Robert Wood Johnson Foundation

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ACAView

Tracking the Impact of Health Care Reform

Observations on the Affordable Care Act: 2014

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ACAView's Second Report on the Affordable Care Act

The year 2014 brought great changes to American health care as implementation of the Affordable Care Act continued and its central provisions on coverage expansion took effect. Millions of people have gained coverage through the new health care marketplaces and through the expansion of Medicaid eligibility in many states. The impact and complexity of the ACA make it essential to monitor its effects on care delivery. The need to track the effects of the ACA becomes even greater as Americans debate potential changes to the law and its implementation that could result from different state approaches to Medicaid expansion, court challenges, and legislative measures from Congress.

The impact and complexity of the ACA make it essential to monitor its effects on care delivery.

ACAView is a joint effort between the Robert Wood Johnson Foundation and athenahealth, a cloud-based health care technology and services company. Because athenahealth is cloud-based, we can analyze and report rapidly on how the ACA is affecting physician practices. For this report, we looked at the following questions:

1. With roughly 10 million newly insured individuals in 2014, are physicians seeing more new patients in their practices?
2. Did new patients have greater health needs in 2014 than in the past?
3. What percentage of patients who were uninsured in 2013 obtained insurance in 2014?
4. To what extent did the ACA bring new coverage to patients of different ages?
5. How did the ACA change the insurance coverage of patients seen in providers' practices in 2014?

Summary of Findings

The following is a summary of our findings based on analysis of the ACAView sample of nearly 16,000 health care providers.

New-patient volumes

1. Concerns that physicians would be overwhelmed by new patients have not been borne out.

Prior to health care reform, some commentators expressed concern that physicians and other providers might be overwhelmed by new patients. This has not occurred. The proportion of new-patient visits to primary-care providers increased very slightly, from 22.6 percent in 2013 to 22.9 percent in 2014.[1] (See page 7.)

2. Although the proportion of visits from new patients increased only slightly, providers are conducting a higher proportion of more comprehensive patient evaluations.

Although providers are not seeing a materially higher proportion of new patients, they are more likely to conduct comprehensive new-patient assessments. The proportion of visits for comprehensive evaluation and management of new patients, including taking a patient history, conducting a physical exam and making medical decisions, increased from 6.7 percent in 2013 to 7.0 percent in 2014, a relative increase of 4.5 percent. (See page 7.)

3. New patients visiting physician offices in 2014 were not sicker or more complex than in 2013.

We found no evidence that patient complexity increased in 2014: physician work intensity per visit remained flat, diagnoses per visit increased slightly, and the percentage of visits with high-complexity evaluation and management codes actually decreased slightly. Primary care providers are seeing a higher proportion of patients with diagnosed mental disorders, but this appears to reflect a continuing trend that predated coverage expansion. (See pages 7-8.)

[1] New-patient visits are defined as those where an individual has not seen a given provider in at least two years.

Increased Insurance Coverage

4. From the physician perspective, the proportion of patient visits by uninsured individuals has fallen much more in expansion states than in non-expansion states.

As a result of the 2012 Supreme Court decision on the constitutionality of the ACA, states may elect whether or not to increase the number of individuals who qualify for Medicaid. About half the states elected to do so, while the others generally maintained their approaches to Medicaid eligibility. The numbers of uninsured patients have fallen much more precipitously in expansion states than in non-expansion states. From 2013 to 2014, the proportion of visits by uninsured patients in Medicaid expansion states fell from 4.6 percent to 2.8 percent, a relative decrease of 39 percent. In the non-expansion states, the proportion of visits by uninsured patients fell from 7.0 percent to 6.2 percent, a decrease of only 11 percent. (See page 9.)

5. The ACA has dramatically benefited uninsured individuals with stable provider relationships, particularly in expansion states.

We analyzed data for 100,000 patients with stable physician relationships who were uninsured for at least part of 2012-2014. The proportion of these individuals who obtained insurance after ACA implementation increased dramatically and much more in the expansion states (from 34.8 percent to 57 percent) than in non-expansion states (from 27.8 percent to 36.5 percent). (See page 9.)

6. Prior to coverage expansion, fewer uninsured adults in older age brackets obtained insurance; the ACA has all but eliminated these age disparities.

In 2013, adult patients between 35 and 64 were significantly less likely to obtain insurance compared with those between 18 and 34. With coverage expansion, these age differences have largely disappeared, particularly in the Medicaid-expansion states. (See page 10.)

Changing Payer Mix

7. Coverage expansion has changed the payer mix in physician practices, boosting the proportion of Medicaid patients in the Medicaid-expansion states and increasing the share of commercially insured patients in the non-expansion states.

The ACA has changed physician payer mix substantially. In non-expansion states, the proportion of visits from commercially insured patients increased from 72.0 percent to 74.0 percent. In expansion states, the proportion of visits from Medicaid patients rose from 12.8 percent to 15.6 percent. (See page 11.)

8. Although Medicaid enrollment increased in non-expansion states, Medicaid patient volumes in these states are actually declining.

Under the ACA, the number of individuals enrolled in Medicaid increased by1.5 million in non-expansion states despite the fact that eligibility criteria remained relatively constant.[2] This is likely due to the fact that publicity around the ACA encouraged qualified individuals to obtain Medicaid coverage they had not previously applied for. Despite this increased Medicaid coverage, the number of Medicaid enrollees seen in physician offices in non-expansion states actually decreased by 10.8 percent. (See page 11.)

9. The increase in Medicaid utilization in expansion states occurred very quickly, with a substantial uptick occurring within three months of ACA implementation.

Physician payer mix[3] tends to be extremely stable over time. In expansion states, however, the proportion of visits with Medicaid patients spiked quickly, from 12.2 percent in December 2013 to 15 percent in March 2014. Medicaid mix peaked at 16.7 percent of all visits in September. (See page 11.)

10. A small but increasing number of patients switched from commercial insurance coverage to Medicaid.

In the Medicaid expansion states, 1.1 percent of individuals with commercial coverage switched to Medicaid from 2012 to 2013. This number increased to 1.8 percent between 2013 and 2014, a significant increase in relative terms. This increase in switching from commercial to Medicaid coverage could reflect both individuals who lost their jobs and low-income workers who chose Medicaid to avoid premium contributions and to reduce their out-of-pocket costs. (See page 12.)

[2] Kaiser Family Foundation, Total Monthly Medicaid and CHIP Enrollment, http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/#, accessed 9 February 2015.
[3] Physician payer mix refers to the proportion of patients with particular types of insurance coverage as a percentage of all visits.

About ACAView

ACAView is a joint initiative of the Robert Wood Johnson Foundation (RWJF) and athenaResearch, a department of athenahealth. RWJF is the nation's largest foundation focused solely on improving health and health care. athenahealth is a health care information technology and services company serving more than 62,000 providers in approximately 100 specialties across the country.

The ACAView initiative provides researchers, policymakers, and the public with regular updates on how the Affordable Care Act (ACA) is affecting provider practices. We focus on the ACA's goal of increasing insurance coverage through expanding Medicaid eligibility and providing affordable commercial insurance through federal subsidies on new health insurance marketplaces. ACAView uses data aggregated from athenahealth's ambulatory-care software platform, a cloud-based system for managing patient health records, billing and communication. athenahealth data offers near real time visibility into patient demographics, clinical services and practice economics. athenahealth's data represents actual patient-provider encounters, and therefore provides greater precision and a larger range of metrics than self-reported surveys permit.

Our first report, which was published in July 2014, provided an early description of changes in insurance and health status following implementation of the ACA.[4] This second report covers data through 2014. We will continue to publish regular reports as changes in the health care system become more apparent. athenahealth is also providing monthly updates to RWJF, and additional information is available on the RWJF website and on CloudView, an athenahealth blog.[5]

Sample Overview

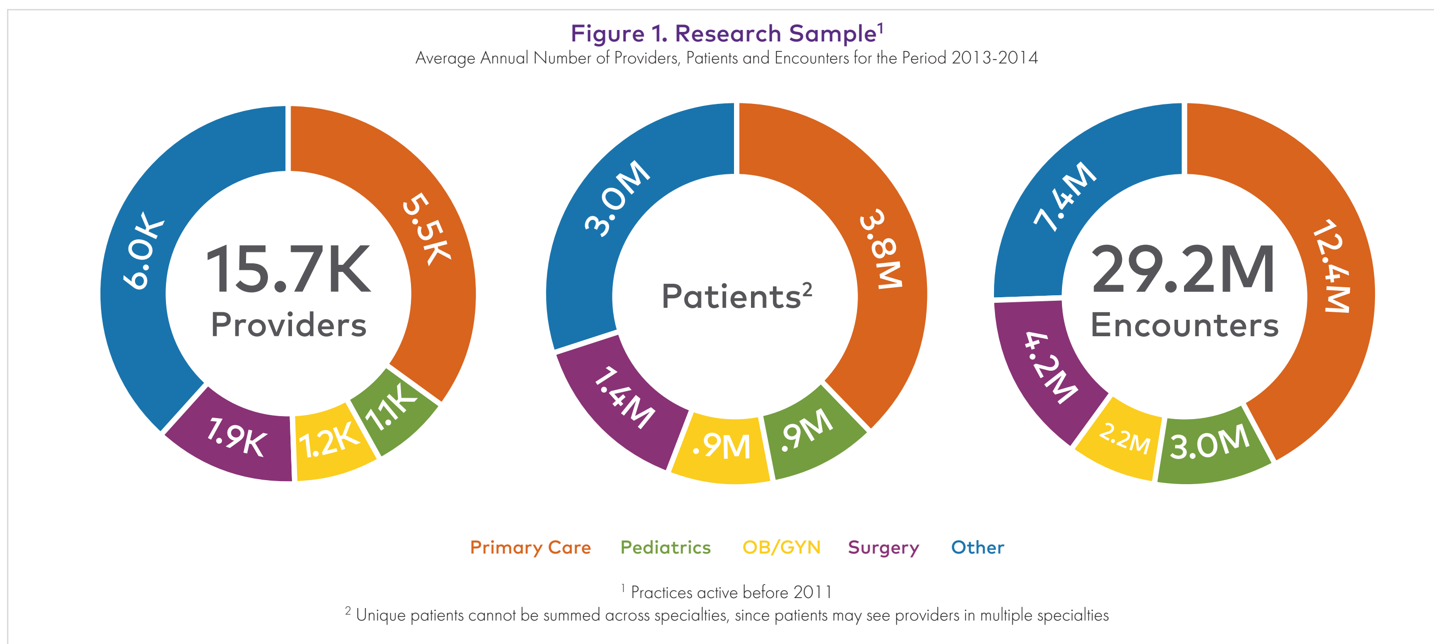
ACAView tracks provider activity among practice locations that have used athenahealth's cloud-based software continuously since at least December 31, 2010. Comparing data over time within a single practice cohort allows us to capture shifts in patient demographics, practice patterns and payer policies.

The practices reported in the ACAView metrics, a subset of all practices in athenahealth's database, include roughly 15,000 providers. Approximately 35 percent are primary-care providers, 7 percent are pediatricians, 7 percent are obstetricians or gynecologists, with the remainder distributed across various specialties. (See Figure 1 for more detailed data on the providers, patients and encounters in the research sample.)

Relative to the nation's practitioners as a whole, the ACAView cohort has fewer solo practices and more practices with 10 or more physicians, as well as a higher proportion in the South and a smaller proportion in the West. Most of the physicians in the sample are community practitioners, rather than affiliates of academic medical centers. Our sample does not include visits to emergency departments or inpatient settings. The appendix to this report includes a more detailed comparison of the ACAView sample to selected national benchmarks.

[4] Available for download at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414550.

[5] Reports and blog posts online at http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/03/athenahealth.html and at http://www.athenahealth.com/blog/.



New-Patient Volumes

1. Concerns that physicians would be overwhelmed by new patients have not been borne out.

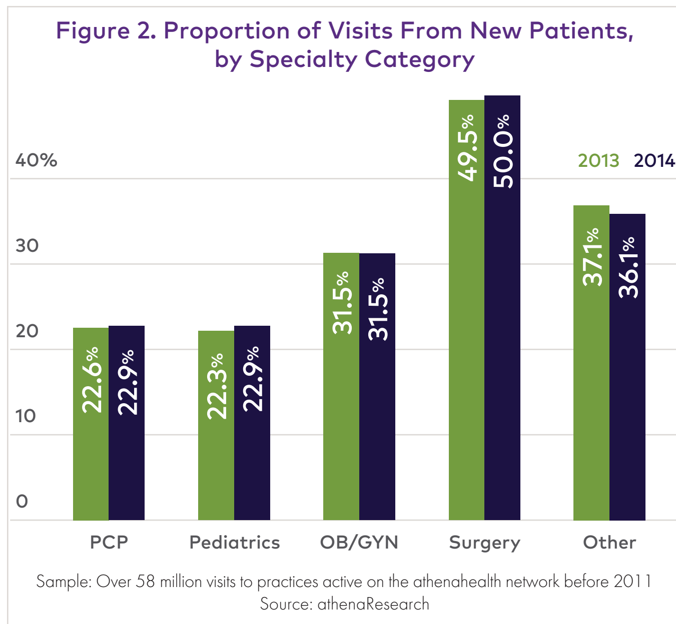
The ACA was intended to dramatically reduce the number of individuals without health insurance so as to improve their health outcomes. In the run-up to coverage expansion, some commentators expressed concern that physicians' offices would be overwhelmed by the demand for visits by newly insured patients.[6] As we explore below, these concerns did not materialize in the first year of coverage expansion. In fact, the number of new patients that doctors are seeing has increased only slightly.

We analyzed two measures of patient access to physician services. The first is the proportion of all patient visits accounted for by new patients. We define a new patient as one who has not seen a given provider in at least two years. We carry the new-patient designation through the year; a patient who satisfied our new-patient criteria in January 2013, for example, is considered new through all of 2013. This definition allows us to measure the proportion of total physician work devoted to new patients over the course of the year.

Although millions of people have gained insurance, providers have not seen an overwhelming influx of new patients. Figure 2 shows that the proportions of visits from new patients for five physician categories did not change appreciably from 2013 to 2014. For example, PCPs had 22.6 percent of their visits from new patients in 2013 and 22.9 percent in 2014. Similarly, small increases were evident for pediatricians and surgeons, while the proportion of new-patient visits was flat for OB/GYNS and declined slightly for other medical specialists.

There are several possible explanations for this small increase in the proportion of visits by new patients. Approximately 10 million individuals gained coverage in 2014, representing about 3 percent of the U.S. population. Some of these newly insured individuals already had established provider relationships, even without insurance, so would not be counted as new patients. Many others might not have needed to visit a physician after getting coverage or might have sought care in an emergency department. As a result, the overall proportion of new patients visiting PCPs in 2014 might be expected to be modest. In addition, the small increase in new-patient visits could be partly explained by some practices not accepting new patients or not belonging to networks affiliated with plans offered through the exchanges.

[6] See, for example, a study from the Kaiser Family Foundation stating that pent-up demand would strain the primary care health system (https://kaiserfamilyfoundation.files.wordpress com/2013/01/8161.pdf) and from the U.S. Health Resources and Services Administration, warning that shortages of PCPs would be aggravated by new ACA coverage (http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/projectingprimarycare.pdf).



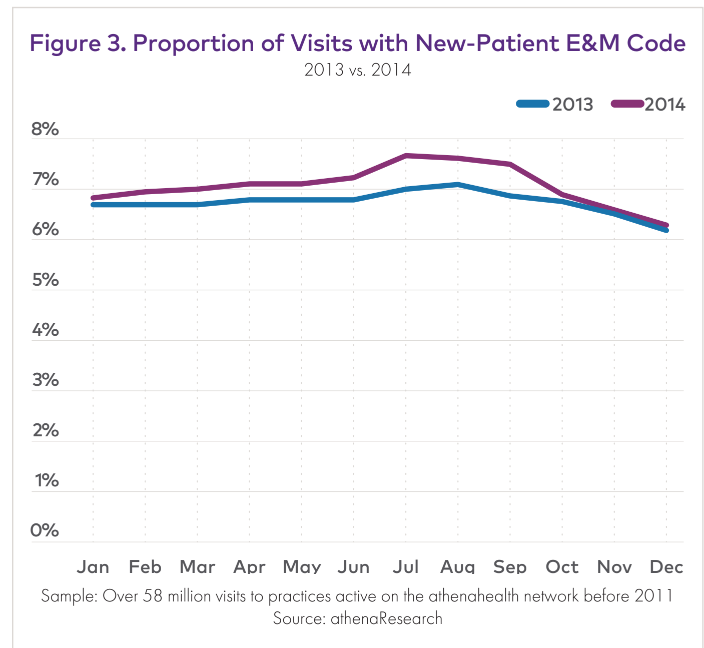
2. Although the proportion of visits from new patients increased only slightly, providers are conducting a higher proportion of more comprehensive patient evaluations.

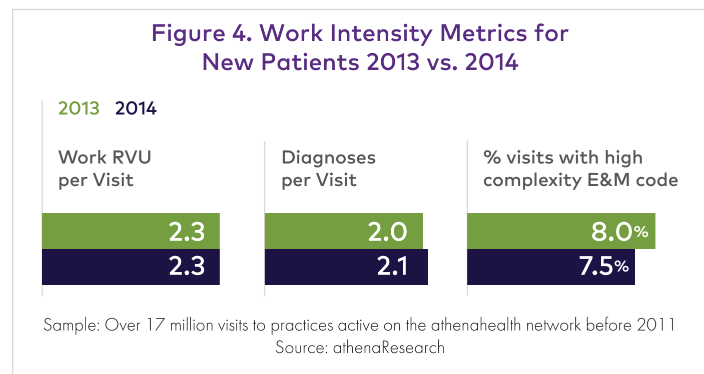
While physicians are not seeing much greater numbers of new patients, there is some indication they are conducting more comprehensive assessments for the new patients they do see. Our second measure of new-patient volumes uses billing codes for evaluation and management (E&M) services. For this more stringent definition of new patients, we counted patients as new if their visit was recorded with the procedure codes indicating a new-patient E&M visit. [7] These new-patient procedure codes are recorded for patients who have not seen a given provider or a provider with the same specialty in a particular practice in at least three years. The visit must also include a patient history, a physical exam, and medical decision-making. This definition of new-patient visits is more likely to indicate visits in which physicians are beginning a new patient relationship rather than merely treating symptoms for patients they have not seen before.

For these reasons, the numbers of these new-patient E&M visits are much smaller than the numbers of new-patient visits under our first definition. Figure 3 shows physicians using new-patient E&M codes at a higher rate in 2014 compared to 2013. In 2014, new patient E&M codes were used in 7.0 percent of all visits, compared to 6.7 percent in 2013, a relative increase of 4.5 percent. A potential implication is that the ACA may have increased the rate at which physicians are establishing new relationships with patients.

3. New patients visiting physician offices in 2014 were not sicker or more complex than in 2013.

On a variety of measures, new patients visiting physician offices in 2014 do not appear to be sicker or more complex than new patients in 2013. Results on patient complexity and required work effort appear in Figure 4 below. Work RVUs per patient visit (a measure of provider effort that takes into account the time, skill and intensity required in different procedures) remained constant; diagnoses per visit increased from 2.0 to 2.1; and the number of "high complexity" evaluation and management codes actually declined from 8.0 percent to 7.5 percent for all visits.[8]





[7] Under this definition, new-patient visits were those with CPT codes of 92002, 92004, 99201-99205, 99321-99328, 99331-99345, or 99381-99387.

[8] We define high-complexity E&M encounters as those with claims billing for CPT codes that are valued more highly within a cluster of E&M codes. For example, within the group of E&M codes 99211-99215, we classify the codes 99214 and 99215 as high complexity.

The data also shows no consistent evidence of an increase in the proportion of patients with chronic disease treated by providers. Figure 5 shows rates of chronic illness recorded in visits to primary care providers among adults (ages18-64) – the group most likely to be affected by the ACA. The changes in chronic disease rates have been modest and inconsistent over the three-year period, 2012-2014. An exception is mental disorders, which increased between 2013 and 2014, and are discussed below.

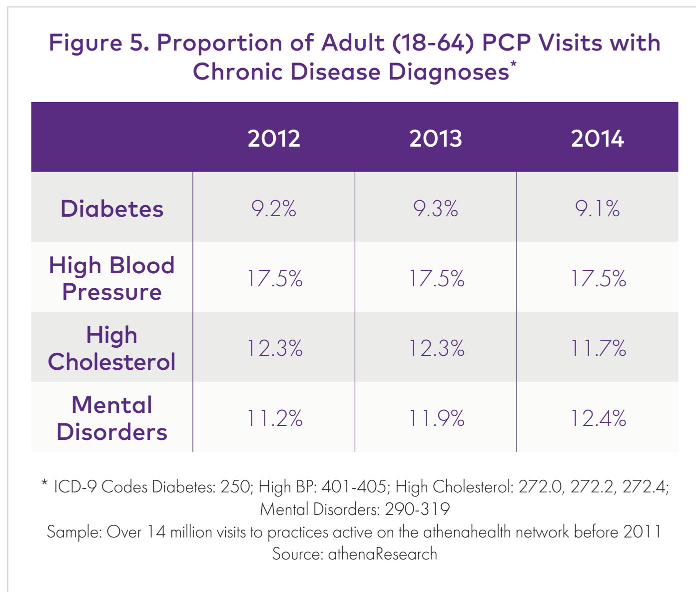


Figure 5. Proportion of Adult (18-64) PCP Visits with Chronic Disease Diagnoses*

	2012	2013	2014
Diabetes	9.2%	9.3%	9.1%
High Blood Pressure	17.5%	17.5%	17.5%
High Cholesterol	12.3%	12.3%	11.7%
Mental Disorders	11.2%	11.9%	12.4%

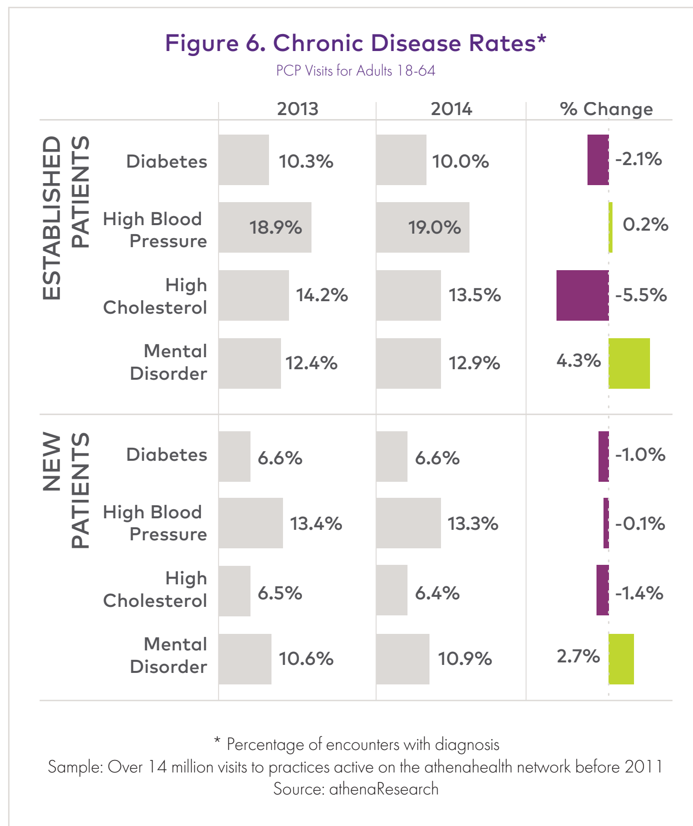
* ICD-9 Codes Diabetes: 250; High BP: 401-405; High Cholesterol: 272.0, 272.2, 272.4; Mental Disorders: 290-319
Sample: Over 14 million visits to practices active on the athenahealth network before 2011
Source: athenaResearch

Examining diagnoses separately for new and established patients further supports the conclusion that new patients were no sicker in 2014 than in 2013. Among the adults who were established patients in 2013 and 2014, the rates of diabetes and of high cholesterol fell, the rate of high blood pressure was virtually unchanged, and the rate of mental disorders rose (see Figure 6). Among these adults who were new patients, the rates followed a similar pattern, falling for diabetes and high cholesterol, steady for high blood pressure, and rising for mental disorders. The changes among the new patients, however, were smaller than those among established patients. Overall the data on visit intensity and chronic disease rates suggests that physician offices have not been overwhelmed by previously underserved patients with significant health needs.

The data shows a contrasting increase in patients with mental disorders, which include a wide range of diagnoses for mental illness and substance abuse disorders. New adult patients showed an increase of 2.7 percent in the diagnosis of mental disorders. But in the practices we are tracking, the prevalence of mental health diagnoses also increased for established patients. And the increase in the proportion of mental health visits was also evident in 2012-2013, before coverage expansion went into effect (Figure 5).

Figure 6. Chronic Disease Rates*

PCP Visits for Adults 18-64



* Percentage of encounters with diagnosis
Sample: Over 14 million visits to practices active on the athenahealth network before 2011
Source: athenaResearch

Increased Insurance Coverage

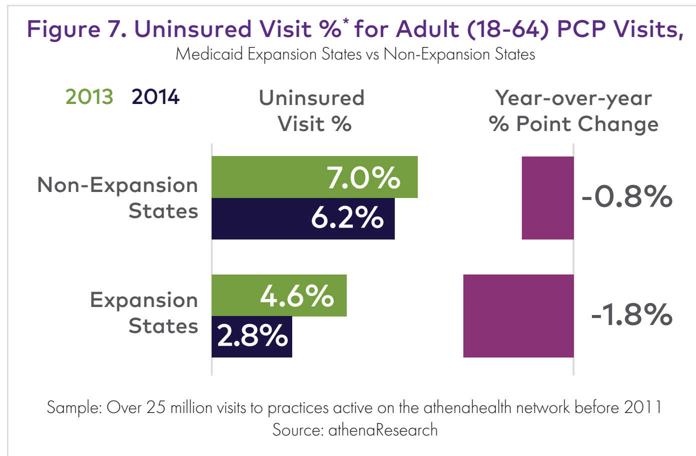
4. From the physician perspective, the proportion of patient visits by uninsured individuals has fallen much more in expansion states than in non-expansion states.

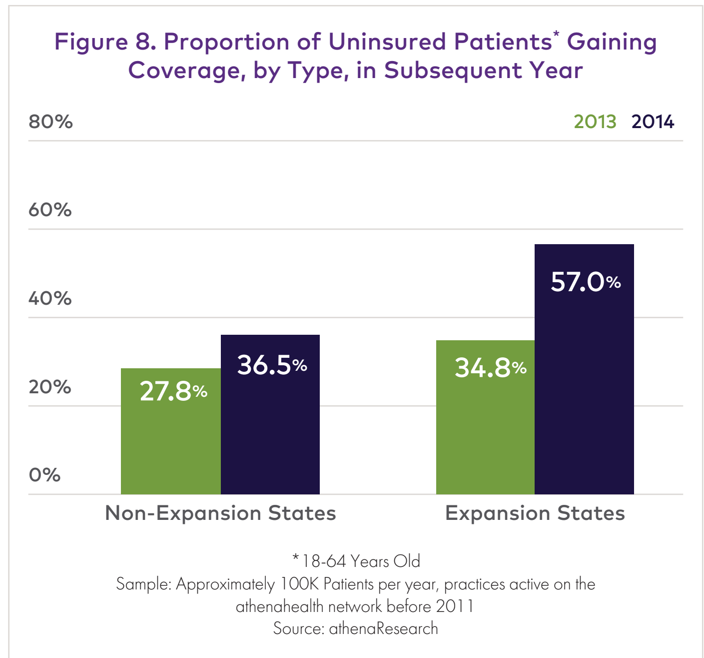
Although providers are not seeing many more new patients, their patients are less likely to be uninsured. The share of visits from uninsured patients fell in both Medicaid-expansion and non-expansion states, but much more steeply in the expansion states.

The states that have expanded Medicaid coverage include California, Illinois, Michigan, New York and a number of less populous states. The states that have not expanded Medicaid include Florida, North Carolina, Pennsylvania, Texas, Virginia and others. See the Appendix for a full list of the Medicaid-expansion and non-expansion states.

The proportion of visits from uninsured patients fell more sharply in the Medicaid-expansion states than in the non-expansion states. Figure 7 provides data for 2013 and 2014 on the proportions of visits to primary care providers (PCPs) that were made by uninsured patients in both the Medicaid-expansion states and the non-expansion states. For patients in the latter states, the proportion of uninsured visits fell from 7.0 percent in 2013 to 6.2 percent in 2014, a drop of 11 percent in relative terms. Among patients in the Medicaid-expansion states, the proportion of uninsured visits fell more sharply and from a lower

base, dropping from 4.6 percent to 2.8 percent, a relative decline of 39 percent. These different declines may be the result of broader Medicaid coverage and more positive publicity around new enrollment options in the expansion states.





5. The ACA has dramatically benefited uninsured individuals with stable provider relationships, particularly in expansion states.

This section looks at individuals who were uninsured for part of the 2012-2014 time periods and had physician visits in at least two of those three years. Although these individuals were uninsured, our data indicates that they had stable provider relationships. Looking at the proportions of patients in 2013 and 2014 who gained insurance after being uninsured the previous year, we find impressively high proportions of the uninsured gaining coverage. Figure 8 shows that in non-expansion states, 27.8 percent of patients who were uninsured in 2012 obtained insurance in 2013; with the ACA, this number increased to 36.5 percent between 2013 and 2014. In the expansion states, the proportion of these patients acquiring insurance increased from 34.8 percent between 2012 and 2013 to 57 percent between 2013 and 2014.

We caution readers on extrapolating from this data to the entire uninsured population. These findings were based on a sample of about 100,000 patients in fairly stable provider relationships. Their experience may therefore not be representative of the uninsured in the country as a whole.

Most of the patients who gained insurance did so by gaining commercial or Medicaid coverage. Figure 9 shows that in the non-expansion states a large share of those who had been uninsured one year gained coverage through commercial insurance (in 2014, 27.1 percent) and very few through Medicaid (in 2014, 4.0 percent). By contrast, in the expansion states, larger shares of those who had been uninsured in one year gained insurance the next year via Medicaid: in 2014, 20.2 percent of those who had been uninsured in 2013 gained coverage through Medicaid.

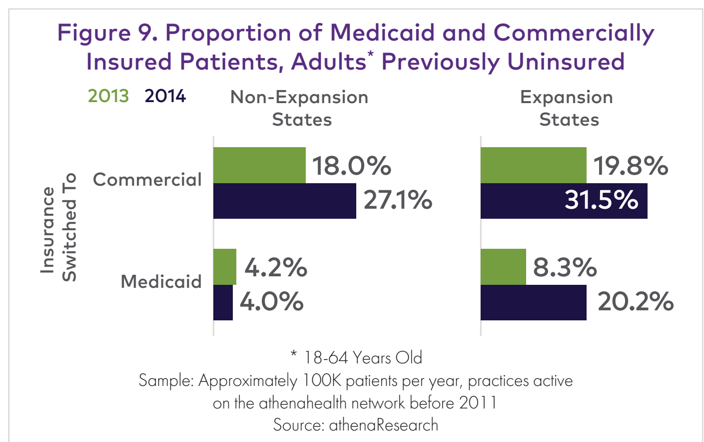
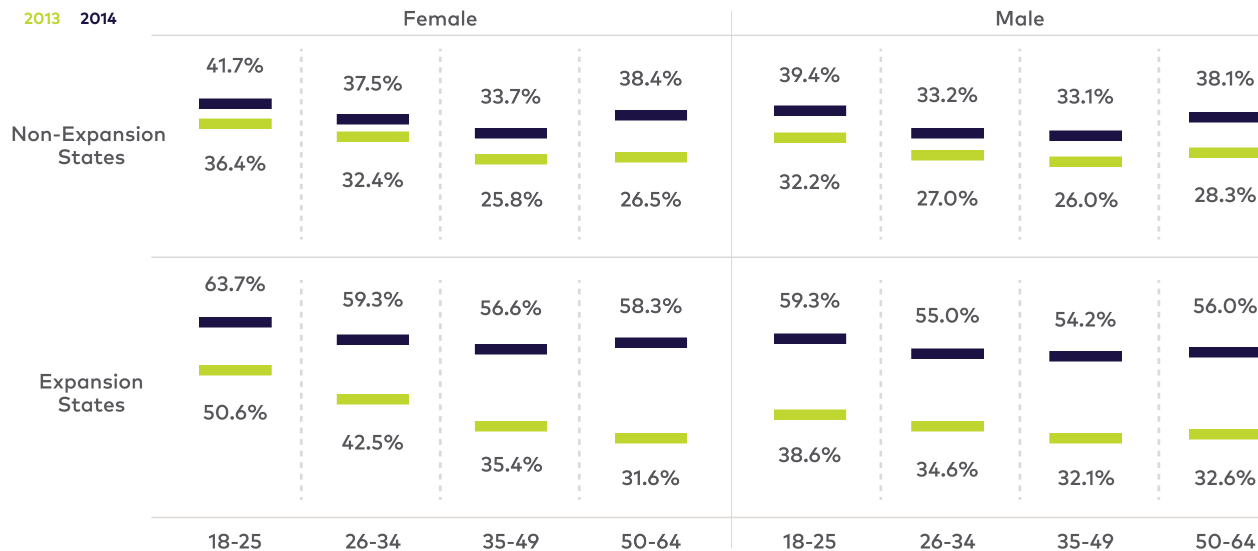


Figure 10. Proportion of Adult* PCP Patients Uninsured in the Prior Year Who Gained Insurance in 2013 and 2014, By Gender and Age Groups



* 18-64 Years Old
Sample: Approximately 100K patients per year, practices active on the athenahealth network before 2011
Source: athenaResearch

6. Prior to coverage expansion, fewer uninsured adults in older age brackets obtained insurance; the ACA has all but eliminated these age disparities.

The varied effects on coverage expansion for different demographic groups merit special attention. Figure 10 shows the proportion of patients gaining insurance in 2013 and 2014 for four major age groups among men and women in the expansion states and non-expansion states. Again, the data describes patients that were uninsured for part of the period 2012-2014 and who visited providers in two of those three years.

For all four major demographic groups (men and women in the expansion states and non-expansion states) the proportion of patients gaining insurance is higher in every age group from 2013 to 2014. For example, 50.6 percent of women aged 18-25 in expansion states who did not have insurance in 2012 gained insurance in 2013, compared with 63.7 percent in 2014. The proportion gaining insurance rose for all 16 demographic groups shown in Figure 10. Men in the expansion states also showed substantially larger gains in 2014. For example the proportion of men aged 50-64 gaining insurance increased from 32.6 percent in 2013 to 56.0 percent in 2014.

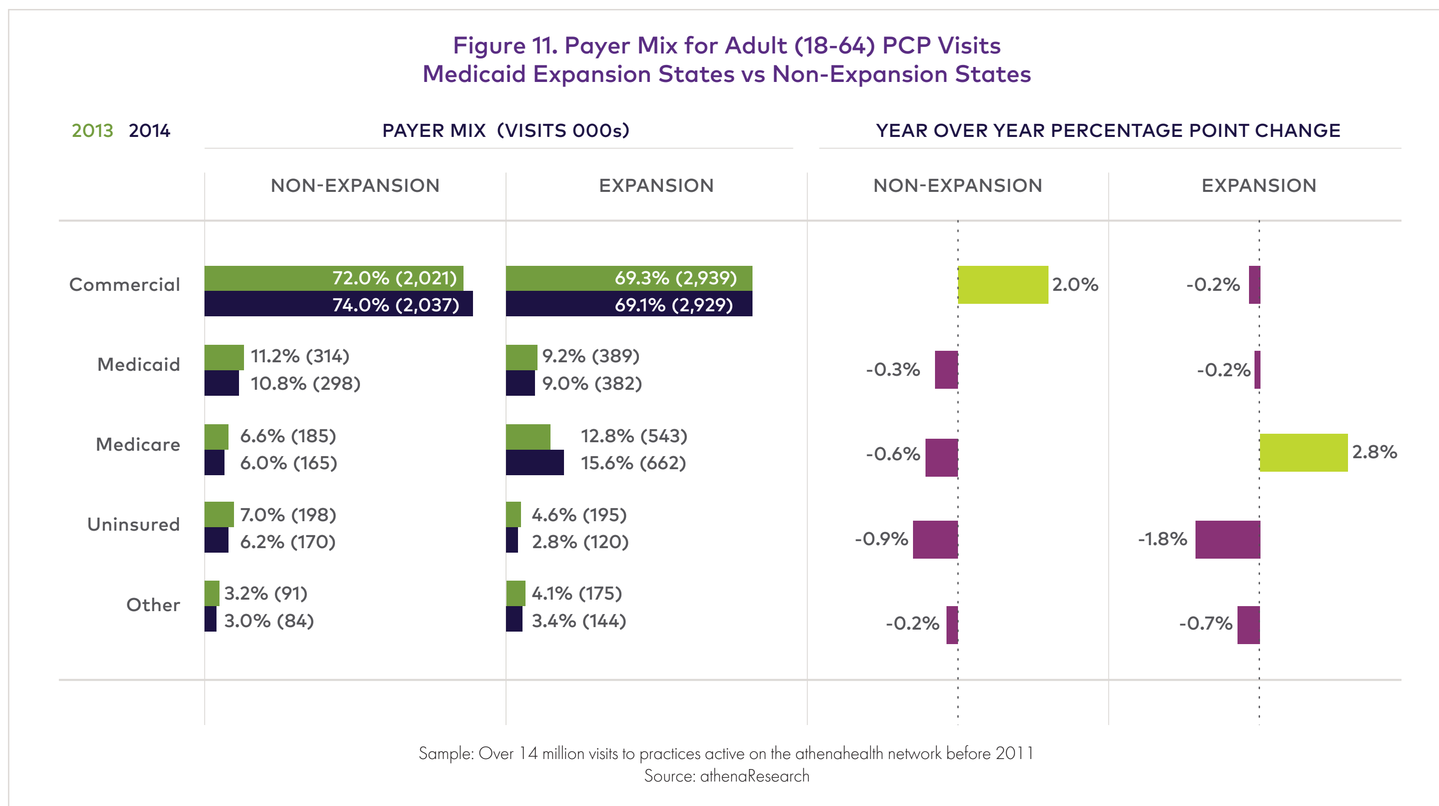
The data also indicates an important shift between 2013 and 2014 in the pattern of gaining insurance across age groups. The four major demographic groups in 2013 show lower rates of gaining insurance among the older age groups. The declining rates of gaining insurance at older ages was especially pronounced among women. For example, in 2013 36.4 percent of the women aged 18-25 in the non-expansion states gained insurance after being uninsured in 2012, while only 26.5 percent of the women aged 50-64 did so.

Looking at the same data for 2014 shows a much different pattern. The rates at which people gained insurance no longer seem to vary consistently by age: the rates are nearly flat across the age groups for women in the expansion states and fall only moderately for women in the non-expansion states. Among men, the rates across the age groups in 2014 appear to rise moderately. It appears that the ACA is changing the lower rates of insurance coverage acquisition among older adults.

Changing Payer Mix

7. Coverage expansion has changed the payer mix in physician practices, boosting the proportion of Medicaid patients in the Medicaid-expansion states and increasing the share of commercially-insured patients in the non-expansion states.

In addition to the reductions in visits by uninsured patients, providers are also seeing significant shifts in the proportion of commercial and Medicaid patients that they see. Figure 11 summarizes payer mix



changes from 2013 to 2014 for PCPs providing over 14 million office visits. The changes in the expansion states differ markedly from those in the non-expansion states. Notably, PCPs in the expansion states are seeing a higher proportion of visits by Medicaid patients, reflecting the expanded number of Medicaid beneficiaries. PCPs in the non-expansion states show a higher proportion of visits from patients with commercial insurance and lower proportions of patients with other insurance or no insurance.

The number of Medicaid-covered visits in our sample in the expansion states increased from 12.8 percent of visits to PCPs to 15.6 percent (from 543,000 to 662,000 visits). In the non-expansion states, the major change was an increase in the proportion of commercially insured patient visits, which increased from 72 percent to 74 percent. The providers in these non-expansion states are likely seeing more patients newly insured through the health care marketplaces.

8. Although Medicaid enrollment increased in non-expansion states, Medicaid patient volumes in these states are actually declining.

Providers in non-expansion states are seeing proportionally fewer Medicaid patients. The proportion of provider visits made by Medicaid patients in the non-expansion states actually declined from 6.6 percent to 6.0 percent between 2013 and 2014 (see Figure 11). This decline is noteworthy, since the number of Medicaid patients increased even in the non-expansion states by an estimated 1.5 million in 2014, as many people realized they were eligible for Medicaid during a period of intensive media attention on health insurance.[9] We speculate that providers in non-expansion states may have prioritized seeing new patients with commercial coverage obtained through the exchanges over patients who gained coverage through Medicaid.

9. The increase in Medicaid utilization in expansion states occurred very quickly, with a substantial uptick occurring within three months of ACA implementation.

The timing of payer-mix changes, shown in Figure 12, provides useful information about the speed at which the ACA brought changes to physician offices. In Medicaid-expansion states, Medicaid case mix increased remarkably quickly. Medicaid visits rose from 12.2 percent percent of all primary care visits in December 2013 to 15 percent in March 2014. Medicaid mix peaked at 16.7 percent of all visits in September before declining to 15.5 percent in December. (Although the decline in 2014 was somewhat more pronounced, Medicaid has declined as a proportion of all visits in the fourth quarter in each of the last three years in both expansion and non-expansion states.)

[9] Kaiser Family Foundation, Total Monthly Medicaid and CHIP Enrollment, http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/#, accessed 9 February 2015.

Figure 12. Proportion of Adult (18-64) PCP Visits From Medicaid and Uninsured Patients

Medicaid Expansion States vs Non-Expansion States

Medicaid, Non-Expansion States — Uninsured, Non-Expansion States — Medicaid, Expansion States — Uninsured, Expansion States

Sample: Over 21 million visits to practices active on the athenahealth network before 2011

Source: athenaResearch

10. A small but increasing number of patients switched from commercial insurance coverage to Medicaid.

As Medicaid eligibility criteria are loosened in expansion states, Medicaid may be an increasingly attractive option for low-income workers. An employed individual who qualifies for Medicaid may find it more attractive than commercial insurance, which typically involves employee premium contribution, and significant copays and deductibles. Medicaid programs do not require premium contributions, and out-of-pocket obligations are very small or completely eliminated.

Figure 13 shows Medicaid is indeed attracting a small but significantly increased share of commercially insured patients. In the non-expansion states, only 0.4 percent shifted to Medicaid in 2013 and 0.5 percent in 2014. In contrast, a larger and faster-growing share of patients shifted from commercial to Medicaid coverage in expansion states. In these states, 1.1 percent of commercially insured individuals switched to Medicaid in 2013 and 1.8 percent in 2014.

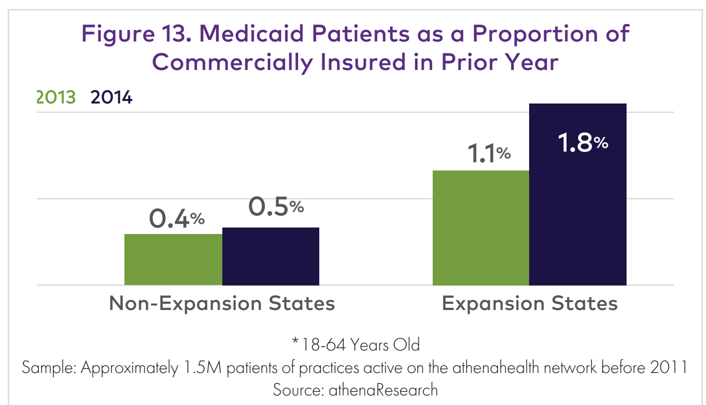


Figure 13. Medicaid Patients as a Proportion of Commercially Insured in Prior Year

*18-64 Years Old

Sample: Approximately 1.5M patients of practices active on the athenahealth network before 2011

Source: athenaResearch

Ongoing ACA implementation will surely bring more changes to American health care in 2015. ACAView will continue to track changes in the number and health status of patients in 2015. We will also continue tracking the number of uninsured patients and the shares of patients with different payers.

Our plans for 2015, however, are not yet set in stone, and we welcome your input. What aspects of change should ACAView focus on? We invite readers to share their thoughts on how ACAView can be most useful.

Please email your thoughts on our current work and suggestions for future efforts to Josh Gray at **jogray@athenahealth.com**.

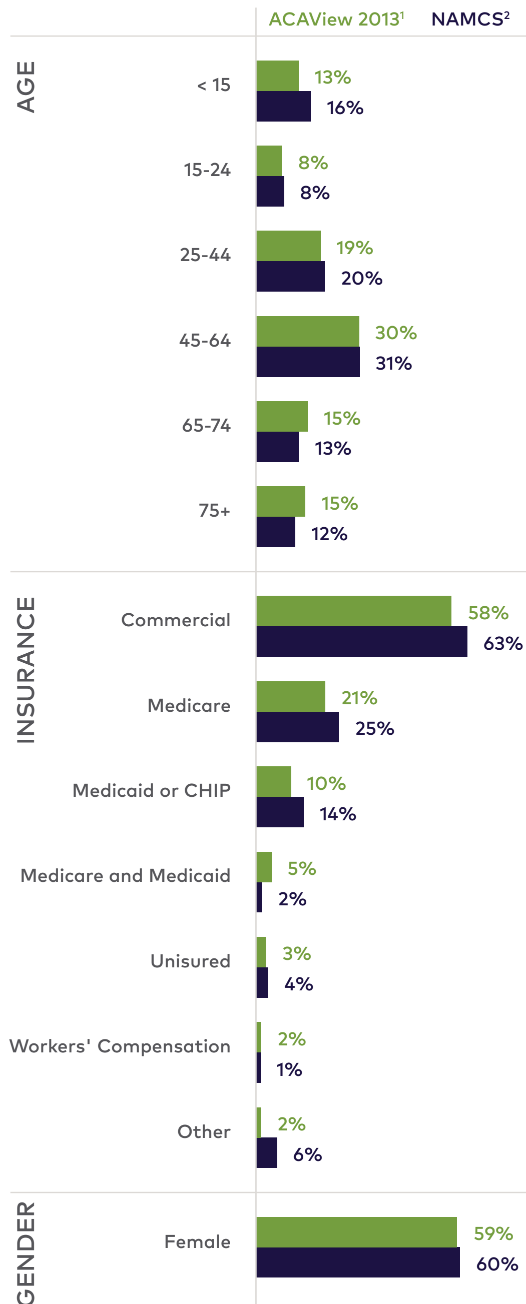
Appendix

Medicaid Expansion Status, 2014

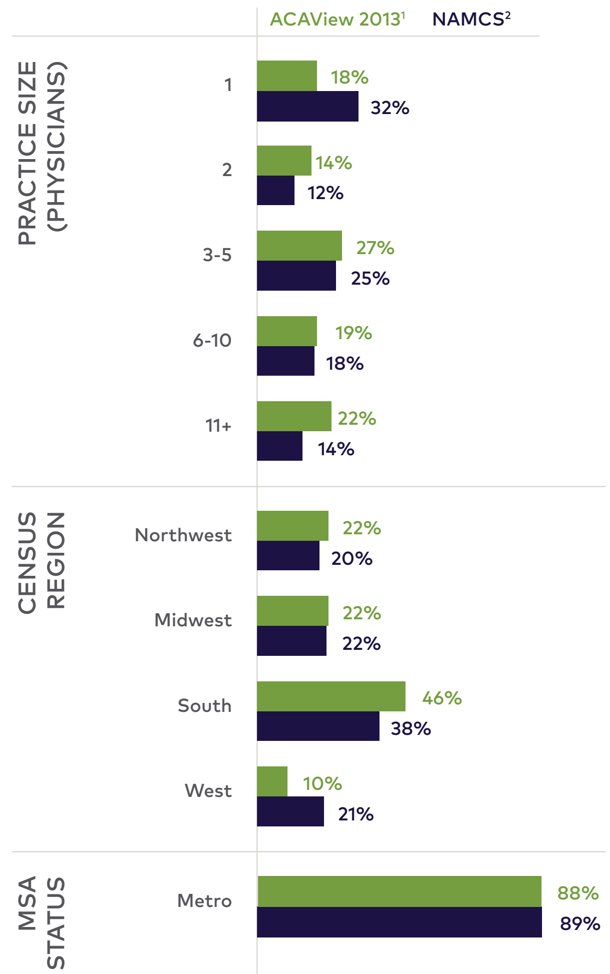
Expansion	Non-Expansion
Arizona	Alabama
Arkansas	Alaska
California	Florida
Colorado	Georgia
Connecticut	Idaho
Delaware	Indiana
District of Columbia	Kansas
Hawaii	Louisiana
Illinois	Maine
Iowa	Mississippi
Kentucky	Missouri
Maryland	Montana
Massachusetts	Nebraska
Michigan	New Hampshire
Minnesota	North Carolina
Nevada	Oklahoma
New Jersey	Pennsylvania
New Mexico	South Carolina
New York	South Dakota
North Dakota	Tennessee
Ohio	Texas
Oregon	Utah
Rhode Island	Virginia
Vermont	Wisconsin
Washington	Wyoming
West Virginia	

Athenahealth ACAView Practice Cohort vs. NAMCS

The following practice visit characteristics compare ACAView's sample with data from the National Ambulatory Medical Care Survey (NAMCS). NAMCS is administered by the Centers for Disease Control and Prevention and provides an authoritative statistical profile of ambulatory medical care in the United States. ACAView's sample is based on 30 million ambulatory visits to practices who have been on athenahealth's network since January 1, 2011. Given the similarity in distribution of patient demographics and ACAView's robust representation across provider demographic segments, we believe our data provides a reliable reflection of community ambulatory practice patterns in the United States.



1: 30 million visits to practices active on the athenahealth network before 2011
2. http://www.cdc.gov/nchs/data/ahcd/namcs_summary/2010_namcs_web_tables.pdf
Source: athenaResearch



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