

clinical characteristics. Data on hospital characteristics (size, teaching status, ownership, region) were obtained from the AHA Annual Hospital Survey.

**Principal Findings:** Among non-obstetric adults, the observed all-cause 30-day readmission rate was 10.7% for Medicaid patients and 6.3% for the privately insured. After adjusting for patient and hospital factors, Medicaid patients showed significantly higher risk of readmission (odds ratio=1.5). Within the Medicaid population, being male, living in large metropolitan areas, having chronic conditions such as diabetes, CHF, lung disease, cancer, blood deficiency, depression, psychoses, substance abuse were significantly at higher risk of readmission. The top five categories of index admissions (grouped by MDC) showing the highest readmission risk included cancers (odds ratio=5.6), blood disease (odds ratio=1.8), mental disorders, substance abuse, and HIV (all with odds ratio=1.6).

**Conclusions:** Medicaid patients appear to have higher hospital readmission rates compared to their privately insured counterparts. Some particular clinical conditions may contribute to a significant portion of the readmissions.

**Implications for Policy, Delivery or Practice:** In light of findings of this study, policy and clinical interventions that target sub-populations with certain high-risk clinical conditions would likely produce better patient outcomes and achieve significant cost savings.

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*Physicians' Perception of Medicaid Payments and Willingness to Accept New Medicaid Patients*

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**Research Objective:** We sought to assess how physicians' perceptions of Medicaid payments influenced their willingness to accept new Medicaid patients.

**Study Design:** Multivariate regression analysis was performed to assess physicians' willingness to accept new Medicaid patients on the three sets of covariates: a) physician characteristics, b) perception of Medicaid payments, and c) information technology used in practice.

**Population Studied:** The physician component of the 2004-2005 Community Tracking Survey, a nationally representative survey which included a total of 6,628 physician respondents was analyzed.

**Principal Findings:** Hospital-based physicians and physicians of non-white races are more likely to accept new Medicaid patients (adjusted odds ratio (OR) 1.25,  $p=0.038$  and OR 1.72,  $p=0.005$ , respectively), compared to solo practice and white physicians, respectively. In addition, surgeons and specialists were more likely to accept new Medicaid patients compared to primary care physicians (adjusted OR 5.31,  $p<0.0001$ ; and adjusted OR 3.87,  $p<0.0001$ , respectively). Physicians' acceptance of new Medicaid patients was positively associated with the amount of hours spent with patients per week (adjusted OR 1.01,  $p=0.001$ ) and the hours of charity care provided (adjusted OR 1.01,  $p=0.018$ ). The acceptance of new Medicaid patients was negatively associated with the perceptions of Medicaid payment issues, including billing and paperwork requirement and filing of Medicaid claims (adjusted OR 0.60,  $p<0.0001$ ), inadequate Medicaid reimbursement (adjusted OR 0.77,  $p=0.014$ ) and delayed Medicaid reimbursement (adjusted OR 0.72,  $p=0.002$ ). The perception of lack of specialists in the service area was positively associated with the physicians' willingness to accept new Medicaid patients (adjusted OR 1.35,  $p=0.033$ ). The availability of information technology, such as electronic prescribing, was not associated with physicians' willingness to accept new Medicaid patients.

**Conclusions:** The factors which significantly influenced physicians' willingness to accept new Medicaid patients included several dimensions in Medicaid payments.

**Implications for Policy, Delivery or Practice:** Regulators and policymakers need to be aware of the possible unintended consequences of cost containment policy actions which may negatively impact access to care by Medicaid patients.

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*CHIP Premiums, Health Status and Price Elasticity*

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**Research Objective:** To estimate the duration of CHIP enrollment as a function of premiums that vary within and between income groups and over time. A secondary objective is to simulate changes in enrollment and calculate price elasticities controlling for health status and age

**Study Design:** We generate a continuous premium variable to estimate the incremental effect of each dollar of premium on enrollment. During a three year time period, effective premiums for children