Penn LDI
Leonard Davis Institute of Health Economics

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ResearchBRIEF

Fragmented Geographic Distribution of Providers Suggests Limited Access to Basic Health Care for Dual Medicaid-Medicare Beneficiaries

Less Than 1% of Clinical Practices Provide 80% of Outpatient Services for Dually Eligible Individuals

By Joshua M. Liao, Paula Chatterjee, Yueming Zhao, Isabelle J. Carroll, Danielle S. Browne, Austin S. Kilaru, Aidan P. Crowley, David Pagnotti, Torrey Shirk, Deborah S. Cousins, Amol S. Navathe

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Key Findings

Outpatient care for people dually eligible for Medicare and Medicaid is heavily concentrated among a small number of clinicians and clinical practices. These practices are geographically dispersed, with substantial within-state variation and large areas where no practices routinely serve this population. Although Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are traditionally considered the primary providers of outpatient safety net care, they deliver only 9% of these services to dually eligible individuals.

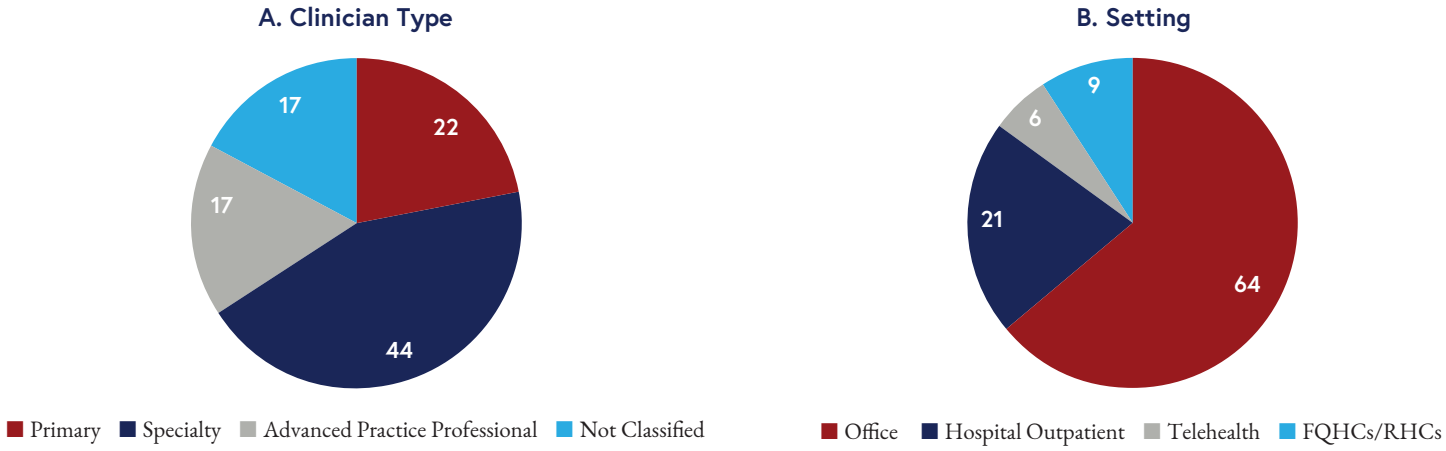
THE RESEARCH QUESTION

Before they can improve access and quality for low-income individuals and reduce costs, policymakers need answers to two questions: Where do these individuals get outpatient care? What types of clinicians provide that care?

The more than 12 million U.S. adults with low incomes who are eligible for both Medicare and Medicaid tend to be sicker and face formidable challenges in getting care. These challenges are reflected in well-documented disparities in access and quality for this group.

Policymakers cannot improve care for low-income individuals without a clear understanding of how they receive outpatient care—which is critical because most health care happens in clinics, doctor's offices, and non-hospital settings. A study led by former LDI

Figure 1. Percent of Services to Individuals Dually Eligible for Medicare and Medicaid by Clinician Type and Setting



Proportion of care for patients who are dually eligible for Medicare and Medicaid. A: A notable proportion of care is from advanced practice professionals and primary care rather than specialty clinicians (compared to non-dually eligible individuals). B: Dually eligible individuals get most care at settings other than Federally Qualified Health Centers and Rural Health Clinics.

Senior Fellow Joshua Liao, with LDI Senior Fellows Paula Chatterjee, Austin Kilaru, Amol Navathe, and colleagues, shows where individuals dually eligible for Medicare and Medicaid get outpatient care and who provides it.

The work builds on this group's study using 2013 data and complements efforts to help policymakers improve hospital care for low-income and other historically marginalized communities.

THE FINDINGS

The researchers applied a method commonly used in economics to quantify inequality and demonstrated that outpatient care was unequally distributed among practices and heavily concentrated: 80% of outpatient services to dually eligible individuals came from only 0.3% of practices. About 14% of practices provided no outpatient care to this group.

The distribution of the practices delivering most of the care to dually eligible individuals varied across the U.S., with substantial within-state heterogeneity. In some areas, multiple, often adjacent counties provided few to no services. This variation was present across both rural and urban areas.

Compared to other Medicare beneficiaries, dually eligible individuals used fewer outpatient services overall and fewer specialty care services (Figure 1). Advanced practice professionals such as nurse practitioners and physician associates provided more than 17% of services to dually eligible individuals but under 13% of all services to their non-dually eligible counterparts.

The study supported the idea that FQHCs and RHCs are important parts of the outpatient safety net for dually eligible individuals. They received 9% of their outpatient care from these sites, which provided under 3% of these services to non-dually eligible individuals. However, dually eligible individuals received the majority of their outpatient care (91%) from clinical settings other than FQHCs and RHCs.

THE IMPLICATIONS

Outpatient care for low-income individuals dually eligible for Medicare and Medicare is unequally distributed, and this inequality has worsened over time. Comparing the new results to the researchers' earlier work on clinicians who care for dually eligible individuals shows a greater concentration of services: In 2013, 35% of clinicians provided 80% of outpatient care to this group, compared to only 30% of clinicians providing this level of services in 2022. The descriptive findings also show a lower use of outpatient specialty care that suggests dually eligible individuals may face barriers to seeing medical specialists until they are sick enough to require hospitalization.

FQHCs and RHCs receive substantial safety net policy attention. However, the study found that other outpatient clinics often serve dually eligible individuals and should not be excluded from safety net policy considerations.

The researchers emphasized that to address challenges to outpatient care for dually eligible individuals, policymakers need consensus on what data and measures define the outpatient safety net. This clarity will inform evidence-based, transparent decisions that support practices disproportionately serving historically marginalized groups. Funding and policy reforms focused on the outpatient safety net could significantly improve access to and quality of care for low-income patients.

Future work from the researchers will examine the amount and variation in outpatient care among other groups, such as Medicaid-only beneficiaries. The team will also study the impact of the unequal distribution of care on patient outcomes and the relationship between outpatient and inpatient services in shaping these outcomes.

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THE STUDY

The researchers used 2022 data from the U.S. Census and the Centers for Medicare & Medicaid Services. The sample covered more than 106,545 practices and 815,827 clinicians, and nearly six million individuals, 967,820 of whom were dually eligible for Medicare and Medicaid, and 4.6 million who were not. This work was funded by Arnold Ventures (Grant 23-09141).

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ABOUT PENN LDI

Since 1967, the University of Pennsylvania's Leonard Davis Institute of Health Economics has been the leading university institute dedicated to using evidence to inform health policy. Penn LDI connects researchers from across the university with a common mission: to improve health and health care by catalyzing collaborative, multidisciplinary research that influences policy and practice.