to better-coordinate care for Medicaid patients, and they indicated they would be able to provide well-coordinated, interdisciplinary care to their patients if rates were enhanced in perpetuity.

Like all patients, those receiving Medicaid benefits should have access to the right care at the right time in the right place – every time. Increasing Medicaid reimbursement for all physicians will improve patients’ access to care that can be provided in more efficient, better-coordinated ways.

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