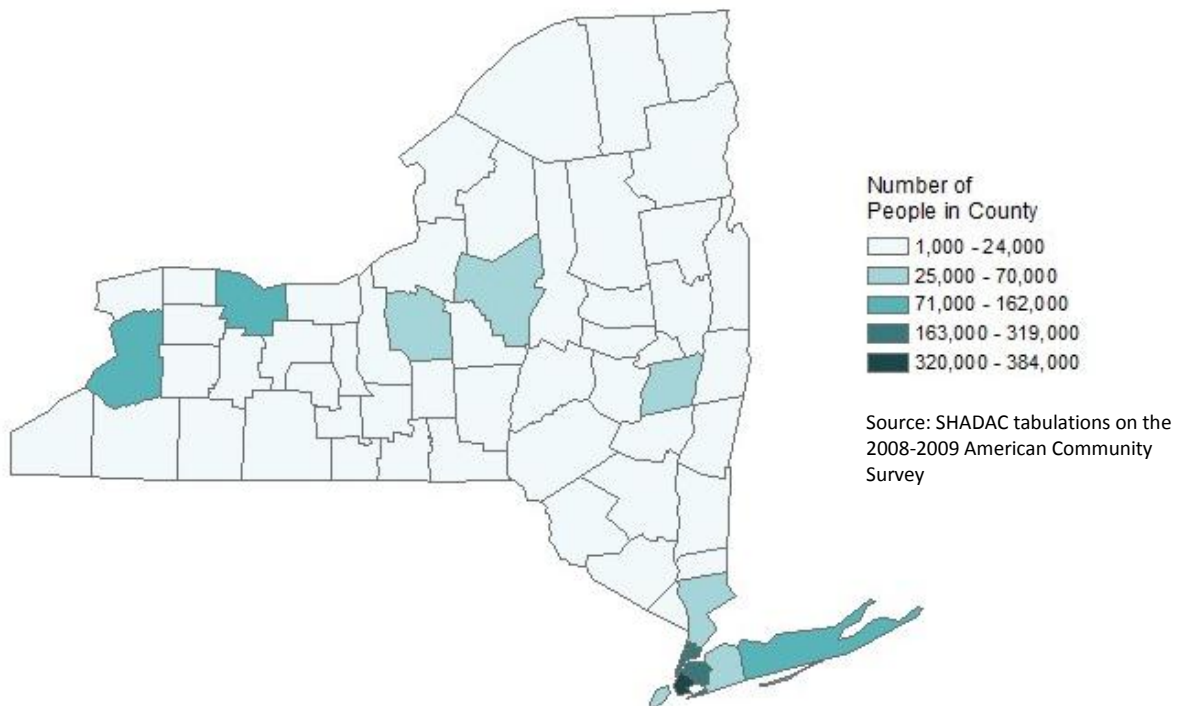


## Primary Care Provider Capacity Analysis Potential Gaps in the Availability of Primary Care Physicians under Health Reform NEW YORK

States have long been concerned about adequacy of supply of primary care physicians. A gradual decline in the number of physicians choosing to practice primary care, the aging physician workforce, and increasing demands of the aging population are already contributing to primary care shortages in many states.<sup>i,ii,iii</sup> The Patient Protection and Affordable Care Act (ACA), which is expected to expand health insurance coverage to 32 million uninsured people by 2019, has exacerbated these concerns.<sup>iv</sup> In particular, states are concerned about Medicaid expansions that will greatly increase the number potentially eligible enrollees and will account for half of the coverage gains. A sizable increase in demand for health care is anticipated with the increase in insurance coverage under the ACA, adding stress to existing primary care resources. If primary care capacity is not sufficient to serve that increase in demand, the ACA may not bring about its intended gains in access to care. Prior research has documented the potential for significant gaps in provider capacity with the expansion in coverage under the ACA at the state level.<sup>v</sup> The new challenges raised by health care reform combined with long standing concerns about primary care capacity enhance the need to monitor and track these issues.

The following maps and tables display one way of analyzing primary care capacity at a state level. The figures include information about the potential need (projected Medicaid eligibility and population characteristics) and capacity (current physician supply) in a visual format. **Map 1** shows the distribution of the population of nonelderly adults who will be eligible for Medicaid in 2014 by county for your state.<sup>vi</sup> Counties with a greater number of Medicaid-eligible adults are indicated by darker shading. **Table 1** illustrates the characteristics of the potentially newly eligible in your state.

**Map 1: Distribution of the Projected Medicaid Eligible Population Ages 19 to 64 in 2014 for New York, by County**



**Table 1. New York - Characteristics of non-elderly adults (19-64) below 139% of FPL 2008-09**

	Estimate	S.E. <sup>1</sup>
<b>Population Count</b>	2,091,039	
<b>Gender</b>		
Male	43.6%	0.30%
Female	56.4%	0.30%
<b>Age</b>		
19-25	22.5%	0.32%
26-34	20.9%	0.30%
35-44	21.7%	0.29%
45-54	20.0%	0.27%
55-64	14.9%	0.23%
<b>Race/Ethnicity</b>		
White Alone, Non-Hispanic	40.9%	0.41%
Black Alone, Non-Hispanic	19.9%	0.34%
AIAN Alone <sup>2</sup> , Non-Hispanic	0.4%	0.05%
Asian Alone, Non-Hispanic	9.0%	0.27%
Other/Multiple, Non-Hispanic	1.8%	0.10%
Hispanic	28.0%	0.41%
<b>Work Status</b>		
Not Working	58.2%	0.33%
Working	41.8%	0.33%
<b>Private Health Insurance<sup>3</sup></b>	28.4%	0.36%
<b>Public Health Insurance<sup>4</sup></b>	48.0%	0.39%
<b>Uninsured</b>	28.5%	0.37%

Source: SHADAC tabulations of the 2008-09 American Community Survey.

Data have been reweighted to reflect the average 2008-2009 population.

1. Standard errors (S.E.) account for the complex sample design of the ACS following Davern et al 2006 and Boudreaux et al. 2011

2. AIAN: American Indian or Alaska Native

3. Private insurance includes employer sponsored insurance, insurance purchased directly from an insurer, TRICARE, and VA coverage

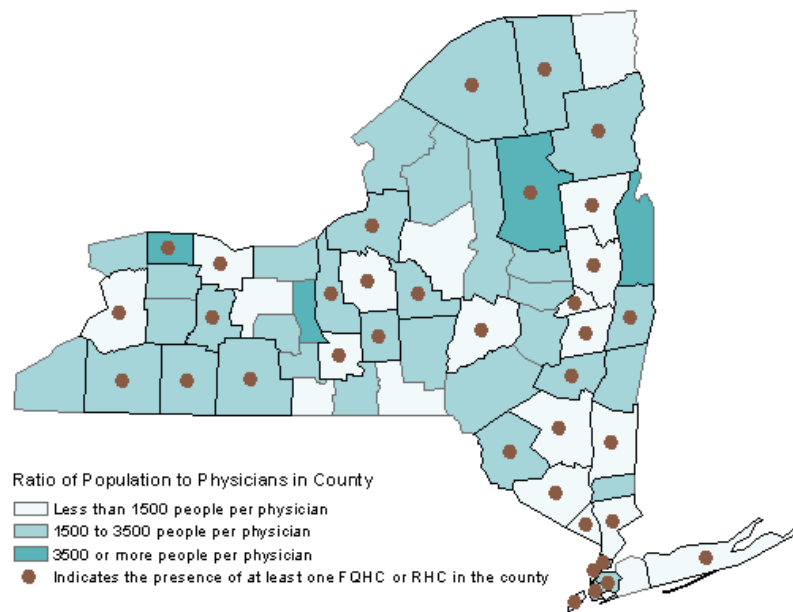
4. Public coverage includes coverage from Medicare and all means-tested coverage such as Medicaid and state specific programs.

Coverage note: All coverage variables reflect data editing procedures consistent with the Census Bureau's 2010 data editing routine. People may have public and private coverage.

Column totals may not sum to 100 due to rounding.

**Map 2** shows the distribution of primary care providers by county in your state.<sup>vii</sup> The darker shading indicates counties with more residents per primary care physician. The darkest shading represents counties with 3,500 or more people per physician (the current standard for designating health professional shortage areas.) By comparing the two maps, states may find that counties with large numbers of Medicaid-eligible adults are also counties with a potentially inadequate primary care supply.

**Map 2: Primary Care Physician Supply Relative to Population in New York, by County**



Source: SHADAC tabulations on the 2008-2009 American Community Survey and the Area Resource File.

Notes: Primary care physicians are defined as M.D.'s that are non-Federal, active, office-based M.D.'s in general, family, or general internal medicine; general pediatrics, or OB/GYN as of 2008; and office based primary-care non-federal D.O.'s that are in general/family care, internal medicine, general pediatrics, or OB/Gyn as of 2007. The count of office based D.O.'s was determined by applying the share of all D.O.'s that were office-based to the count of primary care D.O.'s. All providers are counted as 1 FTE. Population counts are the average population in county between 2005 and 2009.

A Federally Qualified Health Center (FQHC) is a health organization that offers primary care and preventative health services to all patients regardless of their ability to pay. It must be a public or private nonprofit organization and meet specific criteria to receive government funding. A Rural Health Clinic is a clinic located in a rural, medically under-served area and must meet specific criteria to receive government funding.

### Provider Capacity Data

The provider data used in the analysis above came from the Health Resources and Services Administration's (HRSA) Area Resource File (ARF): <http://arf.hrsa.gov/>. The ARF compiles county-level data from a breadth of sources on health and health system topics, including counts of health care professionals and facilities, and summary characteristics for the county population. Limitations of these data include the lack of geographic detail (county-level is the smallest geographic area for which data is publicly available), time lag (the most recent physician data is for 2008, other provider data is even older) and concerns about the quality (e.g. accuracy of practice status and location of practice).

Though the ARF is a good and very broad source of information on provider capacity, state-specific data often provide an even better assessment of provider capacity issues. Often these data are available from government agencies (e.g., local public health, counties, various state agencies) or professional associations/boards. These data are generated through surveys, but are also collected for administrative purposes such as through the licensure process. Many states are considering the licensure process as a vehicle for collecting provider data. In addition to standard information on demographics and specialty, data elements of interest include: information on multiple practice locations, is the provider accepting new Medicaid patients, language proficiency, ethnicity, patient payer mix, etc. Two resources to consider when reviewing your state data options:

- ✓ In 2008, the Center for the Health Professions at the University of California, San Francisco compiled a list of states that collect provider information through their professional boards. A summary can be found here: [http://futurehealth.ucsf.edu/Content/29/2008-09\\_Collecting\\_Health\\_Workforce\\_Data\\_in\\_California.pdf](http://futurehealth.ucsf.edu/Content/29/2008-09_Collecting_Health_Workforce_Data_in_California.pdf)

- ✓ The North Carolina Health Professions Data System (HPDS), housed within the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill has some of the most robust workforce data in the country. Data is collected in close partnership with the North Carolina Area Health Education Centers (AHEC) Program, and in collaboration with the North Carolina health professional licensing boards. A summary of the data system can be found here: [http://www.shadac.org/files/shadac/publications/StateDataSpotlight\\_NC\\_jan2011.pdf](http://www.shadac.org/files/shadac/publications/StateDataSpotlight_NC_jan2011.pdf)

### Provider Capacity Questions to Consider

Several factors beyond the number of eligible individuals and primary care providers will be important for understanding your state's capacity to serve the newly covered populations in 2014. Some questions to consider include the following:

- Newly eligible adults:
  - What is their current health insurance coverage?
  - What are their current health care needs and patterns of health care access and use?
  - Who are the providers that they are relying on for care?
- Uninsured adults that will NOT be eligible:
  - What are their current health care needs and patterns of health care access and use?
  - Who are the providers that they are relying on for care now?
  - How will those providers be impacted by the eligibility expansion?
- Variations in access and use:
  - How does it vary across the state?
  - How does it vary for individuals with different characteristics, such as by age, income, or type of health insurance coverage?
  - How does it vary with community characteristics, such as population characteristics (poverty, linguistic isolation, race/ethnicity segregation) and characteristics of the local health care system?
- Provider and Facility Supply:
  - How does the supply vary across the states?
  - How does it vary by characteristics (age, income, or type of health insurance coverage)?
  - What level of supply (people per providers) and what mix of providers (physicians, nurses, etc.) are needed to achieve what outcome (reduced wait times? reduced travel times? more providers to choose from?)

<sup>i</sup> Association of American Medical Colleges. (2008). The Complexities of Physician Supply and Demand: Projections Through 2025.

<sup>ii</sup> Friedberg MW, Hussey PS, Schneider EC. (2010). Primary care: a critical review of the evidence on quality and costs of health care. *Health Affairs* 29(5): 766-772.

<sup>iii</sup> Colwill JM, Cultice JM, Kruse RL. (2008). Will generalist physician supply meet demands of an increasing and aging population? *Health Aff (Millwood)*. 2008;27:w232-41.

<sup>iv</sup> Congressional Budget Office. (2010). Cost estimate for the amendment in the nature of a substitute for H.R. 4872, incorporating a proposed manager's amendment made public on March 20, 2010. Available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

<sup>v</sup> Hofer AN, Abraham JM, Moscovice I. (2011). Expansion of coverage under the Patient Protection and Affordable Care Act and primary care utilization. *Milbank Quarterly*. 89(1): 69-89.

<sup>vi</sup> Estimates from local ACS geographies were converted to county estimates using Census 2000 population shares.

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