Attracting Rural Physicians: New Findings on Rural Training, Practice Choices, and Care for Vulnerable Populations

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This research was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreement #U1CRH03712. The information, conclusions and opinions expressed in this presentation are those of the authors and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred.
Health system changes:
- Provider consolidation
- Legislative/regulatory/fiscal changes
- Payment for value rather than production
- More demand with more insured patients

Workforce changes:
- Aging workforce
- Work/life balance
- Dual professional families

Population changes:
- Aging
- Poverty
- Barriers to health
Recruit, retain, expand capacity,…

- Get more providers to rural areas
- Keep more providers in rural areas
- Expand capacity
  - task shifting
  - teams
  - technology
  - incentives
- Reduce need and demand for services
Recruit, retain, expand capacity,…

- Get more providers to rural areas
- Keep more providers in rural areas
- Expand capacity
  - task shifting
  - teams
  - technology
  - incentives
- Reduce need and demand for services
Rural physician studies

- Recruitment/Retention
  - “Family medicine rural training track graduates: determinants of rural and urban practice”
  - “Rural family medicine residency training: program models and graduate outcomes”
  - “What impact will unified GME accreditation have on rural-focused physician residencies?”

- Incentives to expand capacity
  - “The impact of Medicaid primary care payment increases in Washington State”
Family Medicine Rural Training Track Graduates: Determinants of Rural and Urban Practice

Family Medicine Physician Early Career Choices Study

Some items in this questionnaire refer to "rural" or "urban" areas. These terms can be defined in many ways, so please respond according to your understanding.

### BEFORE MEDICAL SCHOOL

1. Before college, did you participate in any paid or volunteer activities…
   - serving urban underserved populations? Yes/No
   - serving rural populations? Yes/No

2. Did you attend a rural college or university for any of your undergraduate degree?
   - Yes/No

3. As an undergraduate, did you participate in any paid or volunteer activities…
   - serving urban underserved populations? Yes/No
   - serving rural populations? Yes/No

4. Between college and medical school, did you participate in any paid or volunteer activities…
   - serving urban underserved populations? Yes/No
   - serving rural populations? Yes/No

### MEDICAL SCHOOL

5. Did you go to medical school in the state you consider your home state?
   - Yes/No

6. Did you complete a required clerkship or elective in the following locations during medical school?
   - An urban underserved community
   - A rural community

### RESIDENCY

7. During the Match, how did you rank the residency you eventually attended?
   - First choice
   - Second choice
   - Third choice
   - Below third choice
   - Did not rank the residency you attended

8. Were you accepted into the residency you attended before the "scramble" or Supplemental Offer and Acceptance Program (SOAP)?
   - Yes/No
What leads family physicians to choose rural vs. urban practice?

Focus: physicians completing residency training in rural places

- Surveyed graduates (2008-2013) of “rural-centric” family medicine residency programs (rurally located or urban with a rural track): 62% response rate (213/342)
Survey content

- Individual/social factors, educational experiences, practice/community factors:
  - Personal background/demographics
  - Premedical education
  - Medical school
  - Residency training
  - Post-residency factors
38% of respondents reported a main practice site in a rural location* in fall 2014. More than double the 17% of all family physicians in 2013 in U.S. non-metro counties

* Rural-Urban Commuting Area codes version 3.1, 2010 ZIP approximation
Pre-residency factors associated with rural practice

<table>
<thead>
<tr>
<th>Background</th>
<th>Rural physicians</th>
<th>Urban physicians</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic white</td>
<td>90%</td>
<td>67%</td>
<td>.00</td>
</tr>
<tr>
<td>Male</td>
<td>52%</td>
<td>45%</td>
<td>.33</td>
</tr>
<tr>
<td>Residing in a rural area as a child or adolescent</td>
<td>81%</td>
<td>71%</td>
<td>.16</td>
</tr>
<tr>
<td>Foreign citizen</td>
<td>6%</td>
<td>8%</td>
<td>.59</td>
</tr>
</tbody>
</table>

Premedical education

<table>
<thead>
<tr>
<th></th>
<th>Rural physicians</th>
<th>Urban physicians</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural undergraduate school</td>
<td>41%</td>
<td>29%</td>
<td>.08</td>
</tr>
<tr>
<td>Work or volunteer with rural</td>
<td>71%</td>
<td>77%</td>
<td>.38</td>
</tr>
<tr>
<td>or underserved</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical education

<table>
<thead>
<tr>
<th></th>
<th>Rural physicians</th>
<th>Urban physicians</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural clerkships</td>
<td>88%</td>
<td>79%</td>
<td>.10</td>
</tr>
<tr>
<td>Medical school in home</td>
<td>56%</td>
<td>51%</td>
<td>.52</td>
</tr>
<tr>
<td>state</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underserved clerkships</td>
<td>64%</td>
<td>74%</td>
<td>.14</td>
</tr>
<tr>
<td>U.S. medical graduate</td>
<td>84%</td>
<td>70%</td>
<td>.03</td>
</tr>
</tbody>
</table>
Residency factors

There were no statistically significant differences between rural and urban physicians in the amounts of required or elective rural training during residency:

<table>
<thead>
<tr>
<th>Residency</th>
<th>Rural physicians</th>
<th>Urban physicians</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average total months of <strong>required</strong> rural training</td>
<td>14.2</td>
<td>15.3</td>
<td>.570</td>
</tr>
<tr>
<td>Average total months of <strong>elective</strong> rural training</td>
<td>6.2</td>
<td>7.0</td>
<td>.639</td>
</tr>
</tbody>
</table>
### Residency factors

#### 11. To what extent did the following residency training experiences **increase** or **decrease your interest** in rural practice?

<table>
<thead>
<tr>
<th></th>
<th>Not applicable</th>
<th>Increased greatly</th>
<th>Increased somewhat</th>
<th>Did not change</th>
<th>Decreased somewhat</th>
<th>Decreased greatly</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural rotation</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Continuity clinic in a rural area</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Full time training in a rural area</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Having relationships with rural patients outside the clinical setting during training</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Living in a rural community during training</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Broad scope of practice skills training</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Residency factors affecting interest in rural practice

2 = increased **greatly**, 1 = increased **somewhat**, 
0 = did not change, 
-1 = decreased **somewhat**, -2 = decreased **greatly**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rural physicians</th>
<th>Urban physicians</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad scope of skills training</td>
<td>1.58</td>
<td>1.16</td>
<td>.00</td>
</tr>
<tr>
<td>Rural training full time</td>
<td>1.33</td>
<td>.92</td>
<td>.01</td>
</tr>
<tr>
<td>Rural rotation</td>
<td>1.29</td>
<td>.88</td>
<td>.00</td>
</tr>
<tr>
<td>Rural continuity clinic</td>
<td>1.23</td>
<td>.90</td>
<td>.02</td>
</tr>
<tr>
<td>Living in a rural community</td>
<td>1.20</td>
<td>.78</td>
<td>.01</td>
</tr>
<tr>
<td>Relationships with rural patients outside of practice</td>
<td>1.06</td>
<td>.74</td>
<td>.02</td>
</tr>
<tr>
<td>Rural way of life</td>
<td>.94</td>
<td>.70</td>
<td>.11</td>
</tr>
<tr>
<td>Rural recreational and cultural activities</td>
<td>.86</td>
<td>.50</td>
<td>.02</td>
</tr>
<tr>
<td>Quality of education for children</td>
<td>.45</td>
<td>.08</td>
<td>.04</td>
</tr>
</tbody>
</table>
**Residency factors associated with rural practice**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rural physicians</th>
<th>Urban physicians</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ranking the residency attended #1 choice</td>
<td>86%</td>
<td>76%</td>
<td>.09</td>
</tr>
<tr>
<td>Being accepted into residency before the “scramble”</td>
<td>77%</td>
<td>69%</td>
<td>.23</td>
</tr>
<tr>
<td>Feeling very prepared for rural practice</td>
<td>77%</td>
<td>63%</td>
<td>.04</td>
</tr>
<tr>
<td>Feeling very prepared for rural living</td>
<td>67%</td>
<td>53%</td>
<td>.07</td>
</tr>
<tr>
<td>Spouse/partner from a rural area</td>
<td>60%</td>
<td>27%</td>
<td>.00</td>
</tr>
</tbody>
</table>
Post-residency factors associated with increased interest in rural practice

2 = increased **greatly**, 1 = increased **somewhat**, 0 = did not change, -1 = decreased **somewhat**, -2 = decreased **greatly**

<table>
<thead>
<tr>
<th>Initial (I) and/or current (C) location choice</th>
<th>Rural physicians</th>
<th>Urban physicians</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad scope of practice (I, C)</td>
<td>1.40</td>
<td>1.13</td>
<td>.03</td>
</tr>
<tr>
<td>Need for healthcare in the community (I)</td>
<td>1.27</td>
<td>.98</td>
<td>.01</td>
</tr>
<tr>
<td>Rural way of life (I, C)</td>
<td>1.26</td>
<td>.72</td>
<td>.00</td>
</tr>
<tr>
<td>Rural recreational and cultural activities (C)</td>
<td>1.26</td>
<td>.64</td>
<td>.01</td>
</tr>
<tr>
<td>Live in similar environment to where grew up</td>
<td>1.12</td>
<td>.92</td>
<td>.21</td>
</tr>
<tr>
<td>Spouse/partner's satisfaction in the community (I)</td>
<td>1.08</td>
<td>.75</td>
<td>.05</td>
</tr>
<tr>
<td>Perceived fiscal stability of hiring organization</td>
<td>1.02</td>
<td>.89</td>
<td>.30</td>
</tr>
<tr>
<td>Reputation for high quality care in the community</td>
<td>.92</td>
<td>.80</td>
<td>.33</td>
</tr>
<tr>
<td>Income potential</td>
<td>.89</td>
<td>.70</td>
<td>.16</td>
</tr>
<tr>
<td>Proximity to friends or family</td>
<td>.84</td>
<td>.68</td>
<td>.33</td>
</tr>
<tr>
<td>Sufficient providers to share call duty</td>
<td>.68</td>
<td>.72</td>
<td>.79</td>
</tr>
<tr>
<td>Quality of education for children</td>
<td>.61</td>
<td>.43</td>
<td>.29</td>
</tr>
<tr>
<td>Proximity to spouse/partner's friends or family</td>
<td>.59</td>
<td>.35</td>
<td>.19</td>
</tr>
<tr>
<td>EMR/HIT</td>
<td>.46</td>
<td>.37</td>
<td>.54</td>
</tr>
<tr>
<td>Spouse/partner work or school opportunities</td>
<td>.45</td>
<td>.46</td>
<td>.93</td>
</tr>
<tr>
<td>Proximity to shopping/urban amenities (C)</td>
<td>-.05</td>
<td>.41</td>
<td>.02</td>
</tr>
</tbody>
</table>
Post-residency factors associated with rural practice

<table>
<thead>
<tr>
<th>Post-residency service obligation</th>
<th>Rural physicians</th>
<th>Urban physicians</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>54%</td>
<td>42%</td>
<td>.11</td>
</tr>
</tbody>
</table>
All other things being equal, these factors distinguished those choosing rural practice:

- Having a spouse/partner from a rural area
- Rural recreational and cultural activities / less interest in urban amenities
- Broad scope of practice (the most appealing aspect of both residency and of the practice community)
Most background, premedical and medical school factors did not predict rural and urban practice.

- In this sample, rural background of the physician not a predictor

Multiple rural aspects of residency training increased physicians’ interest in rural practice.

Multiple aspects of the rural practice community were more appealing to physicians who chose rural.

- Service obligations, income and most practice characteristics, proximity to family, were not predictors.

Broad scope of practice was important both during residency and in practice post-residency.

- Life course: spouse/partner from a rural background
Choosing a practice location is complex and multi-factorial.

Personal or premedical background factors alone probably won’t propel someone to rural practice without supportive experiences all along the way, especially residency.

There is real value in exposure during residency to

- living and training in rural communities
- a broad scope of skills
- rural healthcare need
What does the recruitment pipeline via residency training look like?

Rural family medicine residency training: program models and graduate outcomes

What impact will unified GME accreditation have on rural-centric physician residencies?
29% of 583 family medicine residencies met one of these criteria:
- in a rural location (self-reported or according to Rural-Urban Commuting Area [RUCA] or Urban Influence Codes)...
- urban with a “rural track” (self-reported)

We surveyed residencies meeting the above criteria about locations and content of training (77% response rate)
88% of residencies surveyed actively recruited applicants with an interest in rural practice

58 (44%) reported requiring at least 8 weeks of rural training (total over 3 years).

At least 58 “rural-centric” family medicine residencies (out of 583)

- Great variation in the amount of time residents actually spent in rural training and in coverage of rurally-relevant content.
Rural-centric family medicine residencies: % providing training in relevant clinical skills

- Advanced Cardiac Life Support: 98%
- Orthopedic care: 95%
- Pediatric ALS: 93%
- Prenatal/delivery care: 93%
- Colposcopy: 89%
- Trauma/emerg cocare: 87%
- Neonatal Resusc Program: 85%
- Ultrasound: 74%
- OB ultrasound: 70%
- ALS Obstetrics: 67%
- Endoscopy: 57%
- General surgery: 54%
- Surgical GYN: 53%
- Advanced Trauma Life Support: 42%
- Operative OB: 41%
Not enough rural training available for family medicine or other rurally-relevant specialties!

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Total Residency Programs*</th>
<th>Programs Surveyed**</th>
<th>Respondents</th>
<th>Rural-centric programs***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>145</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>214</td>
<td>17</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>492</td>
<td>35</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>271</td>
<td>9</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>204</td>
<td>11</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>213</td>
<td>16</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>General Surgery</td>
<td>310</td>
<td>28</td>
<td>24</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1849</strong></td>
<td><strong>118</strong></td>
<td><strong>97</strong></td>
<td><strong>30</strong></td>
</tr>
<tr>
<td>Percent of total (1849)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Allopathic only, osteopathic only, dual-accredited

**In a rural location or urban with a rural training track

***Require at least 8 weeks total of rural training
Core competencies: % of “rural-centric” residencies providing rural-specific training

- Patient Care and Procedural Skills: 55%
- Systems-based Practice: 55%
- Medical Knowledge: 46%
- Interpersonal and Communication Skills: 41%
- Professionalism: 41%
- Practice-based Learning and Improvement: 32%
Core competencies: rural-specific skills mentioned

- Patient Care/Procedural Skills:
  - Emergency medicine: “No stroke team, no sepsis team, no ICU team, no STEMI team, no trauma team, just you kid in a few years good luck work hard.”
  - Pediatrics: “STABLE course for newborn care; neonatal resuscitation; procedural skills lab”

- Systems-based Practice:
  - Psychiatry: “Access/utilizes outside resources, integrates other mental health professionals into the treatment team”
  - Surgery: “Skills in decision-making re: transfer to higher level of care”

- Other: “Osteopathic Principles and Practice”
The supply of physicians to care for vulnerable populations:

The Impact of Medicaid Primary Care Payment Increases in Washington State

http://depts.washington.edu/uwchws/
The Washington State Health Care Authority funded this study to inform state budget priorities for the 2015 legislative session:

- Increased Medicaid payments for primary care services (equal to Medicare), authorized by the Affordable Care Act for 2013 and 2014, have ended.
- How will the loss of these payments affect providers’ willingness to care for Medicaid patients?
- Which strategies would encourage primary care providers to see Medicaid patients?
Method: two surveys (fall 2014)

“Smaller practices”: Surveyed family medicine, general internal medicine, and pediatric physicians in solo or group practices of up to 50 physicians from a sample of 15 counties representing rural and urban areas of Washington state (response rate: 72%)

“Large healthcare organizations”: Surveyed leaders of WA state’s largest healthcare organizations (response rate: 54%)
Rural physicians report less influence on the decision to accept Medicaid patients

- 73% of urban physicians vs. 46% of rural physicians reported they had “a great deal” of influence on whether their practices accept Medicaid patients.
  - Rural physicians were less often than urban physicians self-employed or in private practice—the two groups that had the greatest influence.
Rural physicians were less aware of receiving incentive payments

- Fewer rural than urban physicians reported that their practice had received the payments (32% vs. 52%).
  - More rural physicians “did not know” or were “not sure” (54% vs. 35%).
Primary care physician* responses to discontinuing the Medicaid payment increase in 2015

*Family medicine, general internal medicine, or pediatric physicians in practices of 50 physicians or fewer. Multiple responses possible; percentages may not total 100. Primary care physicians who indicated not applicable (17.8%) were excluded.
What will rural physicians do?

- Rural were less likely than urban physicians to report they would
  - stop accepting new (24% vs. 42%) or
  - reduce/stop seeing current Medicaid patients (7% vs. 23%).
Implications

Who decides: Physician autonomy was associated with perceived influence on whether to see Medicaid patients.
- Rural primary care physicians had less autonomy.

Awareness: Rural physicians less aware of receiving the incentive.
- Did some providers not receive the incentive? Is there sufficient detail on paychecks?
Summary and implications

- **Access**: How sustainable are increased Medicaid enrollments achieved under the ACA?
  - A NEJM study* found that appointment availability increased proportionally with the payment increase.
  - Many rural physicians expressed commitment to providing primary care to Medicaid patients even with reduced payment, but about a quarter reported they would stop accepting new Medicaid patients and about a third would limit new Medicaid patients.

* Polsky et al. 2015
Executive budget proposals (President Obama, Governor Inslee) did include funding for continuing the Medicaid primary care payment bonus, but it was not included in legislative budgets.

- The federal budget addresses Medicare, but ignores this other “doc fix.”

What’s happening in other states?
Study limitations

- Small and select samples
  - representativeness and generalizability
- Perceptions of the past and future behaviors may be biased
- Primary care: nurse practitioners and physician assistants not surveyed
Rural physician supply: implications

- Don’t overlook providers from urban backgrounds
- RuralMatch.com?
- Need for more education in rural places! (especially residency education)
  - More likely to lead to rural practice and rural competencies
  - Point of pride and self-sufficiency for rural communities
  - Economic benefit to rural communities
- Rural providers more willing to take vulnerable patients, but not unlimited capacity
Other WWAMI RHRC workforce supply studies

- Nurse practitioners in rural America: findings from the 2012 National Sample Survey of Nurse Practitioners
- What strategies are nurse practitioner educational programs using to encourage rural practice?
- Which physician assistant programs produce rural PAs?
- The supply of physicians waived to treat opioid addiction in rural America / Who treats opioid addiction in rural America?
- The supply and distribution of the behavioral health workforce in rural America
- Rural Training Track Technical Assistance Program studies ("1-2" RTT family medicine residencies)
The Rural Health Research Gateway provides access to all publications and projects from seven different research centers. Visit our website for more information.

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WWAMI Rural Health Research Center
UW Center for Health Workforce Studies

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- 206.543.1892

http://depts.washington.edu/uwrhrc/
http://depts.washington.edu/uwchws/
Rural training track graduate survey methods

1. We identified family medicine physician residency programs requiring at least 8 weeks of rural training.
2. 27 of these “rural-centric” programs identified their 2008-2013 graduates.
3. Graduates were matched to National Provider Identifier (NPI) data.*
4. We searched the Web to verify or update the address for mailing the survey.
5. We mailed a 7-page survey with $20 cash to 342 graduates in fall 2014.

* Sean Finnegan, Robert Graham Center
Figure 1. Washington counties of primary care physicians in smaller practices* in the study

* Family medicine, general internal medicine, or pediatric physicians in practices of 50 physicians or fewer
### Awareness of Medicaid payment increase provisions

<table>
<thead>
<tr>
<th>Provision</th>
<th>Yes, I was aware</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary care physicians*</td>
</tr>
<tr>
<td>Family medicine, general internal medicine, and pediatric physicians, as well as subspecialists in these fields, qualify for the Medicaid payment increase.</td>
<td>70%</td>
</tr>
<tr>
<td>Medicaid payments must be at least equal to Medicare payments for the above primary care services.</td>
<td>58%</td>
</tr>
<tr>
<td>The Medicaid payment increase is for services provided in 2013 and 2014 only.</td>
<td>54%</td>
</tr>
<tr>
<td>The Medicaid payment increase will end in 2015 without new legislation to continue it.</td>
<td>51%</td>
</tr>
<tr>
<td>Managed care organizations must pay physicians the Medicaid payment increases (whether directly or through a capitated arrangement).</td>
<td>42%</td>
</tr>
<tr>
<td>Providers in federally qualified health centers (FQHCs), rural health clinics (RHCs), and similar settings do not qualify for the payment increase.</td>
<td>20%</td>
</tr>
</tbody>
</table>

* Family medicine, general internal medicine, or pediatric physicians in practices of 50 physicians or fewer.
Physician* perceptions: did they themselves or their practices** receive increased Medicaid payments?

* Family medicine, general internal medicine, or pediatric physicians in practices of 50 physicians or fewer

** Based on primary care physicians’ responses about whether they themselves and whether their practices/organizations had received the increased Medicaid payments in 2013 or 2014.
Effect of Medicaid payment bonus on physician* willingness to care for *current or new Medicaid patients

<table>
<thead>
<tr>
<th>Primary care physicians with fewer Medicaid patients**</th>
<th>Primary care physicians with more Medicaid patients***</th>
</tr>
</thead>
<tbody>
<tr>
<td>38%</td>
<td>79%</td>
</tr>
<tr>
<td>Increased willingness to continue care for current Medicaid patients</td>
<td>Increased willingness to continue care for current Medicaid patients</td>
</tr>
<tr>
<td>30%</td>
<td>68%</td>
</tr>
<tr>
<td>Increased willingness to accept new Medicaid patients</td>
<td>Increased willingness to accept new Medicaid patients</td>
</tr>
</tbody>
</table>

*Family medicine, general internal medicine, or pediatric physicians in practices of 50 physicians or fewer

**Primary care physicians reporting 50% of patients or fewer on Medicaid

***Primary care physicians reporting >50% of patients on Medicaid
Program changes “very likely” to encourage providers to care for Medicaid patients

<table>
<thead>
<tr>
<th>Change Description</th>
<th>Primary care physicians</th>
<th>Large healthcare organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raising Medicaid payment rates to commercial insurance levels</td>
<td>84%</td>
<td>71%</td>
</tr>
<tr>
<td>Receiving a payment increase for complex Medicaid patients</td>
<td>62%</td>
<td>29%</td>
</tr>
<tr>
<td>Continuing the Medicaid primary care payment increase beyond 2014</td>
<td>55%</td>
<td>29%</td>
</tr>
<tr>
<td>Having greater access to specialists for referral of Medicaid patients</td>
<td>52%</td>
<td>14%</td>
</tr>
<tr>
<td>Reducing Medicaid paperwork</td>
<td>41%</td>
<td>14%</td>
</tr>
<tr>
<td>Reducing the waiting time for Medicaid payment</td>
<td>34%</td>
<td>14%</td>
</tr>
</tbody>
</table>

* Family medicine, general internal medicine, or pediatric physicians in practices of 50 physicians or fewer