

The Availability of New Patient Appointments for Primary Care at Federally Qualified Health Centers: Findings From an Audit Study

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April 7, 2014

Executive Summary

This brief compares the availability of primary care appointments for new patients at Federally Qualified Health Centers (FQHCs) and other non-FQHC providers using data from an experimental simulated patient (audit) study that was conducted in late 2012 and early 2013. It provides summary measures for new patient appointment rates and wait times (number of days to see a provider for callers who were offered an appointment) for Medicaid, private, and uninsured (i.e., self-pay) callers seeking primary care services. The brief also examines differences in out-of-pocket cost for the uninsured group. In the aggregate, we find that 80 percent of FQHCs and 56 percent of non-FQHCs scheduled appointments for Medicaid callers—a difference of 24 percentage points ($p < 0.001$). FQHCs were 39 percentage points more likely to offer uninsured callers a visit for less than \$75 compared to non-FQHC providers. Median wait times for a new Medicaid patient appointment for primary care was nine days at FQHCs and six days at non-FQHCs. The audit data suggest that FQHCs were more willing than other non-FQHC providers to accommodate new Medicaid patients, but that FQHC wait times were slightly longer. Altogether, these results show that FQHCs provide better appointment availability for Medicaid patients. However, even with enhanced funding, it is uncertain how well they will be able to absorb new patient demand caused by the Affordable Care Act's (ACA) Medicaid expansion and other provisions.

Introduction

Access to care has been a longstanding concern for individuals with Medicaid in part because Medicaid has historically had lower reimbursement rates than other payers. In 2012, for example, Medicaid was reimbursing physicians at 59 percent of the rate that Medicare pays for primary care services.¹ Physicians indicate a lower willingness to take new Medicaid patients compared with patients with other insurance types; about one-third of all primary care providers said they were not accepting new Medicaid patients according to the most recent data available from the National Ambulatory Medical Care Survey.² With the recognition that provider access could be strained with the expansion of Medicaid coverage under the ACA, the ACA included a two-year federally financed increase in Medicaid reimbursement for primary care services that began in January of 2013.³ The ACA also included other provisions aimed at increasing the supply of primary care clinicians and increasing the capacity of community health centers, such as Federally Qualified Health Centers (FQHCs).⁴

FQHCs are nonprofit community health clinics that adhere to federal regulations and receive federal grants

to provide primary care in low-income underserved neighborhoods. FQHC “look-alikes” are nonprofit clinics that have the same mission without the federal grant support. Both FQHCs and FQHC look-alikes (hereafter referred to as FQHCs) play a central role in the delivery of primary care to medically underserved populations.⁵ These centers may be an attractive option not only because of their location, but also because they provide sliding fee scales for uninsured patients, value cultural competence, and have a mission of caring for poor, low-income, and other vulnerable patient populations.⁶

Reliance on these safety net primary care providers has grown in recent years. The 2001 Health Center Growth Initiative nearly doubled federal spending on FQHCs, and funding for FQHCs has been further augmented over the past 15 years. These investments and expansions of FQHCs have been linked to better access for low-income adults.⁷

Nonetheless, FQHCs may still be under-resourced and lack the capacity needed to absorb the large volumes of those newly enrolling in coverage under the ACA. Demand for care is expected to increase not only in the 26 states (including the District of Columbia) that are

expanding Medicaid but also in the 25 states that are not expanding Medicaid where Medicaid enrollment is expected to rise among currently eligible adults and children, while coverage provided through the marketplaces increases. There will also continue to be large numbers of uninsured patients particularly in areas with large immigrant populations.⁸

In this report, we examine the availability and wait times of new patient appointments for primary care at FQHCs in comparison to non-FQHCs using an experimental simulated patient (audit) study conducted in 10 states by researchers from the Urban Institute, University of Pennsylvania, and University of Chicago Survey Lab. The audit examined the rate primary care offices schedule appointments for callers with Medicaid, private, or no health insurance coverage (self-pay). In an accompanying study,⁹ Rhodes and colleagues found that overall, 85 percent of primary care offices that were included in the study offered new patient appointments to the privately insured callers and 58 percent offered new patient appointments to the Medicaid callers. For offices with availability, the median wait times until the appointment were typically less than a week for both Medicaid and private callers. New patient appointments for primary care were offered to 79 percent of uninsured callers, but this does not reflect appointment availability for uninsured callers who have a limited ability to pay for the appointment. Thus, they examined the availability of appointments for uninsured callers that required \$75 or less at the time of the visit and found an appointment rate of 15 percent.

We find that FQHCs were 24 percentage points more likely than non-FQHC providers to offer a new patient appointment to the Medicaid callers and that they were 39 percentage points more likely to offer an uninsured caller a visit for less than \$75. These findings suggest that Medicaid enrollees will have much greater success obtaining new patient appointments and that uninsured patients will be much more likely to obtain low-cost appointments for primary care at FQHCs than at other primary care practices.

Data

The audit study was conducted from October 2012 to March 2013.¹⁰ Trained staff, following standardized scripts, posed as patients with three different insurance types (private, Medicaid, uninsured [i.e., self-pay]), who then contacted a random sample of physician offices in 10 states (Arkansas, Georgia, Illinois, Iowa, Massachusetts, Montana, New Jersey, Oregon, Pennsylvania, and Texas). Medicaid calls were placed only to offices listed as participating in the state's

Medicaid managed care or primary care case management program. Privately-insured callers stated that they had the largest commercial plan in their county.

Callers requested a new patient primary care visit from a randomly selected physician practicing at the sampled physician office location, but would accept a visit with any provider including mid-level providers (nurse practitioners or physician assistants). If granted an appointment, callers recorded the number of calendar days until the appointment. Uninsured callers, when given an appointment, asked how much they would have to pay out of pocket at the time of the visit. For this brief, we focus on the lower-cost category for the uninsured, which is the subset of office that offered the uninsured callers an appointment that required payment of less than \$75 at the time of the visit. The full study design and initial findings can be found in a recent publication.¹¹

The subset of audit clinics that were FQHCs were retrospectively identified using a comprehensive list of providers from the Uniform Data System, a database of federal grantees maintained by the Health Resources Services Administration in the U.S. Department of Health and Human Services.¹²

Results

Table 1 provides the total number of calls made to FQHCs by states. Overall, a total of 235 calls were made to FQHCs from privately insured callers and 255 were made from Medicaid callers. Table 2 presents the pooled 10-state average new appointment rates for calls to FQHC and non-FQHC providers, showing separate data for private, Medicaid, and uninsured callers. The unadjusted difference in the FQHC and non-FQHC new appointment rates is shown as well as each *p* value

Table 1. Number of Calls to Federally Qualified Health Centers (FQHC) in Each Study State

State	Private	Medicaid
Arkansas	38	34
Georgia	18	25
Iowa	9	10
Illinois	33	46
Massachusetts	42	32
Montana	20	19
New Jersey	10	13
Oregon	31	32
Pennsylvania	13	22
Texas	18	20

Source: Primary Care Simulated Patient Study conducted between October 2012 and March 2013.

Note: The FQHC group includes FQHC look-alikes.

Table 2. Rates of New Patient Appointment Availability for Private, Medicaid, and Uninsured Callers by Federally Qualified Health Center Status

	Pooled 10-state Estimates				Difference	P value
	FQHC		Non-FQHC			
	N	Estimate	N	Estimate		
Private	232	0.84	5,143	0.85	-0.01	0.849
Medicaid	253	0.80	4,092	0.56	0.24	< 0.001
Uninsured ^a	54	0.53	1,131	0.14	0.39	< 0.001

Source: Primary Care Simulated Patient Study conducted between October 2012 and March 2013.

Notes: FQHC stands for Federally Qualified Health Centers. The FQHC group includes FQHC look-alikes.

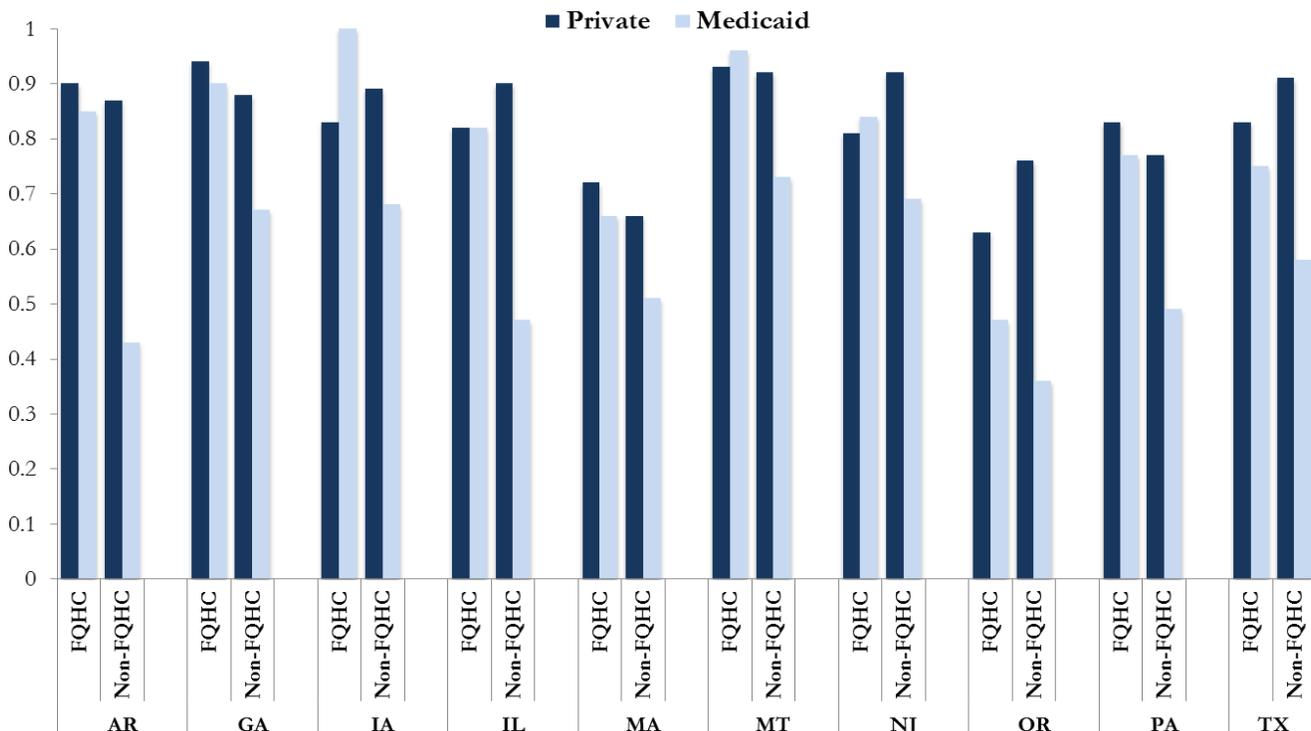
^aNew patient appointments for the uninsured are defined as those that would require less than \$75 at the time of the visit.

testing for differences in the rates. For the uninsured group, the rate reflects the percentage of all offices that offered an appointment that required a payment of less than \$75 at the time of the visit.

Across the 10 states, 84 percent of FQHCs and 85 percent of non-FQHCs scheduled appointments for privately insured callers. This difference was not statistically significant ($p=0.798$). By comparison, 80 percent of FQHCs and 56 percent of non-FQHCs scheduled appointments for Medicaid callers—a difference of 24 percentage points ($p<0.001$). FQHCs offered uninsured callers a visit requiring less than \$75 at the time of the visit 54 percent of the time compared to 15 percent of the time at non-FQHCs—a difference of 39 percentage points ($p<0.001$).

Figure 1 extends these results by showing the appointment rates for private and Medicaid patients at FQHC and non-FQHC clinics in each of the 10 states (there was not an adequate sample to examine the uninsured by state). In each of the 10 states, non-FQHC clinics offered appointments to Medicaid patients at substantially lower rates than privately insured patients. By comparison, new patient appointment rates were similar between Medicaid and privately insured callers at FQHCs in each of the 10 study states. While the state-specific estimates for the FQHC samples are imprecise due to small samples, they demonstrate a consistent pattern of higher appointment rates for Medicaid callers at FQHC as opposed to non-FQHC clinics.

Figure 1. New Patient Primary Care Appointment Rates for Privately Insured and Medicaid for Federally Qualified Health Centers and Non-Federally Qualified Health Center Offices



Source: Primary Care Simulated Patient Study conducted between October 2012 and March 2013.

Note: FQHC stands for Federally Qualified Health Centers.

As noted, uninsured callers who were granted appointments asked how much money they would need to bring to their appointment in order to be seen. Table 3 takes a closer look at the distribution of initial out-of-pocket payment amount at FQHC and non-FQHC clinics. At the median, FQHCs required \$60 at the time of the visit compared to \$123 at non-FQHC providers. The magnitude of this difference in out-of-pocket payment at the time of the visit, \$63 at the median, was similar at the 25th percentile and 75th percentile as well.

Table 4 describes the median number of days until the caller could actually be seen among those granted an appointment for private and Medicaid patients in the 10 states, as well as the difference in the medians and the associated *p* value. The median wait time for privately-insured callers at FQHCs was 8 days, compared to 6 days at non-FQHC providers. The difference of two days was statistically significant (*p*=0.001). For Medicaid callers, the median wait time at FQHCs was 9 days compared to 6 six days at non-FQHC providers. The difference of three days was statistically significant (*p*=0.001).

Discussion

This analysis suggests that Medicaid patients looking to establish care with a new primary care provider may be more successful at finding appointment availability at FQHCs than at other primary care practices. Our findings suggest that as of late 2012 and early 2013, FQHCs were able to accommodate new patients with Medicaid coverage. Although the waiting period for new appointments for Medicaid and privately insured patients was slightly longer at FQHCs (2–3 days at the median) compared with other providers, these differences are unlikely to be clinically meaningful for most primary health care concerns, especially because most new patients could be seen within two weeks. In addition to having a higher likelihood of appointment availability for Medicaid patients, FQHCs are designed to provide the routine preventive care (such as vaccinations and screenings) and chronic disease management that many Medicaid patients may require.

Table 3. Out-of-Pocket Payment Required at the Time of Visit for the Uninsured, 10 States

	25 th percentile	50 th percentile	75 th percentile
FQHC	\$30	\$60	\$120
Non-FQHC	\$85	\$123	\$175

Source: Primary Care Simulated Patient Study conducted between October 2012 and March 2013.

Note: FQHC stands for Federally Qualified Health Centers.

FQHCs may also offer on-site mental health services, culturally tailored programs for minority populations, and interpreters for non-English-speaking populations.¹³ Additionally, FQHCs may also provide a source of primary care for newly insured individuals with coverage in the health insurance Marketplaces (also known as health insurance exchanges).

There are some limitations to this study. First, we only examined 10 states, each with a unique approach to Medicaid and the uninsured. Moreover, we did not purposefully sample FQHCs and do not control for other important differences related to practice size and use of midlevel providers (nurse practitioners and physician assistants) between FQHCs and other primary care practices that could contribute to the patterns that we see. In addition, the providers in the non-FQHC category include a mix of private offices, hospital outpatient departments, and other safety net providers, such as rural health centers, academic medical center outpatient clinics, and public hospital clinics. Future analysis will explore patterns of new patient availability within this group.

The ability of FQHCs to sustain and even expand access to low-income patients will depend on appropriate investments in staffing (including nurses, caseworkers, and community health workers) and in physical infrastructure.¹⁴ Some of the funding for these investments may come from an expansion in grant funding, new revenues from private insurers and from Medicaid programs (particularly in those states that are

Table 4. Median Wait-Times by Federally Qualified Health Center Status for Pooled 10-State Sample

	POOLED 10-STATE ESTIMATES				Difference	<i>P</i> value
	FQHC		Non-FQHC			
	<i>N</i>	Median	<i>N</i>	Median		
Private	193	8	4,287	6	2	0.001
Medicaid	202	9	2,295	6	3	0.001

Source: Primary Care Simulated Patient Study conducted between October 2012 and March 2013.

Notes: FQHC stands for Federally Qualified Health Centers. Pearson chi-squared tests were used to test for statistical differences in the medians by clinic type. Outcome is measured in calendar days from the appointment call until the scheduled visit.

expanding their programs). There is concern, however, that levels of payment available from premium assistance and marketplace plans may not be as high for FQHCs as those from Medicaid programs.¹⁵

FQHCs may also play an important role in providing continuity of primary care for low-income adults. Because FQHCs have experience caring for uninsured patients, providers in these clinics may have existing relationships with some newly insured patients. As low-income individuals experience changes in their income over time, they may also be required to change between public and private coverage (a phenomenon known as “churn”). To minimize disruptions in care caused by churn, state regulators can require FQHCs to be included in the provider networks for marketplace insurance plans. It is unlikely, however that FQHCs will be able to absorb all the additional demand generated by those newly enrolling in coverage under the ACA. Therefore, other policies will likely be needed to expand primary capacity, particularly for Medicaid patients, where the provider base is smaller.

These findings represent a snapshot of an evolving environment. While appointment availability was consistently higher for Medicaid patients at FQHCs versus non-FQHC providers, experiences may differ

when considering individual communities that differ in their local financing for safety net providers and sociodemographic conditions. The ability of FQHCs to sustain additional volume and timely appointment availability will therefore depend on many factors. Auditing availability of new patient appointments in both FQHC and non-FQHC settings in the future can provide important information to improve access for all patients.

Conclusion

FQHCs have long been a central component of the primary care safety net in many communities. Our findings confirm that FQHCs are as willing to grant new patient appointments to Medicaid patients as to the privately insured and to provide reduced-cost appointments to the uninsured. Greater ability to schedule new patient appointments is likely one important reason why large segments of the Medicaid population consider community clinics to be their usual source of care and may also explain why low-income Medicaid patients are able to achieve access to care at rates comparable to the privately insured.¹⁵ Providing comparable access in the future will depend on continued investments in the staffing and infrastructure of FQHCs.

Endnotes

1. Zuckerman S and Goin D. “How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence From a 2012 Survey of Medicaid Physician Fees.” Washington, DC: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, 2012. <http://www.kff.org/medicaid/upload/8398.pdf>.
2. Decker SL. “Two-Thirds of Primary Care Physicians Accepted New Medicaid Patients in 2011–12: A Baseline to Measure Future Acceptance Rates.” *Health Affairs*, 32 (7): 1183–87, 2013. doi:10.1377/hlthaff.2013.0361.
3. Health Care and Education Reconciliation Act of 2010. Section 1202: “Payments to Primary Care Physicians.” Pub. L. no. 111-152, 124 Stat 1029 (2010).
4. Health Resources and Services Administration. “The Affordable Care Act and Health Centers.” Rockville, MD: Bureau of Primary Care, Health Resources Services Administration, <http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf>; Shi L, Lebrun LA, Tsai J. “Assessing the Impact of the Health Center Growth Initiative on Health Center Patients.” *Public Health Reports*, 125(2):258–266, 2010.
5. National Association of Community Health Centers. “A Sketch of Community Health Centers: Chart Book 2013.” Bethesda, MD: National Association of Community Health Centers, 2013.
6. Ibid.
7. Gresenz CR, Rogowski J, and Escarce JJ. “Health Care Markets, the Safety Net, and Utilization of Care Among the Uninsured.” *Health Services Research*, 42(1p1): 239–64, 2007; McMorro S and Zuckerman S. “Expanding Federal Funding to Community Health Centers Slows Decline in Access for Low-Income Adults.” *Health Services Research* 2013. doi:10.1111/1475-6773.12141.
8. Kenney GM, Huntress M, Buettgens M, Lynch V, Resnick D. “State and Local Coverage Changes Under Full Implementation of the Affordable Care Act.” Washington, DC: Henry J. Kaiser Family Foundation and the Urban Institute, 2014.
9. Rhodes K, Kenney GM, Friedman A, et al. “Primary Care Access for New Patients on the Eve of Health Care Reform.” *JAMA Intern Med*. 2014, Online First. doi:10.1001/jamainternmed.2014.20, <https://archinte.jamanetwork.com/article.aspx?articleid=1857092>
10. Human Subjects approval was provided by the Institutional Review Board at the University of Pennsylvania.
11. Rhodes et al. 2014.
12. Health Resources and Services Administration. “Health Center Data.” Rockville, MD: Bureau of Primary Care,

Health Resources Services Administration, <http://bphc.hrsa.gov/healthcenterdatastatistics/>

13. National Association of Community Health Centers, *A Sketch of Community Health Centers*; Forrest CB and Whelan E. “Primary Care Safety-Net Delivery Sites in the United States: A Comparison of Community Health Centers, Hospital Outpatient Departments, and Physicians’ Offices.” *Journal of the American Medical Association*, 284(16): 2077–83, 2000.
14. LoSasso A and Byck G. “Funding Growth Drives Community Health Center Services.” *Health Affairs*, 29(2): 289–96, 2010.
15. National Association of Community Health Centers. “Medicaid Premium Assistance and Health Insurance Exchanges: Spotlight on the States #5.” Washington, DC: National Association of Community Health Centers, 2013.
16. Kenney GM, Saloner B, Anderson N, et al. “Access to Care for Low-Income Medicaid and Privately Insured Adults in 2012 in the National Health Interview Survey: A Context for Findings from a New Audit Study.” Washington, DC: The Urban Institute, 2014.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation, the Urban Institute, its trustees, or its funders.

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This research was supported by the Robert Wood Johnson Foundation and the Urban Institute. Dr. Saloner acknowledges funding support from the Robert Wood Johnson Foundation Health and Society Scholars Program. Blue Cross-Blue Shield Foundation of Massachusetts provided funding for a supplemental sample in Massachusetts.

The authors gratefully acknowledge analytical guidance from Michael Richards, MD, PhD at the University of Pennsylvania, the contributions of David Chearo MA and colleagues from the University of Chicago Survey Lab, and the advice and support of Katherine Hempstead of the Robert Wood Johnson Foundation.

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