



Review & Commentary on Health Policy Issues for a Rural Perspective – April 2nd, 2009

Rural Primary Care–We Get What We Incent

From “Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student & Resident Choices?” from The Robert Graham Center, Washington, DC:

“Unlike many Western nations, the United States does not manage or actively regulate the number, type, or geographic distribution of its physician workforce. As a result, medical trainees choose how and where to work. As with most free markets, equitable distribution is at risk without well-informed, evidence-based policies and incentives capable of promoting equitable access to appropriate care. This study contributes to understanding of important policy options and incentives by identifying factors that influence medical student and resident choices about medical specialties and location of practice. Specifically, it identifies factors that are associated with choice of primary care specialties, particularly family medicine, and with caring for rural and underserved populations.”

“Prior studies of the impact of debt on student specialty choice have revealed mixed effects. Recent studies suggest that physician payment disparities and the medical school learning environment are potent factors for specialty choice, and that exposure to Federal Title VII grant-funded programs during medical school and residency is associated with higher likelihood of students choosing primary

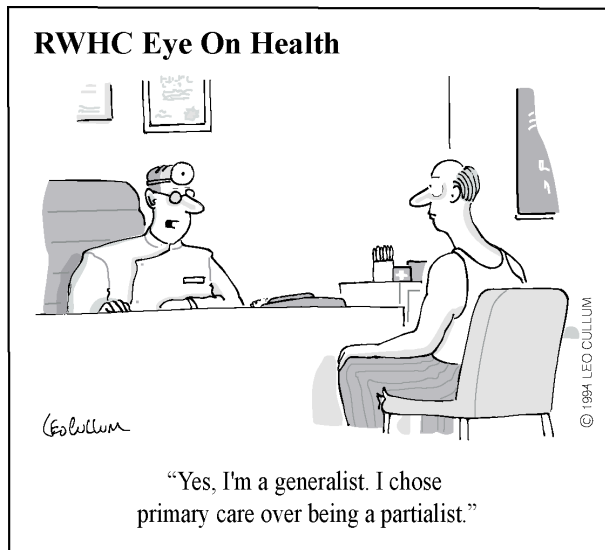
care specialties and practice in underserved settings. Most studies of specialty choice or practice location focus on the decisions students make at graduation or immediately thereafter. This study is perhaps the most comprehensive to date, as it examines multiple factors along the training path and how they relate to the end result, which is specialty of physician practice and where they practice.”

“This study incorporates nearly 20 years worth of survey data from graduating medical students about their experiences, their debt, their beliefs, and their intentions. All of these data about individual physicians were brought together to test for associations between student characteristics and training influences that may have policy relevance for a more purposefully produced health care workforce.”

**Findings**–“The income gap between primary care and subspecialists has an impressively negative impact on choice of primary care specialties and of practicing in rural or underserved settings. At the high end of the range, radiologist and orthopedic surgeon incomes are nearly three times that of a primary care physician.

Over a 35-40 year career, this payment disparity produces a \$3.5 million gap in return on investment between primary care physicians and the mid-point of income for subspecialist physicians.”

“There are measurable student characteristics, intentions, and training experiences that are significant predictors of our study outcomes. Rural birth, interest in serving underserved or mi-



nority populations, exposure to Title VII in medical school, and rural or inner-city training experiences all significantly increased the likelihood of students choosing primary care, rural and underserved careers. Being married increased the likelihood of choosing family medicine. Attending a public medical school significantly increased the probability of choosing a primary care specialty and practicing in a rural, shortage or underserved area, compared with private medical schools. Title VII exposure in residency increased the likelihood of serving in the National Health Service Corps (NHSC) and physician shortage areas but not primary care or rural practice. Other student characteristics reduced the likelihood of study outcomes. Women are much less likely to choose rural practice, and men are less likely to choose primary care.”

“The outcomes associated with debt were complex. Students with no debt and no obligating scholarships (NHSC or Armed Forces) were the least likely to later practice in primary care, in a rural area or in a health center. Debt above \$250,000 also reduced these outcomes compared to other levels of debt. Students who took scholarships and reduced debt were much more likely to have careers in all three. There is a group of students sensitive to debt or agreeable to trading debt for service that chooses NHSC and, possibly, other loan repayment programs. The NHSC is currently only available to 3-4% of physicians despite a much larger applicant pool.”

**Conclusions**—“The outcomes we studied—practicing in primary care, practicing in family medicine, practicing in a rural community, practicing in a health center, practicing in an underserved area, ever having served in the NHSC—are important if we hope to secure primary care for all people in the United States.”

“Within the last decade, US medical student interest in and choices fell well below the thresholds necessary to maintain the physician workforce in primary care and underserved settings, threatening to enhance an existing workforce maldistribution.”

“The complex relationship between debt and career outcomes likely has several explanations. Medical students increasingly come from affluent families who may influence career specialty and income expectations, and limited exposure to rural or underserved

populations. Alternatively, debt-averse students may not apply to medical school due to fear of debt or may choose less expensive public schools. Both suggest a selection bias against our study outcomes—schools may select students less likely to choose these careers, or students more likely to make these choices are not applying. Students willing to accept obligating debt reduction (NHSC, military), are much more likely to later practice and viii remain in primary care and underserved settings and such programs could be an option for more students and residents.”

“This study reaffirms the positive relationship between Title VII exposure and most of our study outcomes despite severe reductions in Title VII funding. It is an important support for the presence and quality of student training experiences and is an immediately relevant policy option that promotes these outcomes as it is currently due for reauthorization.”

“Growing physician income disparities are a major driver of student behavior. It does so directly, but also indirectly through messages about prestige, intellectual rigor, need to increase ‘productivity,’ and status. In many academic health centers, primary care is labeled as the revenue ‘loss leader’ rather than as a core function or even producer of downstream revenue. This income disparity explains much of the difficulty in achieving the balance in specialty and geographic physician distribution and will continue to inhibit achieving the workforce needed for better quality, efficiency and equity.”

“These potent effects of market factors do not absolve medical schools and residency programs of

**Rural Wisconsin Health Cooperative**, begun in 1979, has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the “rural advocate of choice” for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost effective healthcare... assists Members to partner with others to make their communities healthier... generates additional revenue by services to non-Members... actively uses strategic alliances in pursuit of its Vision.

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their role in affecting student choices. We found clear evidence that the student selection process and curriculum are very important in producing primary care physicians and physicians willing to serve in rural and underserved settings. In general, public and rural schools do a better job of producing primary care, rural and health center physicians, which should be an important consideration in the ongoing expansion of medical school capacity and in the design of new schools. They should also be a focus for state and federal funding of programs that enhance their success with these outcomes.”

“Feminization of primary care, particularly pediatrics and family medicine, threatens the rural workforce without efforts to make rural practice a more attractive or viable choice for women. We also need to understand male resistance to primary care careers and how to improve it as an option.”

“Finally, there is a convergence of interest in primary care among large employers and federal advisory bodies and agencies. Previously unthinkable conversations are happening about investing more in primary care and in specific models of care that can unfetter primary care’s capacity to achieve the effectiveness, efficiency and equity realized in other countries. There are also calls for changes in how training is financed and the settings in which training can be supported to purposefully align training with desirable population health outcomes. Both policy efforts—enhancement of primary care functions and accountable training of the next generation of physicians—are needed to reverse the current trends for more expensive and less equitable health care. We believe that this study offers supporting evidence for these policy efforts and suggests ways that the training pipeline can be modified.”

### Recommendations

1. “Create more opportunities for students and young physicians to trade debt for service, through effective programs such as the National Health Service Corps.
2. Reduce or resolve disparities in physician income.
3. Admit a greater proportion of students to medical school who are more likely to choose primary care, rural practice, and care of the underserved.

4. Study the degree to which educational debt prevents middle class and poor students from applying to medical school and potential policies to reduce such barriers.

5. Shift substantially more training of medical students and residents to community, rural and underserved settings.

6. Support primary care departments and residency programs and their roles in teaching and mentoring trainees.

7. Reauthorize and revitalize funding through Title VII, Section 747 of the Public Health Service Act.

8. Study how to make rural areas more likely practice options, especially for women physicians.

9. New medical schools should be public with preference for rural locations.”

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### The UW Physician Asst. Program “Gets It”!

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From “Based Learning Program Supporting the Wisconsin Experience” by Jerry Noack, PA-C, Director of Distance Education, University of Wisconsin-Madison School of Medicine and Public Health, *PA Newsletter*, Winter, 2008:

“UW-Madison PA Program’s unique Community-Based Learning Program (distance education, or DE option) is designed to extend PA education into medically underserved communities. Currently, we are the only PA program in the country to offer this opportunity in this format. **Distance students complete 90% of their education in their home communities over a three year period.** The first summer session (10 weeks) is completed on campus and allows them to work closely with faculty and campus classmates. Distance students return to campus twice each semester. Community mentors help to reduce isolation, provide professional role models, and act as supplementary resources to instruction. Students complete the clinical year on a full-time basis in preceptorships in or near their home communities.”

“The Health Sciences Learning Center housing medical school programs, including PA, opened in mid-2004. This state of the art building permits the technological capture and delivery of course content and the dedicated staff continues to explore and encourage the application of emerging technologies.”

**17<sup>th</sup> Annual Monato Essay Prize Now \$2,000**

A \$2,000 Prize for the Best Rural Health Paper by a University of Wisconsin student. Write on a rural health topic for a regular class and submit a copy by April 15th. Info re submission is available at

[www.rwhc.com/Awards/MonatoPrize.aspx](http://www.rwhc.com/Awards/MonatoPrize.aspx)

“While one (6%) student is ethnically diverse, seven (39%) of the 18 students in the first six cohorts report educationally disadvantaged backgrounds and five (28%) students report being economically disadvantaged. Forty four percent of the students were raised in medically underserved communities. Early analysis of grades and academic progress showed that distance students perform as well, or better than, campus students. All DE graduates passed the NCCPA national board exam in their first attempt and 6 of the 7 students in the first three cohorts are employed in or near their home community.”

“We have developed a strong infrastructure for delivering our curriculum by distance. Our project is well organized and designed to address the needs of students, faculty, and all other involved parties. The Distance Education oversight committee meets weekly to monitor progress, make plans, and address concerns. Through a committed faculty and staff, strong community and university partners, incorporation of emerging technologies, and engaged students we are meeting our goal of educating top quality health care providers committed to their home communities.”

“**The distance education advantage**, *Michael Korbel, Eau Claire, WI DE Class of 2009*: What attracted me to the University of Wisconsin–Madison’s Physician Assistant (PA) program was the Distant Education (DE) option of study. This option let me take classes from home over a two-year period, allowing part-time study, with the traditional full time clinical year [or medical preceptorship] in my home community. We don’t have to uproot our lives to complete the PA program. During the first two years there are some campus visits required but they are infrequent, concise, and yet full of learning. DE students are afforded enough time to be involved in community opportunities and maintain obligations. It’s a win-win-

win situation for the student, the university, and the community.”

“Being a DE student does not detract any quality from the learning experience as compared to the students

attending full-time on campus. The DE student can take advantage of the outstanding PA and Medical School faculty, expert community lecturers and clinical instructors. Curriculum is presented through many modes of on-line learning, being driven by a professional, savvy, and innovative information technology staff. Though most teaching is accomplished on-line, there are still other invaluable modes of instruction available, including access to a huge medical library database, its staff, workshops, live lectures, e-mail, conferences, one-on-one faculty and staff connections, and much more. And for an older student such as me, there is also help available the old fashioned way, only a telephone call away!”

“**Honoring community commitments**, *Agnes Kani-kula, Black Earth, WI DE Class of 2010*: “I am a returning to UW-Madison for a second degree, Physician Assistant, as a student in the Distance Education option. This option makes it possible for me to pursue a career as a Physician Assistant because of the flexibility it offers when trying to balance school, work and family life. In addition to being home to care for my family, I can continue to honor the commitments I’ve made to serve in the local Emergency Medical Service and working at our area hospital. I appreciate the opportunity to stay connected to my community, the place where I feel invested, supported, and where I hope to be of continued service.”

“**Why I chose the distance education option**, *William Smoot, Iron Mountain, MI DE Class of 2009*: “I was offered a seat in either the traditional or distance education (DE) program. I chose the distance ed. option. I found the staff to be incredibly receptive regarding tech issues and suggestions, especially the dedicated tech support staff. Each semester presents its own tech obstacles, and each semester provides its own improvements on the past semesters. In my opinion, these are advantages of the DE program: 1. Ability to continue to work in allied health care field (in my case, full-time as a paramedic). 2. Ability to fur-

ther connect to my hometown, network with local physicians, etc. 3. Ability to more readily incorporate didactic material with clinical experiences. 4. Ability to set up own clinical rotations.”

**National Rural Health Association  
2009 Annual Conference  
Miami, Florida, May 5-8, 2009  
Information at <http://www.nrharural.org>**

“**A dream come true**, *Sheryl Gauthier, Neenah, WI DE Class of 2010*: “The UW-Madison Physician Assistant program is truly life-changing both for me and for those I will soon be able to help. With the distance education opportunity, I can do my part to impact the issue of care for those who cannot afford health care and to help people when they need it most. I currently am employed in a full time job, have a family, and participate in community volunteer positions. With 120 miles between me and the nearest PA program – distance education is a dream come true.”

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## CAHs’ Electronic Medical Record Challenge

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From a “Commentary re Critical Access Hospitals and Health Information Technology Incentives in the Economic Recovery Bill” by Louis Wenzlow, Tim Size and Rich Donkle, RWHC in Sauk City:

### Key Talking Points

- The Economic Recovery Bill stated intent was to incent widespread HIT adoption.
- Medicare currently pays all hospitals what it believes is their share of capital costs.
- The original House Bill had no incentives for Critical Access Hospitals (CAHs), the original Senate Bill had \$1.5 million per eligible CAH; the final Bill may only provide, at best, about \$480,000 in incentives per eligible CAH.\*
- The result is that the Congressional Budget Office estimates that only half of CAHs will be “meaningful users” of HIT by 2019.

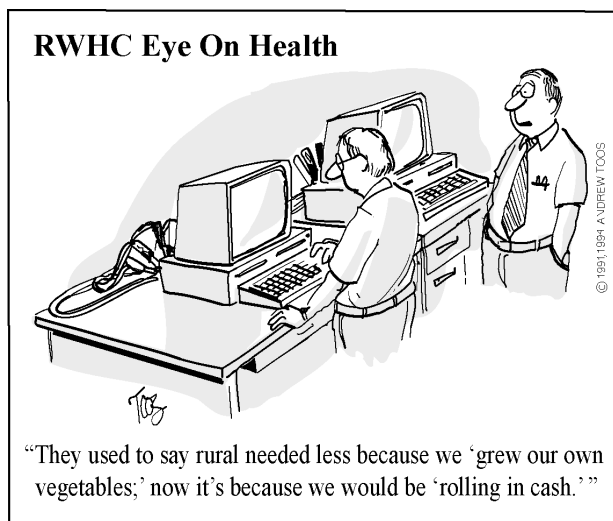
- As the Economic Recovery Bill is implemented, rural voices must work to minimize the above shortfalls.

**Background**—The differences are dramatic between Prospective Payment System Hospital (PPS) and CAH Medicare incentives in the American Recovery and Reinvestment Act (ARRA). Most PPS hospitals that become eligible for incentive payments will receive over \$4 million in added payments. CAHs that become eligible for incentive payments are estimated to receive, in the best of circumstance, about \$480,000 in added payments (assumes \$1.2 million in undepreciated “Certified EHR” costs to apply to the bonus structure).\*

The original House version of ARRA provided no incentives for CAHs; the Senate version would have provided eligible CAHs \$1.5 million in HIT incentives. The Conference Committee created new language not in either the House or Senate versions, with a practical result believed to be much closer to the House bill. In particular, early adopter CAHs will in many to most cases get limited to no incentive payments. As a result, the **Congressional Budget Office estimates that only half of CAHs will be “meaningful users” of HIT by 2019**. Below is the justification used to exclude CAHs from a meaningful HIT incentive on par with PPS hospital incentives, and why the justification is incorrect.

**The justification for treating CAHs differently than PPS hospitals (House bill Sec. 4312; Senate bill Sec. 4202; Conference agreement Sec. 4102):**

“Medicare pays acute care hospitals using a prospectively determined payment for each discharge. These payment rates are increased annually by an update factor that is established. In part, by the projected increase in the hospital market basket (MB) index... **Currently, Medicare’s payments to acute care hospitals under the inpatient prospective payment system (IPPS) are not affected by the adop-**



**tion of EHR technology.** CAHs receive cost-plus reimbursement under Medicare. Under current law, Medicare reimburses CAHs at 101% of their Medicare costs. These reimbursements include payments for Medicare's share of CAH expenditures on health IT, plus an additional 1%."

**Why the statement used to exclude CAHs from receiving a meaningful incentive is considered by many to be misleading:** MedPAC (Medicare Payment Advisory Commission) says, "IPPS pays per-discharge rates that begin with two national base payment rates—covering operating and capital expenses—which are then adjusted to account for two broad factors that affect hospitals' costs of furnishing care: the patient's condition and related treatment strategy, and market conditions in the facility's location." (i.e. PPS hospitals receive payment for capital expenses, including HIT).

PPS hospitals, as well as CAHs, submit cost report data within 5 months after the end of each fiscal year. All capital costs, including those for HIT, get reported. CMS provides proposed DRG updates (that take into account these reported capital costs) in the spring of each year; the final DRG updates are released in the summer; and the new rates, which include inflation factors, become effective on October 1st. It is true that CMS does not reimburse PPS hospitals for their individual capital costs, but they are reimbursed in the capital portion of their Medicare payment for what CMS estimates to be reasonable capital expenses for an efficiently run hospital.

**Understanding why CAHs are reimbursed at actual cost + 1%—**CAHs are reimbursed at actual cost plus 1%, rather than cost through DRG payments in order to maintain a safety net of hospital services in rural America. CAHs have a lower volume of inpatients and a proportionately higher cost of operation and capital (since higher volume allows for greater efficiencies). The PPS system was designed for high volume hospitals. After twenty years of failed attempts to adjust it for the conditions faced by rural hospitals, Congress decided to establish a Medicare payment system that took into account the unique challenges faced by rural hospitals.

The justification for CAH cost-based reimbursement can be roughly understood by thinking of it in terms of

the REA bringing electricity to rural America, and as the rationale for rural broadband subsidies. There is not enough volume in rural areas to provide these services at the same cost as in urban areas, so we need to treat them differently in order to provide rural residents with basic necessities: electricity, broadband, healthcare. Legislators, especially those with rural constituents, need to understand that CAH cost-based reimbursement was not designed to be higher than PPS reimbursement, but rather equivalent to, given the volume disadvantage in rural communities.

### **Why Do CAHs Need Incentives Beyond ARRA**

- Today, even after years of cost-based reimbursement, CAHs average half the EMR adoption of PPS hospitals.
- The CBO estimates that with the incentive as written still only 50% of CAHs will reach meaningful user designation by 2019.
- The impact will be to leave many (half of!) small rural hospitals behind in the next decade's HIT revolution.
- This will severely impact the healthcare needs of 15 million Americans that live in small rural communities served by CAHs.

**Recommended Next Steps—**The legislation is now law, and we are, at least for now, left with making the best of a bad situation. Some areas to focus on will include: (1) a short as possible administrative process for establishing "meaningful use," (2) making sure that the "Certified EHR" costs that are eligible for CAH incentives include all aspects of EHR implementation, such as PACS, HIT infrastructure, and hardware, rather than only those that are covered by current certification programs, (3) making sure that grants (and/or loans) are available for CAH EHR implementation, and not just for broadband and information exchange, and (4) making sure that individuals who understand rural HIT and reimbursement are in the room when key decisions are made moving forward.

\* *The calculation for the "Estimated Additional Value of the Added CAH HIT Incentive" is available with this commentary at <http://www.rwhc.com>*

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## Rural & Race Matter

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From “Health Disparities: A Rural–Urban Chartbook at [www.ruralhealthresearch.org](http://www.ruralhealthresearch.org) by Kevin Bennett, PhD, Bankole Olatosi, PhD & Janice Probst, PhD, South Carolina Rural Health Research Center, 6/08:

“Rural minorities experience disparities in health and health care delivery. Previous studies have illustrated many of the health disparities experienced by rural residents, such as poorer health status, higher obesity prevalence, more with activity limitations, and higher mortality rates. The Chartbook seeks to expand the work of the National Healthcare Disparities Reports, issued annually by the Agency for Healthcare Research and Quality. These Reports are limited in their discussion of disparities experienced by rural residents and present little data regarding disparities among rural minority populations. The present Chartbook expands upon prior work by examining potential disparities among rural populations in health, health behaviors, preventive services and diabetes care.” Key findings include:

### Health & Health Behaviors

- “Residents in any rural county were more likely to report fair to poor health status than were residents of urban counties (19.5% versus 15.6%).
- Rural adults were more likely to report having diabetes than were urban adults (9.6% versus 8.4%).
- Rates of diabetes were markedly higher among rural American Indian (15.2%) and black adults (15.1%).
- Rural residents were more likely to be obese than were urban residents (27.4% versus 23.9%).
- Rural black adults were particularly at risk for obesity; their obesity rate ranged from 38.9% in rural micropolitan counties to 40.7% in remote rural counties.
- Rural residents were less likely than urban residents to meet CDC recommendations for moderate or vigorous physical activity (44.0% versus 45.4%).
- Rural black adults were less likely to meet recommendations for physical activity than other rural residents; this difference persisted across all levels of rurality.”

### Access to Healthcare Services

- “Rural residents were more likely to be uninsured than urban residents (17.8% versus 15.3%).
- Hispanic adults were most likely to lack insurance, with uninsured rates ranging from 40.8% in rural micropolitan counties to 56.1% in small remote rural counties.
- Most rural and urban residents report having a personal health care provider (81.0% and 79.4%, respectively). Across rural counties, residents in remote rural counties were least likely to have a personal physician (78.7%).
- Rural white adults were more likely to report having a personal health care provider than were other adults. Among Hispanic adults, the proportion with a personal provider ranged from 60.4% in rural micropolitan counties to 47.7% in remote rural counties.
- Rural adults were more likely than urban adults to report having deferred care because of cost (15.1% versus 13.1%).
- Black, Hispanic and American Indian rural adults were more likely to report having deferred care due to cost than were white rural adults.”

### Receipt of Preventive Services

- “Rural women were less likely than urban women to be in compliance with mammogram screening guidelines (70.7% versus 77.9%).
- Rural women were less likely to report having a pap smear done within the past three years than urban women (86.0% versus 91.4%).
- Rural residents over age 50 were less likely ever to have had a colorectal cancer screening than were urban residents (57.7% versus 61.4%).”

### Quality of Diabetes Care

- “The proportion of adults with diabetes who reported receiving at least two hemoglobin A1c tests within the past year was low among both rural (33.1%) and urban (35.0%) residents.
- White rural residents with diabetes were more likely than black or Hispanic residents to receive at least two hemoglobin A1c tests in the past year.
- Only 64.2% of rural and 69.1% of urban adults with diabetes reported receiving an annual dilated eye exam (not significantly different).”

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## Promoting Healthy Fast Food

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RURAL HEALTH CAREERS  
WISCONSIN

We regularly showcase a RWHC member from the Wisconsin Hospital Associations' annual Community Benefits Report. Wisconsin hospitals provide over \$1.6 billion in community benefits; twice that if you include Medicare shortfalls and bad debt. This month's story is from Boscobel Area Health Care:

"Boscobel Area Health Care sponsored the first annual 'Nutrition to Go Challenge' in November to encourage parents to share their tips for eating healthy on the run. The hospital's goal was to help parents identify healthy food choices that are fast and portable for busy families. The participants were varied in their approach to making nutrition a priority. Some focused on how to speed up meal preparation, others controlled the food available to teens, and others named specific snacks that they took along on trips. Winning entries were selected based on the ease of preparation, cost, and nutritional value."

"Kimberly Schildgen, a participant in the challenge and parent of four Lancaster graduates, said, "Some of our best memories were at the kids' sporting events." Schildgen planned ahead and packed a cooler for her young athletes.

Portable snacks in her tote bag included string cheese, apples, bananas, yogurt, venison sticks, and home-made trail mix."

"Aaren Schultz, parent of two Boscobel graduates, focused on making healthy food as easy to grab as candy or chips. Schultz washes fruit and vegetables as soon as she gets home, so they are handy and ready to eat."

"Nutrition to Go tips developed by Boscobel Area Health Care's dietician and athletic trainer, along with tips from parents submitted as part of the challenge, were shared with the public. Tips were posted on the Web site, printed in the local paper, displayed at booths at basketball games, and distributed at the 'Taste of Homes' show."

Space Intentionally Left Blank For Mailing