

## **Billing Issues and Delayed Reimbursement are Key Factors Inhibiting Medicare and Medicaid Access to Office-Based Physicians**

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*Office-based physician practices are an important part of our overall national health care delivery system, yet access continues to be a challenge for both Medicare and Medicaid beneficiaries. This study explores significance of the obstacles that limit Medicare and Medicaid participation by office-based physicians. Findings indicate inadequate reimbursement is indeed the greatest obstacle, though timeliness of reimbursement as well as paperwork requirements relating to filing of claims is a close second. Policymakers would be wise to well consider all three of these factors as they seek solutions for improving beneficiaries' access to office-based practitioners.*

### **INTRODUCTION**

Improving Medicare and Medicaid beneficiaries' access to office-based physicians has long been a concern at the national level. These two social welfare programs support much of the nation's most vulnerable; the elderly, disabled, young and low income, yet just forty-four percent of US office-based practices are accepting all or most new Medicaid patients (Center for Studying Health System Change, 2008). According to the Health System Change national survey, eighty-six percent reported their practices were accepting all or most new privately insured patients but just seventy percent reported their practices accept all or most Medicare patients. Exacerbating the access issue is the expansion of insurance coverage under the Affordable Care Act, not to mention the aging and retirement of the baby-boomer generation together with overall increase in life expectancy.

This study explores this national conundrum from the physicians' perspective. Drawing upon data from the 2008 Health Tracking Physician Survey restricted-use file, this study examines the financial pressures faced by physicians in office-based practices who limit their acceptance of new Medicare and Medicaid patients. Financial pressures represent reimbursement issues associated with revenue and various administrative concerns specific to cost.

It is acknowledged that physicians confront a great deal of uncertainty about the revenue and cost implications of treating their patients (Evans, Kim & Nagarajan, 2006). In serving Medicare and Medicaid patients, financial pressures associated with operating physician practices are appraised to be more pronounced. Operating a physician practice is made more difficult when having to run at reduced net revenue margins owing to lower reimbursement rates. What is more, expenses of the physician practice are in no way reduced by taking on Medicare and Medicaid patients. On the contrary, serving Medicare and Medicaid patients can require additional expense owing to costs associated with monitoring the billing and collection process to minimize possibilities for delayed reimbursement and maintaining compliance with regulatory billing and paperwork requirements. Moreover, the additional clinical burden

and capacity needs that exist when attending to an older, disabled, poorer, young population can be challenging.

Knowing the significance of the factors associated with physicians' decisions to limit acceptance should provide opportunities for potential public policy solutions. The importance of a good national health care delivery system is paramount to safeguarding the wellbeing of one's citizens and access to care is a fundamental dimension upon which the entire system rests.

## LITERATURE REVIEW

Both the peer-reviewed literature and popular press are well versed on the matter of inadequate reimbursement as a disincentive for physicians to take on new Medicare and Medicaid patients. It is also known that the revenue-related issue has been more pronounced with the latter, Medicaid.

"Medicaid pays most health care providers poorly" according to Charles Phelps (2012, p. 367), author of *Health Economics*. Zuckerman, et al. (2009) report Medicaid physician primary care reimbursement stood at 66 percent of Medicare reimbursement and is even lower relative to private insurance payment rates. Alleviating this issue in 2013 and 2014, states were required by Affordable Care Act to reimburse primary care providers at the rate that would be paid for the service under Medicare. Now that the mandated primary care increase has expired, MACPAC (2015) is reporting that at least twenty-four states reverted to their previous primary care payment rates and at least fourteen states are paying higher levels in 2015 than their pre-2013 levels though not necessarily as high as Medicare.

Albeit greater, Medicare's physician schedule is also criticized for inadequacy. CNN Money reports that Medicare's allowed charges today stand at approximately 80% of the charges allowed by private insurers overall, which is relatively unchanged since 1999 (Luhby, 2014). Like that for Medicaid, in the Medicare program the physician fee schedule is legislatively established. The physician acts as a price taker; no longer setting their own fee for service (Hadley et al., 2009; Weis, 1990).

A second financial pressure relates to billing requirements including paperwork and filing of claims. One major challenge is the excessive complexity inherent in conducting routine transactions. As it relates to Medicare and Medicaid, billing is complicated. One must fully understand the ins and outs of the claim submission process and issues surrounding claim denials. The Mayo Foundation has estimated that the number of pages of federal regulations and related paperwork that doctors must comply with in order to treat Medicare and Medicaid patients totals almost 132,000 (Arnett et al., 2000). Regulation and bureaucracy remain a point of physician dissatisfaction in the present-day.

A third financial pressure from the physician's perspective is that of concern for an audit. As the Medicare and Medicaid programs have grown in both size and complexity, accountability and accuracy of claims has become more important for these government agencies. As a case in point, additional series of audits for the Medicare program was newly implemented as a requirement by the Section of the Tax Relief and Health Care Act of 2006 (H.R. § 6111). From the perspective of the physician it may provide for a level of angst as increased diligence in coding, documentation and ultimately billing are called for.

Capacity constraint and clinical burden are the fourth and fifth financial pressures. Capacity constraint is fairly straightforward meaning that the practice already has enough patients. Certainly, this would prove a limitation for accepting new Medicare & Medicaid patients. Scheidet and Thibadoux (2005) articulate the fact that if a practice is operating at full capacity, additional business could only be met by replacing one group of customers with another otherwise the practice needs to be physically expanded.

Medicare patients, typically age 65 years and older, demand more medical care and more specifically experience higher utilization rates, which is accompanied by higher variability in treatment costs (Phelps, 2012; Cross, 2007; Leone, 2002; Rosenthal & Landefeld, 1993). Moreover, this patient population may require services that are increasingly costly and complicated. This is referred to as clinical burden and it is reasonable to surmise that an underprivileged population that qualifies for Medicaid may also be met with higher variability in treatment costs. Moreover, Fox (1996) finds "a rule of thumb relating to resource

requirements for servicing the elderly finds it to be at least three times that of which is associated with the nonelderly” (p. 3).

## METHODOLOGY

### Data Collection, Population & Sampling Frame

The data for this study comes from the Health System Change’s 2008 Health Tracking Physician Survey (HSC-PS)<sup>1</sup>. The 2008 HSC-PS represents a fifth round of data, with previous surveys known as the Community Tracking Study (CTS) conducted in 1996-97 and repeated with similar samples in 1998-99, 2000-01 and 2004-05. However, because of changes in the sample and data collection approach, results from the 2008 physician survey cannot be analyzed against earlier CTS Physician Surveys.

More specifically, the dataset employed in this study is that of the more comprehensive restricted-use file. There are two versions of the data file: a public-use and restricted-use version. The two differ in the amount of information they contain and ease of accessibility.

The survey asks physicians from around the country about their practice and their views about the challenges facing physicians today. The target population was based on information provided by the American Medical Association (AMA).

### Measurement and Preparation

Given that the central problem of this study concerns obstacle that limit Medicare and Medicaid participation by U.S. office-based physicians, physicians employed by universities, health maintenance organizations (HMOs) and hospitals were excluded from this study. The dataset examined was further scaled back due to a negligible number of missing records and outliers. As a result of the previously mentioned, the Medicare dataset has a total of 3,559 physician survey responses (75.4% of the total 4,720 responding physicians). The Medicaid dataset examined has a total of 3,469 physician survey responses (73.5% of the total responding physicians).

In exploring the financial pressures of physicians that limit acceptance of new Medicare and Medicaid patients, a qualifying question served as the basis from which physicians within the sample to draw. Providing for internal validity, the qualifying question is as follows: “*Is your practice accepting all, most, some, or no new patients who are insured through Medicare (Medicaid)?*” If the physician answered “accepting some” or “accepting no” new patients who are insured through Medicare (Medicaid) then their responses to the five questions referencing reason for limiting acceptance of new Medicare (Medicaid) patients are included.

Of the 3,559 office-based physicians represented in the Medicare dataset, 1,063 (29.9% of the sample) responded to the qualifying question as “accepting some” or “accepting no” new patients who are insured through Medicare.

Of the 3,469 office-based physicians represented in the Medicaid dataset, 1,954 (56.3% of the sample) responded to the qualifying question as “accepting some” or “accepting no” new patients who are insured through Medicaid.

Each of the questions pertaining to reason for limiting acceptance of new Medicare patients were measured using a Likert-type Summated Scaling technique. The instrument included 4-points where 1 represented agreement with “not at all important”, 2 with “not very important”, 3 with “moderately important” and 4 with “very important”. A fifth response option, labeled “not ascertained”, was grouped into the “1- not at all important” physician response category.

The five questions in the survey associated with the topic of reasons for limiting acceptance of new Medicare (Medicaid) patients are as follows:

***Billing issues*** - Reason why physician practice accepts only some or no new Medicare (Medicaid) patients: billing requirements, including paperwork, and filing of claims.

***Inadequate reimbursement*** - Reason why physician practice accepts some or no new Medicare (Medicaid) patients: inadequate reimbursement.

Capacity constraints - Reason why physician practice accepts some or no new Medicare (Medicaid) patients: practice already has enough patients.

Clinical burden - Reason why physician practice accepts some or no new Medicare (Medicaid) patients: Medicare patients have high clinical burden.

Concern about audit (MEDICARE only) - Reason why physician practice accepts only some or no new Medicare patients: concern about a Medicare audit.

Delayed reimbursement (MEDICAID only) - Reason why physician practice accepts some or no new Medicaid patients: delayed reimbursement.

## **Empirical Analysis**

Friedman's two-way analysis of variance by ranks is used to explore the problem in this study: the financial pressures of physicians that limit acceptance of new Medicare and Medicaid patients. As aforementioned, the five financial pressures identified in the survey include: 1) billing issues, 2) inadequate reimbursement, 3) capacity constraints, 4) clinical burden and 5) concern about an audit (Medicare) and delayed reimbursement (Medicaid). Hypotheses addressing the problem statement include:

*H<sub>1</sub>: There is no difference between the five identified financial pressures for physicians likely to reject acceptance of new Medicare patients.*

*H<sub>2</sub>: There is no difference between the five identified financial pressures for physicians likely to reject acceptance of new Medicaid patients.*

The Friedman test examines differences between three or more groups when the dependent variable being measured is ordinal. This test is appropriate for this study which examines an ordinal dependent variable and five different reasons for why physicians who do limit new Medicare (Medicaid) patients as measured on an ordinal scale from not at all important to very important.

Should results from the Friedman's Rank Test indicate that statistically significant differences do in fact exist, the Wilcoxon signed-rank tests is explored so as to examine where the pairwise differences actually occur.

## **RESULTS**

### **Medicare - Financial Pressures**

Five financial pressures identified in association with taking on new Medicare patients are billing issues associated with billing requirements including paperwork and filing of claims, concern about a Medicare audit, inadequate reimbursement, capacity constraints where the practice already has enough patients and high clinical burden associated with Medicare patients. Each financial pressure is examined individually and ranked on a scale of 1 to 4, with response options representing agreement with:

1. not at all important
2. not very important
3. moderately important
4. very important

A statistically significant difference is found to exist in physician's perception of financial pressures associated with taking on new Medicare patients,  $\chi^2(4) = 789.312, p = 0.000$ .

**TABLE 1**  
**MEDICARE: FRIEDMAN'S TEST OF FINANCIAL PRESSURES**

<b>Ranks</b>	Mean Rank
Billing Issues	3.30
Concern of a Audit	2.30
Inadequate Reimbursement	3.65
Capacity Constraints	2.96
Clinical Burden	2.79

**Test Statistic<sup>a</sup>**

N	1063
Chi-Square	789.312
Df	4
Asymp. Sig.	.000

a. Friedman Test

Taking a closer look at where the differences occur, Wilcoxon signed-rank test is run individually on the different combinations of related groups: billing issues to concerns for an audit, billing concerns to inadequate reimbursement, billing issues to capacity constraints, billing issues to clinical burden, concern for an audit to inadequate reimbursement, concern for an audit to capacity constraints, concern for an audit to clinical burden, inadequate reimbursement to capacity constraints, inadequate reimbursement to clinical burden and capacity constraints to clinical burden. Results follow.

**TABLE 2**  
**MEDICARE: WILCOXON SIGNED-RANK TEST OF FINANCIAL PRESSURES**

**Test Statistics<sup>a</sup>**

	Audit – Billing	Reimburse – Billing	Capacity - Billing	Burden – Billing	Reimburse – Audit	Capacity – Audit	Burden - Audit	Capacity – Reimburse	Burden - Reimburse	Burden - Capacity
Z	-18.511 <sup>b</sup>	-9.161 <sup>c</sup>	-5.022 <sup>b</sup>	-10.328 <sup>b</sup>	-20.474 <sup>c</sup>	-11.308 <sup>c</sup>	-9.868 <sup>c</sup>	-10.761 <sup>b</sup>	-16.127 <sup>b</sup>	-3.973 <sup>b</sup>
Asymp. Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

c. Based on negative ranks.

Post-hoc analysis reveals across all ten groups there is a statistically significant difference between the financial pressures based upon p-values of .000 < .005.

Overall, results reveal inadequate reimbursement is of greatest concern for physicians who limit the acceptance of new Medicare patients. On average, these physicians cite it as very important in the practice's decision to limit acceptance of new Medicare patients. Of secondary importance is billing issues, indicated to be more than moderately important in their decision to limit new Medicare patients.

Thirdly, capacity constraints are found to be moderately important in limiting physicians' decision and clinical burden, fourthly, is found to be slightly less than moderately important. The fifth financial pressure, concern for an audit, is not considered very important on average to limiting physicians to new Medicare patients.

### Medicaid - Financial Pressures

Five financial pressures identified in association with taking on new Medicaid patient are billing issues associated with billing requirements including paperwork and filing of claims, delayed reimbursement, inadequate reimbursement, capacity constraints where the practice already has enough patients and high clinical burden associated with Medicaid patients. Again, each financial pressure is examined individually and ranked on a scale of 1 to 4 ranging from 1 as "not at all important" through 4 as "very important".

**TABLE 3**  
**MEDICAID: FRIEDMAN'S TEST OF FINANCIAL PRESSURES**

Ranks	Mean Rank
Billing Issues	3.18
Delayed Reimbursement	3.13
Inadequate Reimbursement	3.80
Capacity Constraints	2.36
Clinical Burden	2.53

**Test Statistics<sup>a</sup>**

N	1954
Chi-Square	1715.438
Df	4
Asymp. Sig.	0.000

a. Friedman Test

A statistically significant difference is found to exist in physician's perception of financial pressures associated with taking on new Medicaid patients,  $\chi^2(4) = 1,715.438, p = 0.000$ .

Taking a closer look at where the differences occur, Wilcoxon signed-rank test is run individually on the different combinations of related groups: billing issues to delayed reimbursement, billing concerns to inadequate reimbursement, billing issues to capacity constraints, billing issues to clinical burden, delayed reimbursement to inadequate reimbursement, delayed reimbursement to capacity constraints, delayed reimbursement to clinical burden, inadequate reimbursement to capacity constraints, inadequate reimbursement to clinical burden and capacity constraints to clinical burden. Results follow.

Post-hoc analysis reveals that across nine of the ten groups, there is a statistically significant difference based upon p-values of  $.000 < .005$ . There is no significant difference found, however, between delayed reimbursement and billing issues ( $z = -1.631, p = .103$ ).

Overall, results reveal that inadequate reimbursement is by far the greatest concern for physicians who limit the acceptance of new Medicaid patients. These physicians cite it as very important in the practice's decision to limit acceptance of new Medicare patients. In second place, billing issues and delayed reimbursement are collectively cited as the next financial pressure(s) of concern; indicated to be slightly more than moderately important in their decision to limit acceptance of new Medicaid patients. Clinical burden is reported to be only somewhat important, on average limiting physicians reported it as

being between moderately important and not very. The fifth financial pressure, capacity constraints, is not considered very important on average to limiting physicians to new Medicaid patients.

**TABLE 4**  
**MEDICAID: WILCOXON SIGNED-RANK TEST OF FINANCIAL PRESSURES**

**Test Statistics<sup>a</sup>**

	Delay - Billing	Reimburse - Billing	Capacity - Billing	Burden - Billing	Reimburse - Delay	Capacity - Delay	Burden - Delay	Capacity - Reimburse	Burden - Reimburse	Burden - Capacity
Z	-1.631 <sup>b</sup>	-17.978 <sup>c</sup>	-19.066 <sup>b</sup>	-17.252 <sup>b</sup>	-19.918 <sup>c</sup>	-18.457 <sup>b</sup>	-16.220 <sup>b</sup>	-26.747 <sup>b</sup>	-27.261 <sup>b</sup>	-6.106 <sup>c</sup>
Asymp. Sig. (2-tailed)	.103	.000	.000	.000	.000	.000	.000	.000	.000	.000

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

c. Based on negative ranks.

**CONCLUSIONS AND AREAS FOR FURTHER RESEARCH**

**Discussion of Findings**

Of the five financial pressures identified in association with taking on new Medicare and new Medicaid patients, limiting physicians cite inadequate reimbursement as their greatest concern. On average, these physicians cite it as very important in their practices' decision to limit acceptance of both new Medicare and Medicaid patients. Previously cited literature and popular press are well informed on the matter of inadequate reimbursement as a disincentive for physicians to take on new Medicare and Medicaid patients.

For Medicare, billing issues are observed to be the next greatest obstacle, identified as moderately to very important. Billing issues encompass required paperwork and filing of claims. It is asserted there exists excessive complexity in conducting routine transactions, making billing extremely complicated (Arrow et al., 2000; Kahan, 1999). Results from this study support this position. Considered moderately important as a deterrent to taking on new Medicare patients are capacity constraints and clinical burden. Straightforward, capacity constraints is when the practice is already operating at full capacity and as Scheidet and Thibadoux (2005) point out additional business could only be met by replacing one group of customers with another absent a physical expansion. Capacity constraints are cited as the third greatest financial pressure for limiting Medicare patients. Medicare clinical burden refers to the fact that the 65 years old plus population inherently demands more medical care and, more specifically, experience higher utilization rates, which is accompanied by higher variability in treatment costs (Phelps, 2012; Cross, 2007; Leone, 2002; Rosenthal & Landefeld, 1993). Physicians cite clinical burden as slightly less than moderately important and as such was found to be the fourth greatest financial pressure. Interestingly, concern for a Medicare audit was found to be "not very important" as a limiting factor.

Turning to Medicaid, inadequate reimbursement is by far the greatest concern. Billing issues and delayed reimbursement are collectively cited as the next financial pressure of real concern; indicated to be more than moderately important in their decision to limit acceptance of new Medicaid patients. The other two financial pressures are much less noteworthy, clinical burden reported only somewhat important and capacity constraints was considered not very important on average to limiting physicians to new Medicaid patients.

## Policy Implications

Shown once again to be the greatest deterrent associated in taking on new Medicare and Medicaid patients, inadequate reimbursement is very important in physicians' decision to limit these patients. The corollary then is that reimbursement truly is the main tool for policymakers as they consider ways to alleviate limiting access. The legislative measure which provided for a 2013 and 2014 temporary increase in Medicaid rates provides for a case in point.

Similar to the findings of Cunningham and O'Malley (2009), delayed reimbursement is also a real concern associated with physician participation in the Medicaid program. Additionally, billing issues are found herein to be a significant obstacle for physicians in accepting both new Medicare and Medicaid patients. Policymakers would be wise to further consider these administrative concerns in resolving the issue at hand. The results of this study indicate that further streamlining of processes and providing for less arduous requirements, necessitating less technical knowhow, may go a long way toward aiding physicians to support new Medicare and Medicaid patient acceptance.

## Limitations and Areas for Further Research

An inherent limitation of the survey instrument is that the writer cannot assess the financial pressures for both those physicians that limit acceptance of new Medicare and Medicaid patients and those that do not. If the physician answered "accepting all" or "accepting most" then their responses to the five questions referencing reason for limiting acceptance of new Medicare patients were excluded from tabular results. Another important limitation is the fact Medicaid reimbursement rate and turnaround time varies across the country. The influence of ACA is tremendously important to the issue of access. It will undoubtedly be important to stay apprised of how the Medicaid program evolves and continue to evaluate enrollees' ability to access office-based physicians, which will likely vary considerably state-to-state.

Outside the scope of this study, a natural extension for further research would be to examine the combined effect of the leading financial pressures; namely inadequate reimbursement, delayed reimbursement and billing issues for Medicaid.

## ENDNOTES

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