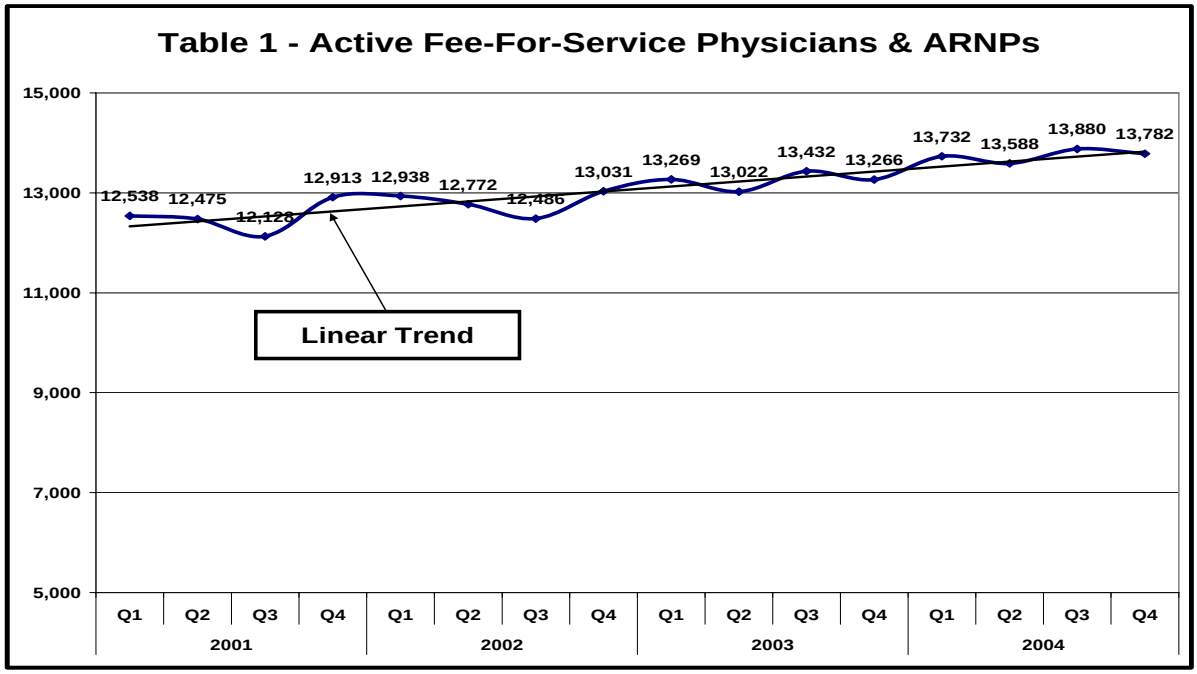
HEALTH & RECOVERY SERVICES ADMINISTRATION FEE-FOR-SERVICE PHYSICIAN & ARNP PARTICIPATION CY 2004 UPDATE

UPDATE SUMMARY

- This is the fourth update of Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA) monitoring of fee-for-service (FFS) physician and Advanced Registered Nurse Practitioners (ARNPs) participation (hereafter providers).

- Overall, calendar year (CY) 2004 statewide data continued to show sustainable trends. However, specialty providers in certain counties had reductions that will continue to be monitored. While physician and ARNP participation has increased, 70% of office visits are still provided by only 25% of the active providers.

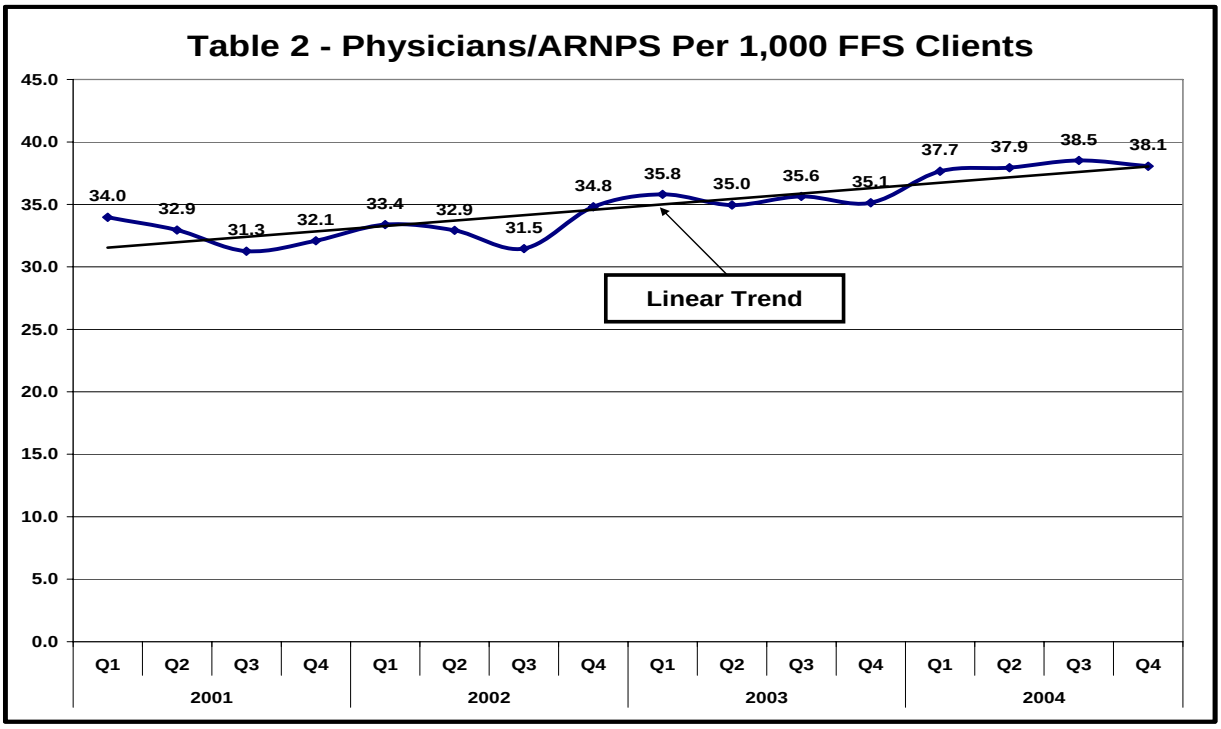
- The number of active providers increased 3.8% from 13,247 average in SFY 2003 to 13,746 average in SFY 2004 (See Table 1). This is a continuation of a trend over the past seven years (1998 through 2004) in which provider participation increased an average of 3.0% per year.



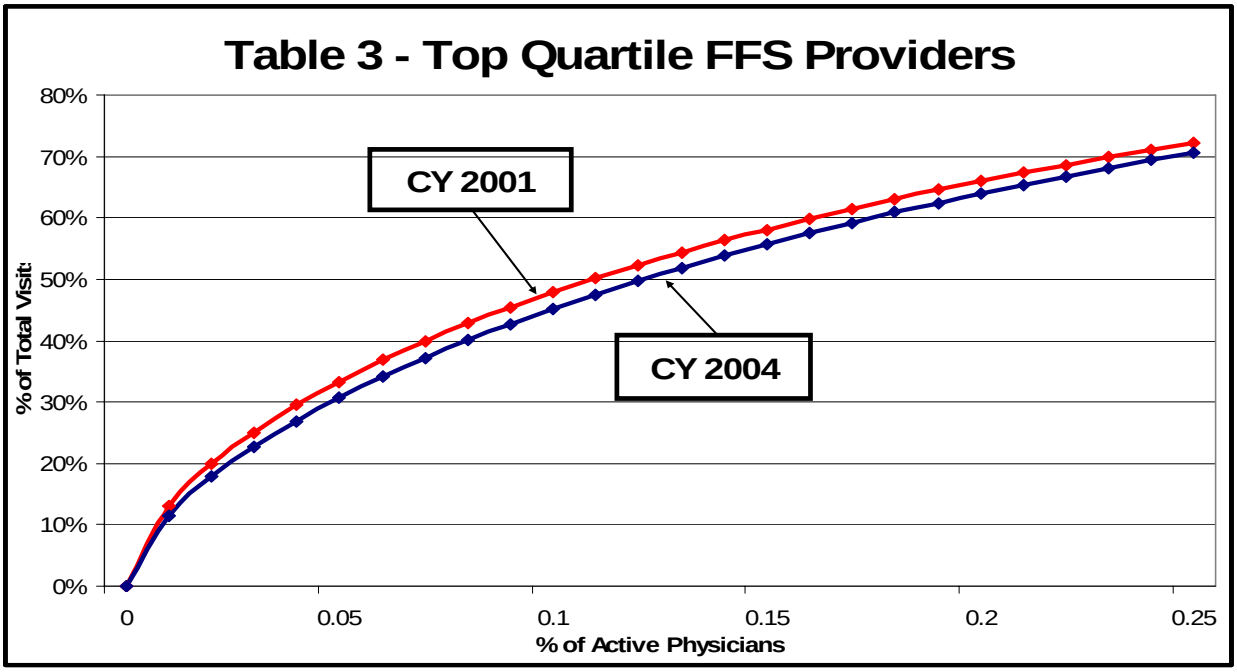
- The CY 2004 increase in the number of providers was relatively broad-based. Twenty-four (62%) of the 39 counties had an increase in providers, while 14 (36%) had a decrease.

- The ratio of providers per FFS 1,000 clients (a measure of capacity) increased 7.5%, from 34.5 per 1,000 average to 38.0 per 1,000 average during CY 2004 (See Table 2). This is a continuation of a trend over the past three years.

- The CY 2004 increase in providers per 1,000 clients also was relatively broad-based. Twenty-two (56%) of the counties had an increase in providers, while 14 (44%) had a decrease.



- Although there were more providers, the distribution of visits provided by the top quartile of providers remained at 71% (See Table 3). Twenty-four (62%) of the 39 counties had a decrease in the percent of visits by the top quartile, while 15 (38%) had an increase.



BACKGROUND

In March 2003, HRSA developed and began tracking a set of measures to monitor HRSA's fee-for-service (FFS) access to physician and ARNP (hereafter referred to as providers) care to medical programs administered by HRSA. [1, 2] These measures are:

1. Number of active FFS providers, which provides a basic measure of physician participation; [3]

2. Capacity of the FFS providers network presented as a ratio of providers to 1,000 clients, which provides a normalized measure of access capacity; and,

3. Distribution of FFS visits performed by the top quartile of active providers, which provides a measure of workload across active physicians.

The number of "active" FFS providers is compared with the reported number of Medicaid Healthy Options (HO) managed care, state employees' PEBB managed care and state employees' Uniform Medical Program (UMP) providers to assess if there is a comparable loss or gain in physicians serving HO, PEBB and UMP members.[4]

The three measures are separately compared for FFS primary care and specialty care providers, and for adult and children providers. Primary care providers are defined as those who were in the following four categories: general practice, family practice, pediatrics, and internal medicine. Specialty care providers are those who were outside the four categories.

Each measure is compared on a statewide and by-county basis to identify overall trends and specific county issues. The measures are updated every six months on a January/June cycle. To ensure complete data, there is a six month lag in generating the data used for the most current periods.

To better assess the burden on providers, two additional measures are being added. These measures are - visits per active provider and visits per 1,000 clients. Visits per provider will indicate whether providers are on average providing more services to Medicaid clients. Visits per 1,000 clients are a utilization measure that will indicate whether providers are seeing clients who are using more services. These measures are being tracked on a quarterly basis beginning July 2003.

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[1] Refer to "*Measuring Fee-For-Service Physician & ARNP Participation and Client Access to Care – Baseline Measures*" report prepared by the Department of Social and Health Services Medical Assistance Administration (March 30, 2004) for overview of the access measures and baseline estimates for SFY 2001 and 2002, with SFY 1998-2000 comparisons.

[2] The HRSA medical programs include: Medicaid, Medical Care Services (GAU/ADATSA), State Children's Health Insurance Program (SCHIP), and Refugee Assistance. Beginning January 2006, it also will include the Children's Health Program (CHP).

[3] "Active providers" is the number of physicians or ARNPs that had at least one patient visit in a given period. The reason for adopting this definition is to fully capture information for the distribution of visits measure.

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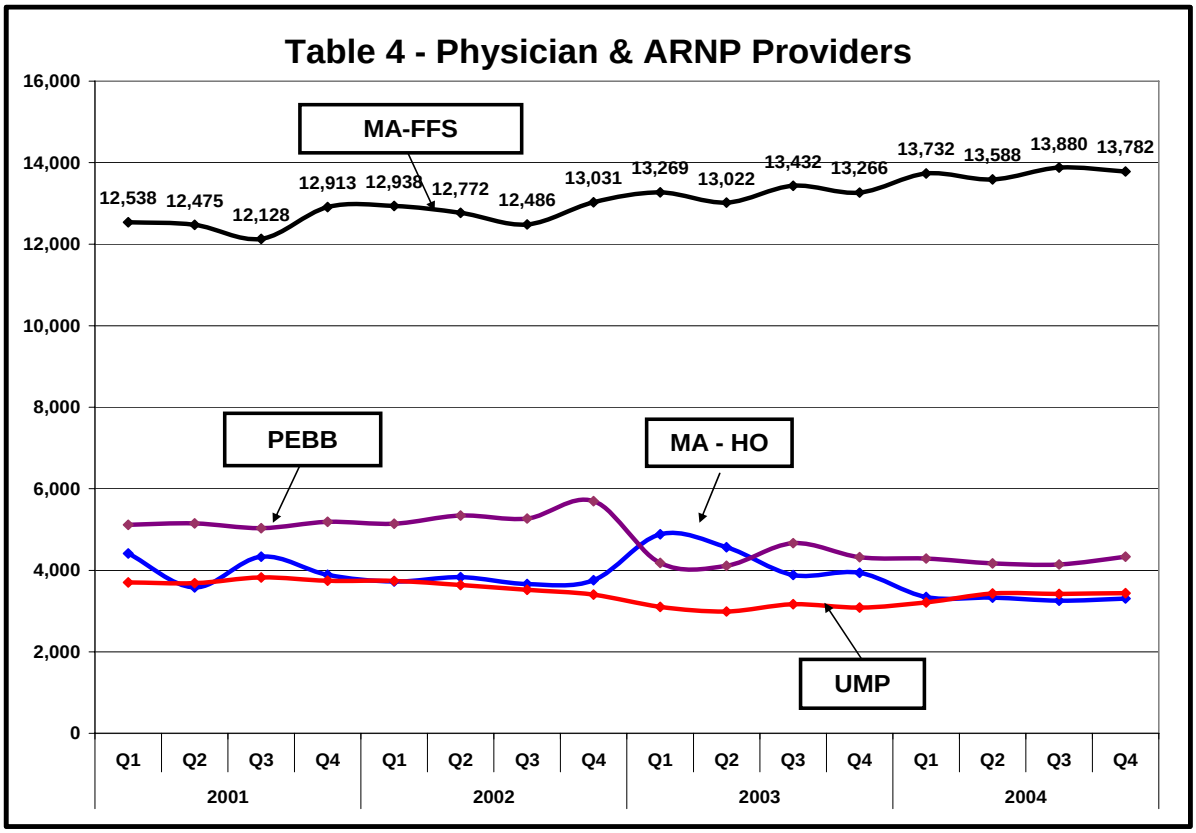
[4] The count of FFS physicians/ARNPs is based on active performing providers in a given period, while HO, PEBB and UMP counts are based on the number of contracting physicians in the health plan's network during that period. Therefore, it is more appropriate to compare the directionality (more or fewer providers between periods) across the plans and FSS than comparing the absolute.

This is fourth in a series of semi-annual update reports. The update reports are available on the HRSA website at http://fortress.wa.gov/dshs/maa/Access/ProviderAccess/. The website also has detailed by-county reports in both PDF and Excel format.

NUMBER OF ACTIVE FFS PROVIDERS - STATEWIDE

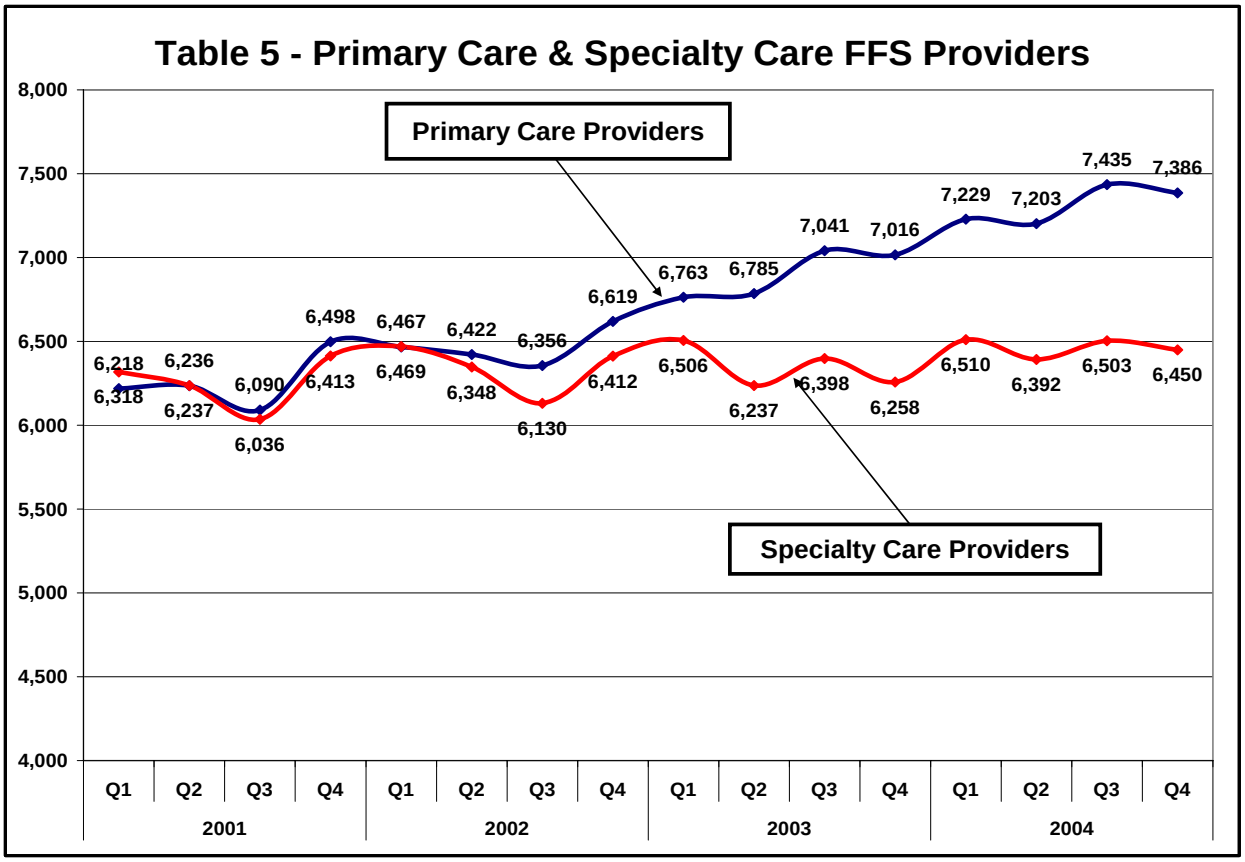
The number of active providers increased 3.8% from 13,247 in CY 2003 to 13,746 in CY 2004 (See Table 1 and 4). This is a continuation of a trend over the past five years. This increase in the number of providers was relatively broad-based. Twenty-four (62%) of the 39 counties had an increase in providers, while 14 (36%) had a decrease and 1 (3%) county had no change.



In comparison, HO had a 23.4% decrease in reported providers in their network in CY 2004 compared to CY 2003 (See Table 4). PEBB had a 2.0% reduction in reported providers, while UMP had a 9.4% increase.

The number of active FFS primary care providers increased 6.0% from 6,901 average in CY 2003 to 7,313 average in CY 2004 (See Table 5). This increase was broad-based, as 27 (69%) of the 39 counties had an increase, while only 7 (18%) had a decrease.

The number of active FFS specialty physicians increased slightly (1.8%) from 6,350 average in CY 2003 to 6,464 average in CY 2004 (See Table 5). The increase in providers is not as broad-based as primary care providers. Twenty-one (54%) counties had an increased number of specialty providers, while 16 (41%) counties had decreases.



NUMBER OF ACTIVE FFS PROVIDERS – BY-COUNTY

As described above, 24 (62%) of the 39 counties had an increase in FFS providers, while 14 (36%) had a decrease. These 14 rural counties accounted for 12% of Medical Assistance program's FFS CY 2004 caseload and 6% of the FFS active providers.

The counties in order of highest percent reductions were: Wahkiakum, Columbia, Pend Oreille, Skamania, Jefferson, Mason, San Juan, Whitman, Klickitat, Kittitas, Asotin, Grant, Cowlitz and Skagit. Wahkiakum has experienced a reduction in providers in each of the last three years, 8 counties (Pend Oreille, Jefferson, Whitman, Klickitat, Kittitas, Asotin, Grant, and Cowlitz) had reductions in two of the past three years.

Table 6 lists DSHS FFS, Healthy Options, UMP and PEBB plans network reductions by-county. The table ranks the 14 counties with highest reductions. There are some overlap amount plans' by-county reductions. All the plans experienced physician reduction in Cowlitz County, HRSA and two other plans had reductions in Wahkiakum, Pend Oreille and Whitman counties. HRSA and one other plan had reductions in Columbia, Skamania, Kittitas and Grant counties.

There is several contiguous grouping of counties with FFS reductions. These include: (a) Asotin, Columbia and Whitman is the Southeast corner of the state; and, (b) Cowlitz, Klickitat, Skamania and Wahkiakum in the Southwest corner of the state.

Table 6
Health Plans' Physician Networks
(COUNTIES IN ORDER OF HIGHEST PERCENT REDUCTIONS)

Rank	DSHS-HRSA FFS	Health Options Plans' Network	UMP Network Providers	PEBB Plans' Network
1	Wahkiakum	Lincoln	Wahkiakum	Wahkiakum
2	Columbia	Pacific	Cowlitz	Garfield
3	Pend Oreille	Stevens	Pacific	Pacific
4	Skamania	Island	Columbia	Pend Oreille
5	Jefferson	Pend Oreille	Ferry	Kittitas
6	Mason	Pierce	Whitman	Okanogan
7	San Juan	Cowlitz	Garfield	Adams
8	Whitman	Spokane	Franklin	Benton
9	Klickitat	Benton	Chelan	Spokane
10	Kittitas	Lewis		Whitman
11	Asotin	King		Cowlitz
12	Grant	Grays Harbor		Grant
13	Cowlitz	Kitsap		Franklin
14	Skagit	Skamania		Whatcom

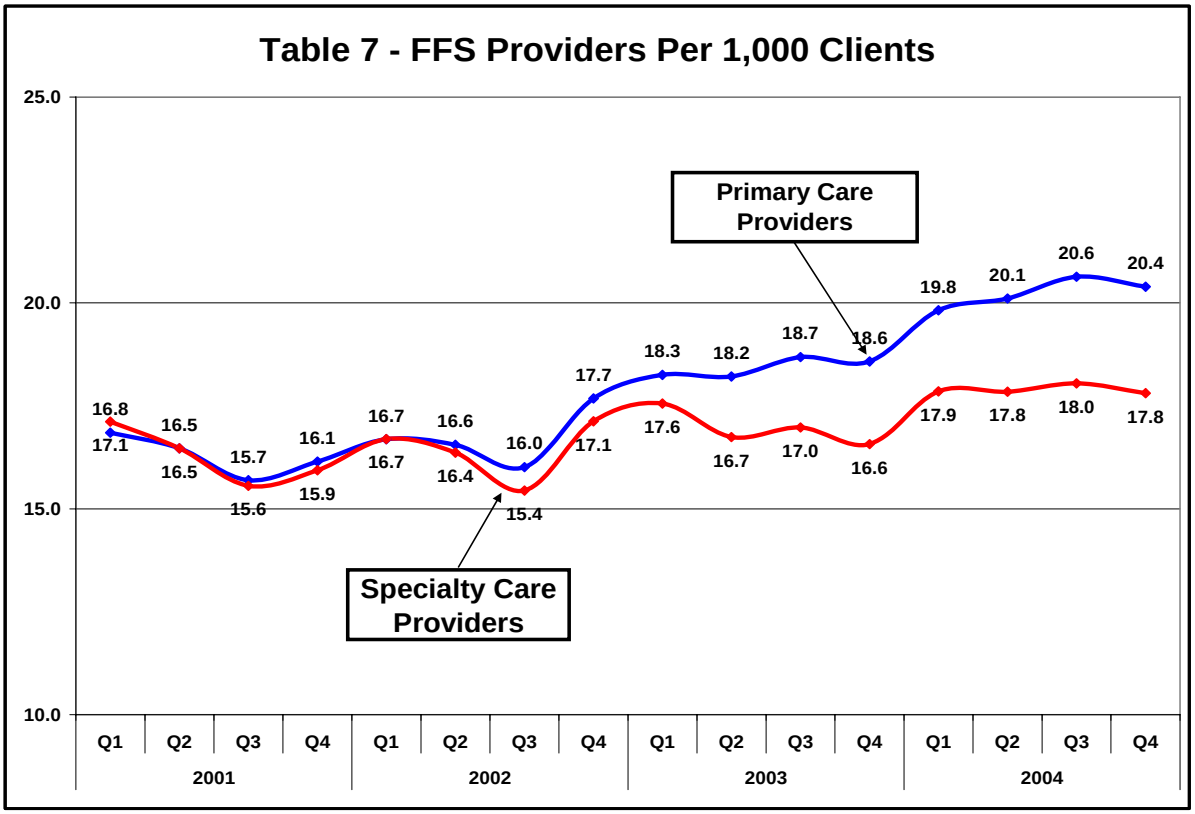
RATIO OF ACTIVE PROVIDERS PER 1,000 CLIENTS

The ratio of FFS providers per 1,000 clients increased 7.5%, from 35.4 per 1,000 in CY 2003 to 38.0 per 1,000 in CY 2004 (See Table 2). This increase was broad-based. Twenty-two (56%) counties had an increase in providers, while 17 (44%) had a decrease.

In the past, the ratio of providers per 1,000 clients increased in part because there was a decrease in FFS clients during this period. The CY2003-04 FFS caseload decreased by 3.5%, and thus was a contributing factor in the increase in providers per 1,000.

The ratio of FFS primary care providers per 1,000 clients increased 9.8% from 18.4 per 1,000 in CY 2003 to 20.2 per 1,000 in CY 2004 (See Table 7). This increase was broad-based, as 27 (69%) counties had increases, while 7 (18%) had a decrease and 5 (13%) had no change during this period.

The ratio of FFS specialist providers per 1,000 clients increased 5.5% from 17.0 per 1,000 in CY 2003 to 17.9 per 1,000 in CY 2004 (See Table 7). This increase was not broad-based, as 19 (49%) counties had increases while 20 (51%) had a decrease.



RATIO OF ACTIVE PROVIDERS PER 1,000 CLIENTS – BY COUNTY

As described above, 22 (56%) counties had an increase in providers per 1,000 client, while 17 (44%) had a decrease. The counties in order of highest percent reductions were: Columbia, Mason, Pend Oreille, Cowlitz, Klickitat, Jefferson, Whitman, Thurston, Kittitas, Asotin, Adams, Clark, Benton, Grant, Yakima, Ferry and King. Seven of the counties (Cowlitz, Klickitat, Jefferson, Whitman, Thurston, Kittitas and Ferry) have had a reduction in provider per 1,000 in three past years, while no other counties had reductions in the past two years.

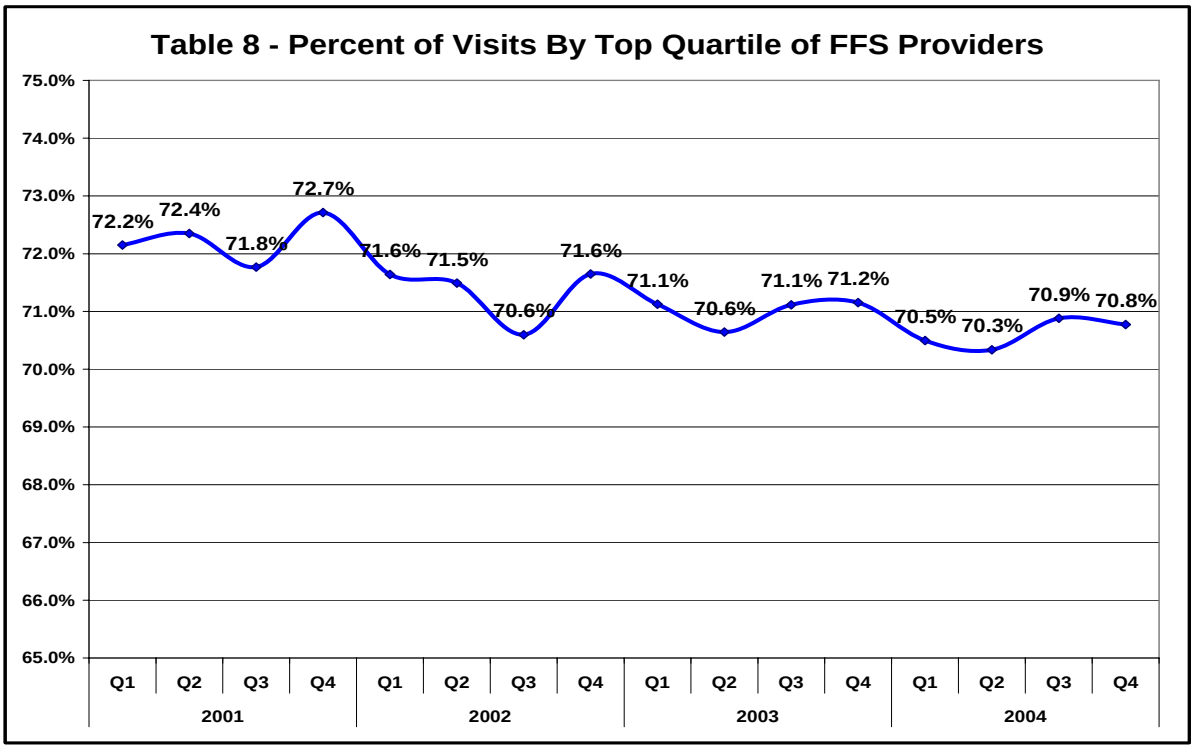
VISITS PROVIDED BY TOP QUARTILE OF ACTIVE PROVIDERS

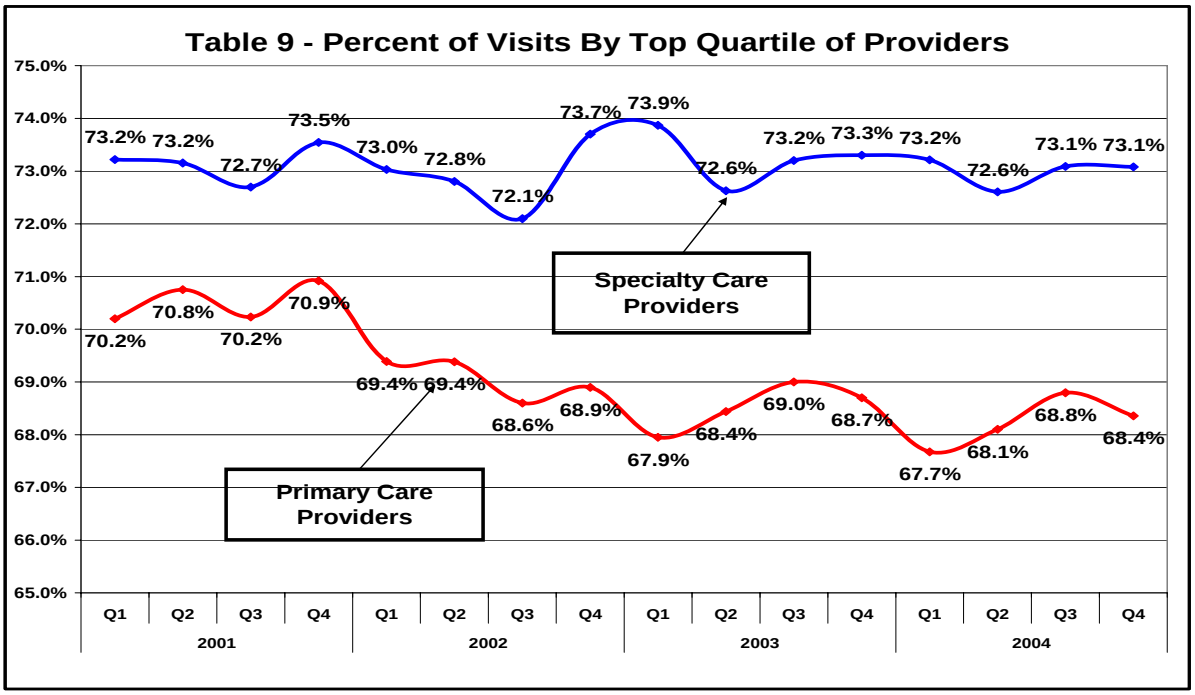
The distribution of FFS visits performed by the top quartile of active providers provides one measure of workload across active physicians. Ideally, the top quartile (25%) of providers would provide 25% of all visits for the report period, the top 50% of the providers would provide 50% of the visits, etc. A reduction in the services by the top quartile represents a reduction in the burden on providers, as more visits are provided by the remaining 75% of active providers.

Over the past seven years, the percent of office visits provided by the top quartile of providers has gone down slightly. In SFY 1998, the top quartile provided 73% of the visits, while the more recent SFY 2004 ratio decreased to 71%. However, the majority of office visits continue to be provided by only 25% of the active providers.

In CY 2004, the distribution of visits provided by the top quartile of providers remained at 71%. Twenty-four (62%) of the 39 counties had a decrease in visits by the top quartile while 15 (38%) had an increase.

On average, the top quartile of primary care providers provided fewer visits compared to specialty providers (See Table 9). Over the past four years (CY 2001 through CY 2004), the average was 69% for primary care providers compared to 73% for specialty providers.



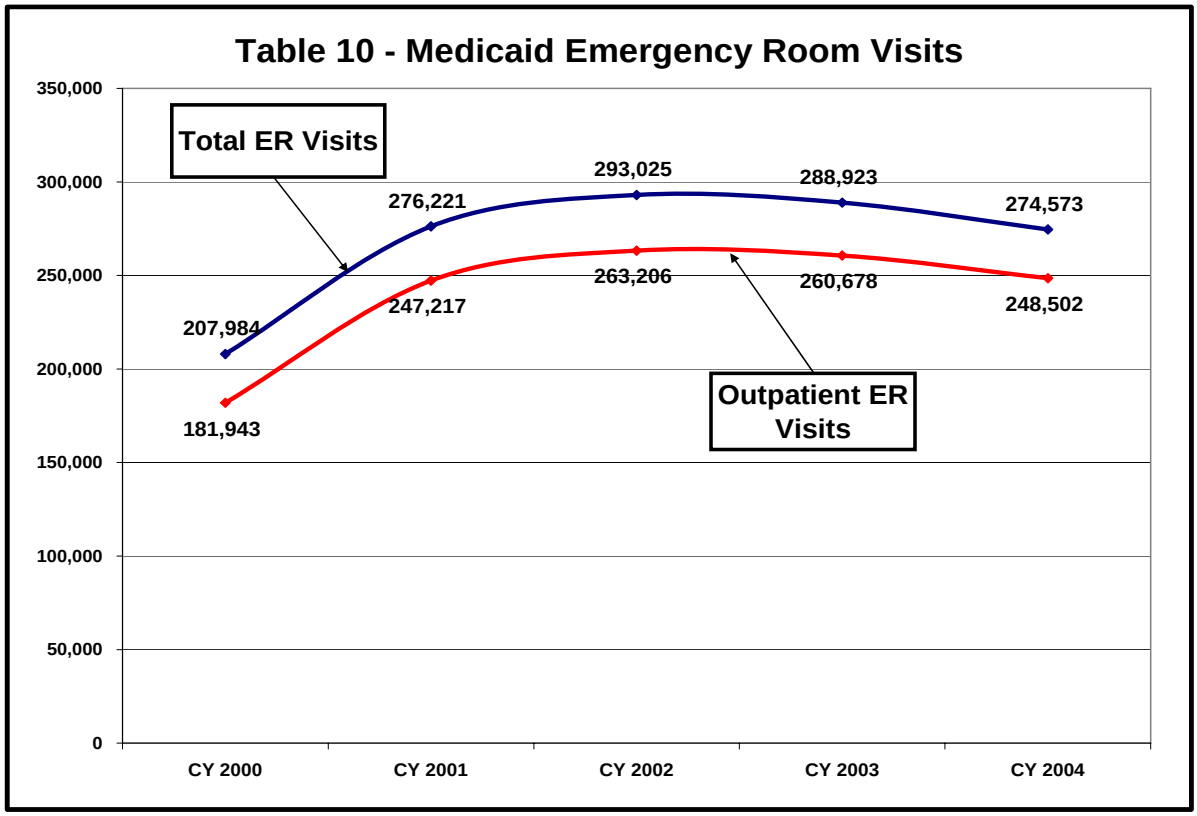


MEDICAID EMERGENCY ROOM VISITS [5, 6]

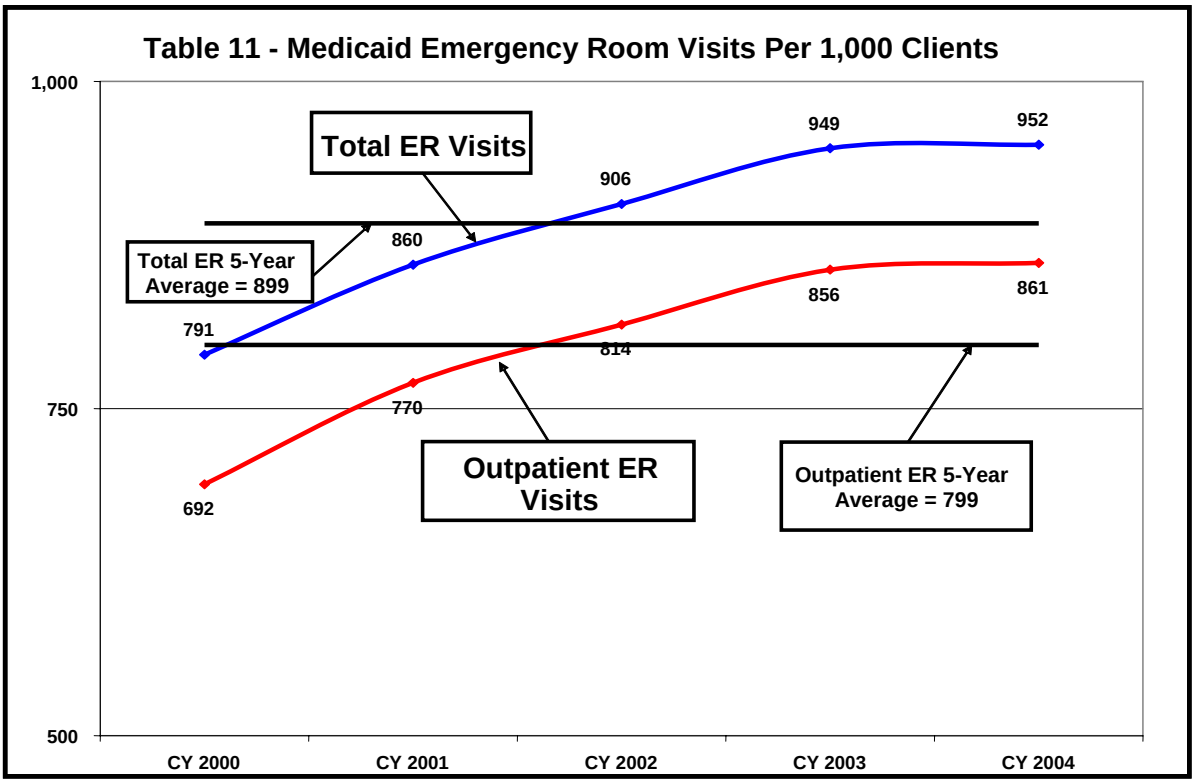
HRSA also tracks hospital emergency room (ER) visits on a bi-annual basis. Changes in outpatient visits can be an indicator of access problems, as clients seek to obtain care through hospital ER because they cannot get timely access to outpatient physician care.

Total ER and outpatient Medicaid ER visits declined for the second year in a row (See Table 10). Total visits declined by 5.0% and outpatient visits by 4.7% between CY 2003 and CY 2004

Total ER visits per 1,000 clients also increased only .3% between CY 2003 and CY 2004, which is the second lowest rate since CY 2001 (See Table 10). Outpatient ER visits per 1,000 clients also increased only .6% between CY 2003 and CY 2004, which is the second lowest rate since CY 2001.



[5] Refer to "*Emergency Room Visits by Washington State Medicaid Fee-For-Service Clients*" (August 2005) report prepared by the Department of Social and Health Services Medical Assistance Administration.
[6] The emergency room visits are for Medical Assistance programs fee-for-service (FFS) clients, excluding Medicaid dual eligibles and family planning programs.



NEXT STEPS

As found in the prior SFY 2004 update report, the growth in the number of active specialty providers does not appear to be keeping pace with FFS caseload growth. HRSA will need to monitor these trends. The monitoring may need to include more detailed trend analysis on a by-specialty care type provider unit of analysis.

The SFY 2004 update included an analysis of Federal Qualified Health Centers (FQHC) to see whether the growth in physician participation was due primarily to an increase in FQHC physicians. The analysis found that this was not the case. After adjusting for FQHC physicians, there was still a 4.0% increase in primary care providers between SFY 2001 and 2003. However, there will still be a need to review whether the increase in both primary care provider and specialty care provider participation is due to FQHC and emergency room providers. This analysis will be done for the SFY 2005 update, available in March 2006.

HRSA began in July 2003 to incorporate two new measures - ratio of number of FFS visits per quarter per 1,000 active physicians and the number of visits per 1,000 eligible FFS clients. Beginning with the SFY 2005 update, these measures will be brought into the ongoing analysis.

The 2005 Legislature has directed HRSA to coordinate with the Department of Revenue and Health Care Authority to develop options for providing financial incentives for physicians to serve the uninsured, Medicare and Medicaid patients. The report will be submitted to the Governor and Legislature in November 2006.