Reimbursement Issues in Rural Family Practice: An Experience in Washington State

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A recent issue of *The Journal of Family Practice* (October 1980) was devoted to reporting practice pattern profiles of family practice residency graduates. Data presented in that issue indicated approximately 50 percent of recently trained family physicians are establishing practice in areas designated "primary care physician health manpower shortage areas."[1] Many of these shortage areas are rural in character. In fact, approximately 17 percent of the graduates in the WAMI region (Washington, Alaska, Montana, Idaho) locate in communities of under 2,500, and 57 percent locate in communities of less than 25,000.[2]

These findings indicate that family practice training programs are making progress in addressing the need for more appropriate geographical distribution of physician resources. Graham points out, however, that "at least half of the graduates of family practice residencies surveyed have altered their practice site one or more times since the initiation of practice."[3] One factor contributing to practice mobility may well be the relative economic burden of rural practice. In the Klickitat-Skamania County Medical Society, for example, there was a turnover of ten primary care physicians in the five years between 1975 and 1980 (out of an average of 11 physicians in the society).

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This has resulted in a net loss of one physician to the area. In one half of the situations, adverse economic circumstances have contributed substantially to the physician turnover.

This paper explores the specific areas of fee-for-service practice that serve to discourage primary care providers in rural areas. Many of the same factors are generic to fee-for-service primary care practice. The economics of rural practice only tend to magnify their impact.

Disincentives and Reimbursement Issues

Looking at the broad picture, it is apparent that there are distinct economic disincentives to rural practice in many areas. The most recent comprehensive data from Washington State were compiled in the spring of 1978 by the Washington Academy of Family Physicians and the University of Washington Department of Family Medicine. The survey indicates that 25 percent of the family physicians in Washington practice in towns of less than 10,000 population. The mean net income of these rural physicians is 20 percent lower than those physicians practicing in cities with a greater than 10,000 population. This deficit is compounded when the generally longer hours and increased night and after-hours responsibility of practice in a rural setting are considered.[4]

Part of the difficulty lies with the relatively high percentage of Title XIX (welfare) recipients in rural areas. According to Cullen, approximately 20 percent of patients in towns of less than 10,000 population are on welfare.[4] More recent data from the Washington Academy of Family Physicians indicate that in many rural settings this figure is greater than 25 percent.[5] When one considers that the average return from Title XIX in Washington is approximately 60 percent of usual and customary charges,[6] the economic burden of a practice with more than four to five percent welfare recipients becomes obvious. In fact, approximately 56 percent of Washington family physicians place limits on the number of welfare recipients in their practice. However, many rural physicians find such restrictions difficult, if not impossible, to impose because alternative sources of care are not readily available.

Another source of fee reduction in rural practice is the Department of Labor and Industries. Many rural practices in Washington are located in logging areas and care for substantial numbers of work related injuries (5 to 10 percent of the practice, depending on seasonal fluctuations). Even though the Division of Industrial Insurance is legally a true insurance program with mandatory premiums collected from employees, the reimbursement structure currently imposes substantial discounts on usual and customary fees (approximately 35 percent average discount).[7]

An additional source of economic difficulty comes from Title XVIII (Medicare). Medicare rates are adjusted by profiling based on submitted charges, but there is at least an 18-month time lag built into the system. According to Bruce Ferguson, Director of the Division of Medical Assistance, at a May 1980 meeting of the Washington State Medical Association-Department of Social and Health Services Liason Committee, recent data for the state of Washington indicate allowable fees for Medicare to be only about 80 percent of current usual and customary fees. Family practices frequently have a relatively high percentage of Medicare recipients because of their commitment to comprehensive and continuous health care. If one accepts assignment from Medicare, the practice accepts a financial penalty. However, not accepting assignment may result in considerable financial hardship for many elderly patients.

The American Medical Association's *Essentials of Approved Residencies*[8] points out that critical to the role of a family physician is a willingness to "evaluate the patient's total health care needs" and accept "responsibility for the patient's comprehensive and continuous health care." Additionally, the family physician "accepts responsibility for the patient's total health care—within the context of his environment, including the community and the family or comparable social unit."

Fee-for-service practice as currently structured provides no economic incentives for developing the community perspective implied in the *Essentials*. Effective patient management frequently

entails relating to Home Health Agency staff, public health personnel, teachers and psychologists in the school systems, and mental health and alcoholism workers in the County Mental Health Department. Even when directly related to the care of individual patients, such interaction is often without effective mechanisms for physician compensation.

The charge of evaluating the patient's total health care needs is difficult when the vast majority of insurance programs have only limited coverage of health maintenance activities. Additionally, approximately 13 percent of the American population have no health insurance,[9] a number that probably understates the situation in most rural areas.

Essentials comments constructively on several of the specialty areas. "Modern pediatrics includes a large component of preventive medicine and emphasizes care of the ambulatory patient and the patient at home." The economics of practice have at least some impact on successfully fulfilling this role.

In White Salmon, Washington, a protocol for care through the first two years of life has been developed. This protocol implies seven visits and includes attention to physical parameters, developmental milestones, and immunization status. During a recent chart review conducted as part of an application for recertification by the American Board of Family Practice, approximately two thirds of the children delivered and followed through the first two years of life were discovered to have substantial deficiencies of compliance with the recommended health maintenance visits. Personal conversations with parents indicate that this lack of compliance is at least in part due to the expense involved and the fact that well-child care is seldom covered by private insurance.

Additionally, many communities have a public health department, which in some respects serves to fractionate rather than enhance appropriate well-child and preventive care. The Southwest Washington Health Department has run well-baby and immunization clinics that are attractive to many parents because of their relatively low direct cost (of course the total cost may not be low at all, since these services are tax subsidized). Consequently some parents choose to take their children to the health department clinics for well-child care and immunizations. This pattern of care obviously has an economic impact on the fee-for-service practices as well as disrupts continuity of care.

On the bright side there has been some recognition of the desirability of promoting preventive care. Title XIX recipients are eligible for well-baby and health maintenance care under the Early and Periodic Screening, Diagnosis, and Treatment Program. The paperwork and billing process involved in treating patients under this program is somewhat complex, but the concept and general program guidelines form a valuable model of health promotion activities that could be emulated by other third party carriers.

Another area of appropriate concern for the family physician is mental health and counseling. In speaking of psychiatry, the *Essentials* states that psychiatry "is one of the necessary bases for a Family Practice Program." The family physician "should . . . diagnose and manage most psychosomatic and emotional problems." He "should . . . recognize the neurosis and psychosis and provide the after care which many patients require following discharge from a mental institution." Additionally, "marriage counseling and sex education are important areas of responsibility for the family physician."

Many economic disincentives discourage effective psychiatric care in the rural family practice setting. Certainly, a great deal of evaluation and some effective therapy occurs in the 10- to 20-minute time frame of the office visit. However, there are numerous cases in which more extensive counseling is both desirable and potentially effective.

Very few insurance programs cover ambulatory psychiatric service, and even when patients are willing to pay, overhead considerations frequently price family physicians out of the market. For example, in the mid-Columbia area, there are several competent clinical psychologists who charge between $30 and $50 an hour. In addition, there is a board certified psychiatrist with fees ranging between $50 and $60 an hour. Because of office overhead, family physician fee structure is adjusted to accrue between $80 and $100 an hour. This tends to make any substantial commitment to psychiatric care either economically noncompetitive to the patient or economically painful for the family physician. The situation is compounded by the fact that Washington Title XIX rules permit payment for counseling services only to a psychi-

atrist.[10] This regulation has been vigorously protested by the Washington Academy of Family Physicians and the program directors of a number of family practice residency programs in this state. Despite these protests no changes have occurred.

Comment

Recent data indicate that despite the WAMI regional commitment to provide an adequate number of family physicians to fill the Northwest's health care needs, the number of general/family physicians per 10,000 population in the ten smallest counties of Washington is actually less than in 1969 (4.5 per 10,000 population in 1978 vs 5.0 per 10,000 in 1969).[11] The relative shortage of primary care physicians in rural areas is in part due to supply problems, but at least in part it reflects the relative economic disincentives of rural practice.

This paper has explored some of the reasons for the relatively unfavorable economics of rural practice. Current fee-for-service reimbursement mechanisms discourage certain activities generally accepted as desirable within the context of family practice. Particularly affected are the areas of preventive maintenance, community health coordination, and psychiatric and counseling care.

Additionally, inadequate reimbursement schedules in federal and state sponsored health care programs have a disproportionately negative impact on rural practices because of the high percentage of eligible patients in many rural areas.

The impression should not be formed that one cannot earn a livable income as a family physician in a rural area. Obviously, the economic circumstances vary from area to area (eg, practice in a wealthy Iowa corn belt community is more lucrative than practice in economically depressed south central Washington). Despite the financial difficulties outlined in this paper, the mean income of general/family physicians in Washington towns of under 10,000 population in 1978 was nearly $48,000 annually.

Clearly, the disincentives are only relative. In view of the recent presidential election, however, it is unlikely that the economics of rural care will change significantly in the near future. In terms of geographic maldistribution of physicians and long-term stability of practice, it remains to be seen whether social commitment and the satisfaction of serving populations with clear health needs will overcome the negative impact of long hours and low wages.

References

1. Black RR II, Schmittling G, Stern TL: Characteristics and practice patterns of family practice residency graduates in the United States. J Fam Pract 11:767, 1980

2. Geyman JP, Ciriacy EW, Mayo F, et al: Geographic distribution of family practice residency graduates: The experience of three statewide networks. J Fam Pract 11:761, 1980

3. Graham R: Public policy implications of graduate follow-up studies in family practice. J Fam Pract 11:779, 1980

4. Cullen TJ, Gromko WA: Family Practice in the State of Washington. Seattle, Washington Academy of Family Physicians Health Care Services Commission, October 1978, pp V, 30

5. Gillanders WR: Results of DSHS Participation Survey. Wash Acad Fam Physician J 7:7, 1980

6. Testimony before the Washington House Select Committee on Health Care Reimbursement, October 1980. Summary published in WSMA Reports, West J Med, 133:6 1980

7. Medical Aid Rules and Maximum Fee Schedules, revised. Olympia, Washington State Department of Labor and Industries, Jan 1, 1980

8. Special requirements for residency training in family practice. In Essentials of Approved Residencies. Chicago, American Medical Association, 1968

9. Thirteen percent in US not insured, study shows. AMA News 23(43):19, 1980

10. Schedule of Maximum Allowances and Program Descriptions. Olympia, Wash, Department of Social and Health Services, Division of Medical Assistance, January 1980, p 14

11. Beare A: Allopathic and Osteopathic Physicians in Washington State. Olympia, Washington Department of Social and Health Services, Center for Health Statistics, Health Services Division, 1978, p 46