

An Analysis of the Effect of Lower Medicare Reimbursement on Spokane and Kootenai Counties' Healthcare Sectors

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It is with great pleasure that I introduce you to the monograph series of the Institute for Public Policy and Economic Analysis from Eastern Washington University. I hope this research from Eastern faculty sheds new light on a particular aspect of life in the Inland Northwest.

The goal of the Institute is for our highly-qualified faculty to provide analysis and data that are relevant to your lives. The vision of a regional university that our Board of Trustees has adopted speaks directly to the notion of relevance to the Inland Northwest. Without relevance to the communities that make up this dynamic and beautiful corner of our country, our university is not fully living up to its mission.

Of course, our main mission at Eastern Washington University is to educate students to the highest levels possible, for the sake of their own careers, the future of the communities in which they will reside, and ultimately their growth as individuals. An increasingly important mission of Eastern is also to encourage faculty research. Not only does this help keep our faculty professionally current, but makes them better teachers, through the sharing of research opportunities with their students.

However, not all faculty research at Eastern need be written for professional audiences. In this day of increasingly specialization and complexity, I see an imperative for an informed citizenry. What better source can our region find to translate this knowledge into jargon-free, accessible information than a university like Eastern?

Since coming here six years ago, I am convinced there is a level of excellence at Eastern Washington University that is worthy of recognition and support. The university is a catalyst in the progress of the region – its economy, culture and way of life. The Board of Trustees and I regard the Institute for Public Policy and Economic Analysis as a striking example of our commitment to this region. My office and that of the Institute director welcome all comments on how we might better serve.

A handwritten signature in black ink, appearing to read 'S. M. Jordan'.

Stephen M. Jordan, Ph.D.

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I. Executive Summary

Medicare reimbursements to healthcare providers have been a concern over the past five years for Spokane and Kootenai Counties. According to one study, *An Analysis of Population Change in Spokane County, Washington, and Kootenai County, Idaho*, these two counties encompass the largest single population center between Seattle and Minneapolis across the northern tier of the U.S. (Hurand, 2003). The largest increases in population have been in workforce-aged people and the elderly. The aging of the population and the relatively large size of the healthcare sector in the regional economy hold the potential for changes in Medicare reimbursements to provoke changes in the healthcare sector of both counties and to impact access to care for Medicare enrollees.

The goal of this study is to measure the impact of changing Medicare reimbursements in Spokane and Kootenai Counties' healthcare sector. Specifically, the study seeks to:

- Identify the change in total Medicare income to healthcare providers.
- Examine change in access to health care for Medicare enrollees.
- Identify the change in the mix of physician specialties.
- Determine the extent of physician "flight".

According to the Centers for Medicare and Medicaid Services (CMS) (July 2001), 14% of the U.S. population are Medicare beneficiaries. Idaho Medicare enrollees make up 13% of the state's total population, while Washington Medicare enrollees make up 12% of the state's total population. In addition, according to CMS (FY 2001), Medicare payments per enrollee by state rank Idaho as 39th and Washington as 41st. The national average (estimated benefit payment per enrollee) was \$5,994. Payments for Idaho and Washington are estimated to be in the range of \$4,000-\$4,500, well below the national average.

The significance of this disparity in payments raises questions for physicians and their patients. Specifically, has it led to physicians leaving the area, leaving patient care, not accepting new Medicare patients in their practices, or entering early retirement? We classify all of these potential consequences as forms of "physician flight" and examine how Spokane and Kootenai Counties compare with Washington and Idaho at the state level and with the nation as a whole.

The findings of this study include the following:

- The trend in the growth rate of *total* Medicare payments is similar in Kootenai County, Spokane County, Idaho State, Washington State, and the U.S. For all these jurisdictions, from 1992 to 1998, there was no clear trend. Instead, volatility of rates was the key feature. From 1999 onward, there has been a steady upward trend in the rates as well as similarity in rates.
- Pre- and post-1997 (Balanced Budget Act) trends in Medicare payments per capita (65 years and older population) exhibit the same pattern as total aggregate Medicare payments.
- The annual growth rates of total payments for Part B of Medicare –payments for physician services– exhibited a clear downward trend from 1998 until 2000, but remained positive. Since 2000, the growth rates have risen, with Idaho State having the largest growth rates of the five comparison areas. In the past five years, average payment rates to physicians for Medicare have not decreased. Medicare Part B payment rates have increased more than the rate of inflation in every year except 2000.
- In both Kootenai and Spokane Counties, physicians now limit the number of Medicare patients that can be seen in their practices. In Spokane County, approximately only 23 percent of primary care physicians see new Medicare patients, compared to 75 percent seeing new privately insured patients. Access to primary care physicians is also inadequate in Kootenai County, with no family physician/primary care provider accepting new Medicare patients in August 2003. Access problems for Medicare beneficiaries are on the rise at the national level. Between 1997 and 2001, the percentage of physicians¹ across the U. S. accepting all new Medicare patients fell from 74.6 percent to 71.1 percent.² There is clearly a dramatic difference in the rate of physicians' willingness to see Medicare beneficiaries between Kootenai and Spokane Counties and the nation.
- From 1998 to 2002, Spokane County experienced a total increase of 11.3% in the absolute number of physicians. During this time the number of newly-licensed physicians in Spokane County decreased in only one year—2000. Kootenai County has had positive growth rates in number of active physicians since 1994.

- For the period 1995 to 2001, growth rates in the ten specialties examined were no worse in Washington State than they were in the nation.
- Losses at the state level in Idaho occurred in Orthopedic Surgery and Neurology between 2000 and 2001.
- From 2000 to 2001, some specialty areas in Spokane County sustained an absolute loss in the number of physicians. Those were: Neurology, General Practice, Family Practice, Cardiovascular Disease, Pulmonary Disease, and Obstetrics-Gynecology. From 1995 to 2001, growth rates in General Practice and Family Practice in all local categories were lower than those at the national level, with Spokane County having the lowest.
- The implementation of the Balanced Budget Act (1997) was a cause for concern among physicians. Changes in reimbursement mechanisms did lead to a redistribution of income among specialties. Volatility and uncertainty associated with the changes resulted in physician concern about the security of the Medicare component of their income. Since the year 2000, however, the volatility has decreased and Medicare payment rates have consistently increased in all years for all comparison areas.

II. Introduction

Over the last decade, there has been concern that Washington State was gaining the reputation as a “lousy place to practice medicine” (Washington State Medical-Education and Research Foundation, 2002). This perception was based primarily on three issues—an alleged exodus of physicians from the state or from patient care in the state, reputed difficulty in recruiting physicians, and Medicare reimbursement rates that have historically been lower than those in other states as well as the national average.³ This concern has been widely publicized in Western Washington but no study has looked specifically at the Eastern part of the state.

The medical provider communities of Spokane and Kootenai Counties have shared this concern relating to Medicare reimbursement payments. Specifically, physicians have complained that reimbursements for their services have not kept pace with increasing costs of providing those services. Like any business, medical practices cannot continue to provide services when the cost of doing so exceeds the revenue received. Additionally, there are local economic, demographic, and historical considerations that help to explain the importance of the problem of inadequate reimbursement rates to the region.

Medical expenditure levels vary by geographic location as a result of differences in proportions of people with disabilities, or of those 65 years old or older, or those elderly who require more extensive care than others. But some variation arises from historical causes that are not related to health status or demography. Providers in the western states, including Washington, have historically had lower overall costs relative to other states. Since Medicare reimbursement rates are based in part on these historical costs, Medicare pays providers in low-cost states at lower levels relative to providers in higher-cost states. If these rates do not cover current costs, some states are at a disadvantage. This, in addition to a highly complex methodology of rate determination and refinement, has led to the complaint by providers in lower-cost states that they are penalized for providing efficient health care.

A look at the importance of the healthcare sector in the regional economy and projected demographic trends for the area demonstrates the significance of this problem for the region. Kootenai and Spokane Counties are projected to increase by a total of at least 100,000 people between 2000 and 2010, and one of the fastest growing age groups is the 65 year-old and older group. According to a report done by David Bunting, “Clearly, health care is the leading industry in Spokane County (Bunting, 2004).” That is, in addition to providing health care, medical practices generate jobs and are important to the economic well being of the community. In Spokane County for the year 2001, the output for the health care sector accounted for almost 12 percent of total county output; direct employment in the sector accounted for almost 12 percent of the county labor force; and, direct health care employment income was 14 percent of total county income. Each of these indicators was more than twice as high as the next leading industry.

Clearly, the issue requires attention. The providers and beneficiaries of Medicare are not the only stakeholders; the community and all its members are also at risk.

Methods and Data

In order to give a complete picture of these issues, this report compares and contrasts several geographic areas: the U.S., Idaho and Washington State, and Spokane and Kootenai Counties. Starting with the national level allows an examination of overall conditions in the U.S. Next, it looks at the state level to give a picture of the region. Finally, this study concentrates on the county level to give an idea of local conditions. All comparisons are made in terms of percentage changes, which are interpreted as growth rates.

The data used in this study come from a variety of sources. The main dataset used for most of the physician numbers is from the Area Resource File. This dataset is compiled by the National Center for Health Workforce Analysis under the Bureau of Health Professions (Area Resource File, February 2003). The database allows for analysis at the county level and can

be aggregated to the state and national level. Other data sources include the Bureau of Economic Analysis (BEA) for Medicare Reimbursements, the Census Bureau for population statistics, the Washington State Department of Health, and interviews with Joe Morris,

CEO, Kootenai Medical Center in Idaho and Arne Michaelson, M.D., president of the KMC medical staff. It is obvious from the above list that no one database exists that gives a complete picture of the issues surrounding Medicare and Medicare funding.

III. Background

“**T**he Balanced Budget Act (BBA) of 1997 was enacted to control the growth of Medicare spending and to provide Medicare beneficiaries with additional choices for care through private health plans. . . providers have asserted that the impact of the BBA has been harsher than was intended by Congress, that the law’s intended effects have imposed undue burdens on them, and that there have been specific problems with the Health Care Financing Administration’s implementation of the law.” (Wilensky, 2000, pgs. 1,2). Some of these issues were addressed in the Balanced Budget Refinement Act (BBRA) of 1999.

The Medicare program was initiated in 1965 as a new dimension of Social Security. “The main goals of the Medicare program were to decrease the financial burdens that the elderly incur in obtaining medical care services and to increase access to care.” (Rossiter, 2001, p. 5). Medicare is made up of four parts. While all four parts are optional, only Part A is of no cost to enrollees. **Part A** of Medicare is a hospital insurance program that pays providers directly and covers inpatient hospital care with a large deductible and further cost sharing over 60 days. Part A also covers skilled nursing facility care following a hospital stay, home health care and hospice care.

Part B of Medicare is a supplemental medical insurance program and has a monthly beneficiary premium (\$66.60 for 2004) and pays providers directly. Part B covers physician and other medical services, outpatient hospital care, ambulatory surgical services, laboratory services, outpatient mental health services and some preventive services with a deductible and coinsurance of 20 percent for most services. This

study will focus on Part B of Medicare—physician services. **Part C** of Medicare, known as *Medicare + Choice*, pays approved managed care plans to cover the services under Part A and B, usually combined with other supplemental services.

Part D is part of the Medicare Modernization Act of 2003 (MMA) and includes prescription drug benefits that will start in 2006. This part is voluntary and will be paid by the beneficiary. Drug discount cards have been available since June 2004. Part D also includes some preventive care and assistance to hospitals treating the highest numbers of Medicare beneficiaries as well a higher reimbursement rate schedule for rural physicians.

Prior to 1992, the physician reimbursement method was a charge-based system. That is, medical services were reimbursed according to what physicians charged for each service. This retrospective methodology has been changed to one that uses a *prospective* approach in an attempt to control increasing expenditures. Physicians are currently paid under a fee schedule.

The current system uses the **Resource Based Relative Value Scale (RBRVS)**. This is a coded listing of physician or other professional services using units that indicate the relative value of various services physicians and others perform. It takes into account the time, skill, and overhead cost required for each service as well as malpractice expenses. Appropriate conversion factors are used to translate the abstract units in the scale to dollar fees for each service.

The relative value units for each procedure do not vary by specialty. But they are adjusted by a **geographic practice cost index, or GPCI**. There is

a separate GPCI for each of the three components of the relative value scale:

- Physician work, based on earnings of professionals in the area, as reported in the decennial census and updated every three years.
- Professional liability insurance, based on data collected from the largest malpractice insurers in each state.
- Practice expense, based on office space, equipment, and supply costs and non-physician staff wages.

The value scale is not the payment amount. The relative value is multiplied by the *conversion factor*, which gives the payment amount. There is one conversion factor for all procedures. It is currently updated by the **Medicare Economic Index (MEI)**, and before the 2003 MMA, by the Sustainable Growth Rate (SGR), an adjustment based on how physicians' expenses compare to a benchmark such as the growth rate of the national economy (GDP). Or, Congress sometimes has mandated what the update will be, overriding the MEI. Congress created the MEI in 1972 to measure the changes in costs of a physician's time and operating expenses. The MEI is a fixed, weighted sum of annual price changes for various inputs needed to produce a physician's services, with an offset for productivity increases.

"In general, Medicare updates payments for physician services by increasing or decreasing the conversion factor" (Med PAC, March 2004). It is one of the most visible measures of changes in physician payments. Basically, a change in the conversion factor is a change in the unit payment (for services) for the year. This is the factor that translates relative values into dollar amounts for each service. Annual adjustments are intended "...to hold Medicare spending for physician services to limits set by a formula specified by legislation" (Trude and Ginsburg, 2002).

There are recognized methodological flaws in "... trying to control spending with an update formula" of this type (Med PAC, May 2004). One problem has been the resulting volatility of the updates. This problem adds to physician concern that payment rates have not adequately kept pace with actual costs and have actually resulted in more efficient physicians receiving lower payments, as explained in the introduction. The update formula not only locks

in historically low reimbursement rates, but also has not succeeded in relating rates to costs. Percentage changes for the last five years are shown in Table 1 below. The large percentage reduction in 2002 is an example of volatility of updates. Had Congress not intervened via the Medicare Modernization Act of 2003, further decreases would have resulted: 4.5 percent was scheduled for 2004 and 1.7 percent for 2005. Among other provisions relating to payment for physician services, the MMA mandated increases of at least 1.5 percent in 2004 and 2005.

Table 1: Changes in Conversion Factor for Medicare Reimbursements.

2000	2001	2002	2003	2004
5.4%	4.5%	5.4%	1.6%	1.5%

Source: Medicare Payment Advisory Commission

Historically, the methodology used to determine physician payment for Medicare patients has been controversial and not without problems. Many of the problems are related to the transition from the historical charge-based approach to a resource-based approach in the practice expense component of payments to physicians. The importance of reimbursement rates to physicians is clear, since changes in both the methods of determination and the amounts directly affect physician incomes. Physician practice expense "...comprises on average about 43% of physician fees" (Marciniak and Om, 2001). According to Trude and Ginsburg (2003), "As a result of the BBA's changes, average payments for all physicians increased about 7 percent overall from 1998 to 2002."

But not all specialties experienced increases. For example, payments fell 14 percent for cardiac surgeons and 10 percent for thoracic surgeons. Marciniak and Om (2001) looked specifically at the impact of changes in Medicare payments for physician office visits. Using national average rates, their conclusion was that specialties that received a majority of their income from office visits sustained substantial overall decreases in Medicare payments. For example, they state that in the U.S. all family physicians lost about \$65 million per year and internists about \$74 million per year in Medicare income.

A change in income from Medicare patients has the potential to change physicians' willingness to see new Medicare patients, especially if rates paid by private payers remain relatively higher. This in turn leads to access to care problems for Medicare beneficiaries.

Access problems are complex and cannot be explained by one measure. What this study tries to capture is change in physician behavior and change in Medicare beneficiary access by geographic location.

IV. Changes in Medicare Payments to Healthcare Providers

This section measures the growth rates of:

- The aggregate amount of Medicare payments made to healthcare providers, which are the total payments the Federal Government makes to healthcare providers on behalf of participants in the Medicare program.
- The per capita Medicare payments to the 65+ population, or the aggregate amount of Medicare payments divided by the number of people who are 65 years old or older.
- The average payment for Part B of Medicare, which is the average payment a physician would receive per Medicare patient.

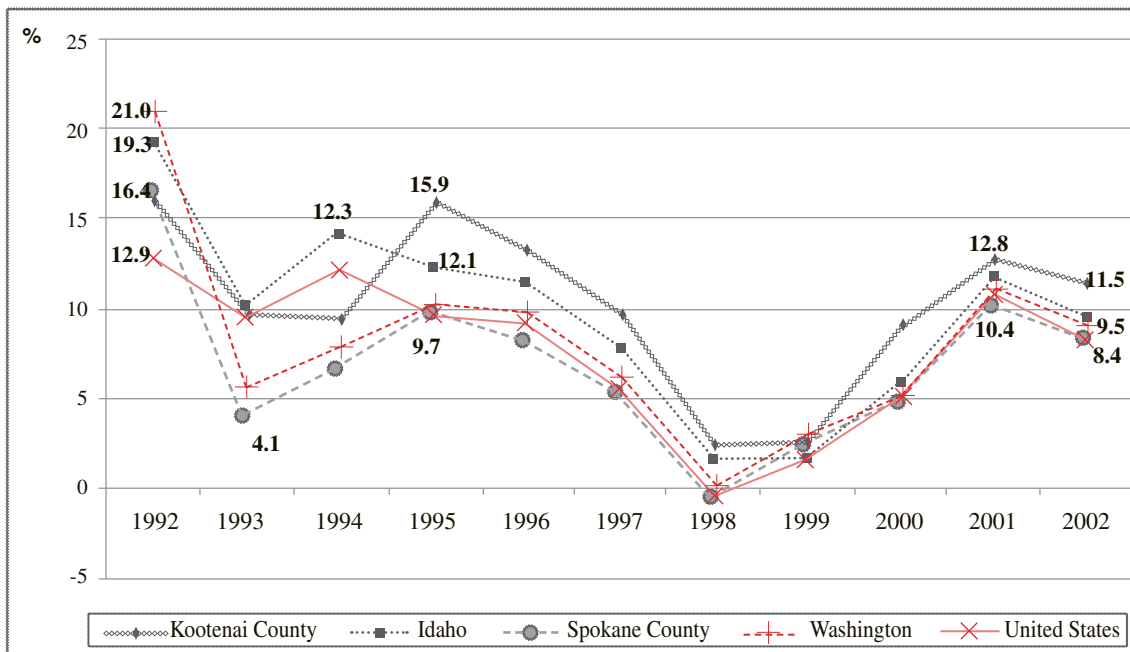
It also compares these rates over time and by geographic location, specifically for Spokane and Kootenai Counties, their respective states and the United States as a whole.

Trends in Total Medicare Payments to Healthcare Providers

Figure 1 shows the annual growth rates for aggregate Medicare payments to healthcare providers over an eleven-year period from 1992 to 2002 for each of the five comparison areas. This eleven-year period will allow us to look at changes prior to the 1997 BBA and compare them to the years following the BBA. This shows the impact of the 1997 BBA on all health care providers. In general, the growth rates prior to 1997 were inconsistent, fluctuating from year to year with no clear upward trend. The degree of fluctuation varied by geographic location, with some areas having less fluctuation and higher growth than others.

The post 1997 period shows a completely different trend. It is clearly upward after 1999 to 2001. This change provides evidence of the volatility that resulted from the update formula then in use. Changes in Medicare conversion factor calculations since then appear to have smoothed out the fluctuations.

Figure 1: Annual Growth Rates of Total Medicare Payments to Healthcare Providers, 1992 - 2002



Source: Bureau of Economic Analysis, Table CA35.

Prior to the 1997 BBA, Kootenai County's growth rate started at a high point in 1992 at 16.3%, followed with a low of 9.5% in 1994 to peak again in 1995 with 15.9%. That is a change of \$6.8 million, from just over \$42 million in 1994 to \$49.2 million total Medicare payments in 1995. The 1994 low was only a change of \$3.7 million from just under \$39 million in 1993. This trend was not repeated at the state level. The state of Idaho experienced a peak growth rate in 1992 of 19.3% and a low in 1997 of 7.8%. It seems, however, that Kootenai County has had higher growth rates than Idaho in every year except 1993 and 1994.

Pre-BBA trends in Spokane County and Washington State were very similar to those of Kootenai County and Idaho, differing only in the magnitude of the growth rates. With the exception of 1992, they are generally lower in both Spokane and Washington State. Spokane County saw a peak growth rate of 16.4% in 1992, which preceded a low of 4.1% in 1993. Spokane County payments increased \$27.7 million, from nearly \$169 million in 1991 to \$196.5 million in 1992. In contrast, the next year saw an increase of only \$8.1 million. Washington State's peak came in 1992 as well, with a 21% increase over 1991 payments, which is the highest of all the areas. The low occurred in 1997 at 6.1% growth.

This trend is not unique to the Inland Northwest area. The United States showed similar growth rates and trends to the two states and counties. The only difference is that the national trend displayed less variance in the fluctuations prior to 1997. The peak growth rate of total Medicare payments in the United States occurred in 1992 at 12.9%, or a change of \$15.1 billion from \$117.5 billion in 1991 to \$132.6 billion in total Medicare payments for 1992. The lowest growth rate corresponded with the 1997 BBA, with a growth rate of 5.6%.

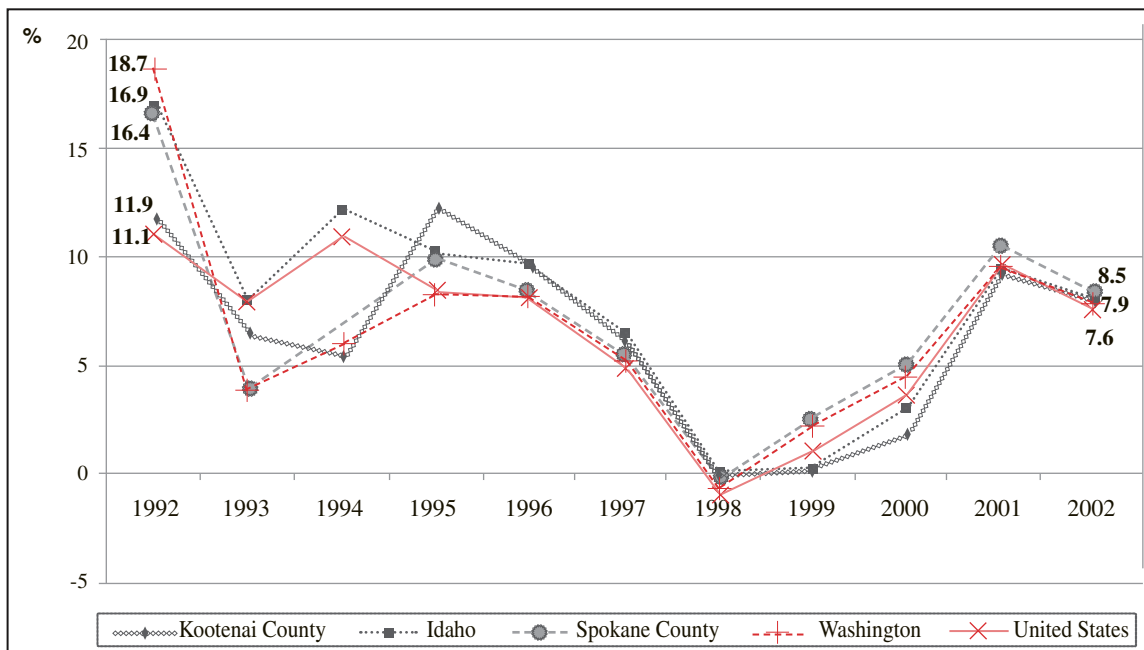
The post-BBA, that is, the post-1997, period paints a different picture for all areas. For example, there are no fluctuations in the growth rates. Instead, total Medicare payments showed a steady upward trend in the growth rates, especially after 1998. Figure 1 shows that the growth rates are close in magnitude for each area. For instance, in 1999, there was only a gap of 1.1% between the highest rate of 2.7% in Spokane County and lowest rate of 1.6% for the United States. Since 1997, Kootenai County has remained at the top in growth rates in every year. After 2001, however, there has been a slight decline in the growth rates for all the areas.

Per Capita Medicare Payments

One explanation for the higher growth rates in Kootenai County and Idaho State could be that the population of those 65 years and older had increased at faster rates than Spokane County and Washington State. That is, areas with larger populations eligible for Medicare will more likely receive greater total Medicare payments. To see if this is the case, the study compared per capita Medicare payments, where the total Medicare payments made to the area are divided by the population that is 65 years and older. Figure 2 shows the growth rates for the per capita Medicare payments over the same eleven-year period, 1992 - 2002.

Generally, the trends, pre- and post-1997, observable in Figure 2 are the same as those of total Medicare payments: wide fluctuations before 1997 and a smooth upward trend after 1997. In fact, there is very little difference between growth rates of total and per capita Medicare payments in Kootenai and Spokane Counties, Idaho and Washington State, and the U.S. The only change came after 1997, where both Kootenai County and Idaho displayed negative per capita growth rates, as did Spokane County and Washington State. However, Kootenai County and Idaho grew at slower rates than Spokane and Washington, with all areas converging at the end of the period at an annual, per capita growth rate of 7.6% to 8.5%. It seems that 2002 is the start of a downward trend in Medicare Payments, both total and per capita.

Figure 2: Annual Growth Rates of Per Capita Medicare Payments to Healthcare Providers, 1992 - 2002



Source: Bureau of Economic Analysis and U.S. Census.

Average Medicare Payment Rates

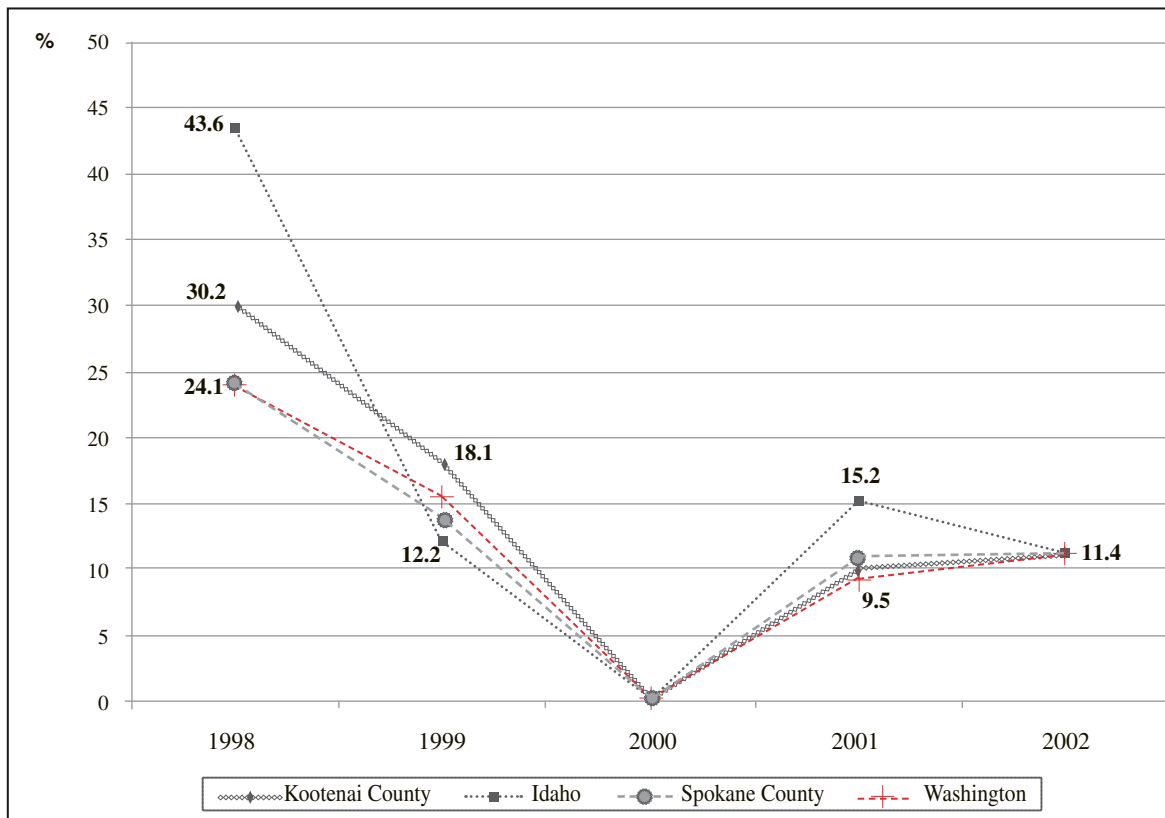
One possible conclusion from the comparison in Figures 1 and 2 is that growth rates in Idaho and Kootenai County are not just due to changes in the eligible population. It could also be that Medicare recipients in Kootenai and Idaho consume more health care than those in Spokane and Washington State. If so, this would contribute to higher total Medicare payments. To examine this possibility, we compared *average payment rates* of Part B of Medicare after 1997. We focus on Part B because this is most relevant to physicians, the focus of our study.

The average payment rate is the dollar amount that physicians receive per Medicare patient. The average payment rate is a base rate for all patients. To arrive at

the actual amount received for a specific patient, one multiplies the average payment rate by a conversion factor. Thus, some Medicare patients would have higher payment rates than others, depending on the extent of care needed. Average payment rates are different from the per capita Medicare payments discussed above in that they measure the amount on a per physician, per patient, per illness basis. The per capita payments are the total divided by the population of those eligible for Medicare.

Figure 3 shows the annual growth rates of average payment rates for Part B of Medicare from 1998 to 2002. The data come from a medical database, the Area Resource File (ARF), compiled by the National Center for Health Workforce Analysis and made available by the Bureau of Health Professions.

Figure 3: Annual Growth Rates of Average Payment Rates for Part B Medicare, 1998 - 2002



Source: Area Resource File, February 2003, Bureau of Health Professions.

Notice that all areas exhibit a steep downward trend until 2000 when Spokane, Kootenai, Idaho, and Washington State all had zero growth in payment rates. After 2000, average payment growth rates rise, with Idaho showing greater growth than the other three. By 2002, all four areas display the same growth rates at 11.4%. While it seems that the higher growth rates in Idaho would give physicians there an advantage over those in the other three geographical units, it only allowed Idaho to catch up in dollar terms. In 1997, Spokane County had an average payment of

\$143.38, which was \$33.18 higher than Idaho's average payment of \$110.20. By 2002, the difference decreased to \$22.78, with Spokane still on top with \$250.69 and Idaho at \$227.91.

What is evident is that the average payment rate to physicians for Medicare patients has not decreased in the last five years. On the contrary, payment rates have increased more than the rate of inflation in every year except 2000, where they remained at the 1999 level.

V. Access to Health Care for Medicare Enrollees

Physicians are an important link between Medicare beneficiaries and health care. If physicians perceive that Medicare reimbursements are inadequate, they may limit the number of Medicare patients seen in their practice, thus limiting access to health services for the elderly. In this section, we examine access in general in the U.S. and then specifically for Spokane and Kootenai Counties.

The U. S.

Analysis of access to care by Medicare enrollees on the national level is based on several different measures. These include whether patients delayed or did not get needed care, whether patients could get a timely appointment with a physician, and whether physicians are taking new appointments.⁴ According to data from the Center for Studying Health System Change's *Community Tracking Study Household and Physician Surveys*, there is evidence that access problems are on the rise at the national level. Between 1997 and 2001, the percentage of Medicare clients who reported not receiving needed care rose from 9.1% to 11.0%. During the same time, a larger percentage of Medicare clients also reported having to wait longer for appointments—13.9% to 23.6% (Trude and Ginsburg, 2002). Ninety percent of beneficiaries reported they “always” or “usually” get a timely appointment for routine care, compared to 93% in 2000 and 92% in 2001 (MEDPAC, May 2004). From

the physician perspective, 93 percent of physicians who commonly saw Medicare patients were accepting new Medicare patients in 2002 (National Ambulatory Medical Care Survey). Moreover, between 1997 and 2001 the percentage of physicians accepting all new Medicare patients fell from 74.6% to 71.1% (Trude and Ginsburg, 2002).

Access to Primary Care in Spokane County by Medicare Patients

According to self-reported survey⁵ data, the following snapshot of conditions concerning Medicare patients' access to primary care existed in summer 2002. Twenty-three percent of primary care physicians were accepting new Medicare patients, compared to 75 percent accepting new privately insured patients. Private practices provided 89 percent of Medicare Fee-for-service (FFS) care, the traditional arrangement in which a patient sees a provider and the provider is then paid by the patient or the insurer, public or private. Ninety-eight percent of Medicare Managed Care, the arrangement in which services are managed in some way such as a health maintenance organization (HMO), is provided by private practices.

The population to provider ratio for Medicare patients was 946 to 1. Based on an ideal capacity ratio of 1,500 to 1, this ratio reflects near universal access for those over 65. However, since private practices provide a

majority of the care for those with Medicare, access to physicians may be a long-term concern if only 23% of existing physicians accept new Medicare patients. One limitation of the report cited is that it does not include specialty physicians in the survey. For example, while 23% acceptance is starkly lower than the national average of 71%, the 23% figure is based on primary care physicians only. Another limitation is that historical data on local access for Medicare patients are not available for comparison.

Another source of access problems for Medicare enrollees lies in Medicare Managed Care plans showing very low penetration rates in Spokane County as well as in all of Eastern Washington. In 1999 and 2000, a total of six HMOs withdrew from the state market, affecting 11,673 Medicare enrollees, or 18.6 percent of those eligible for Medicare.

In terms of population growth, the number of primary care physicians in the county increased from 248 in 1998 to 249 in 2002 (less than one half of one percent), while the population increased by about 3 percent over the same time. Compared to two other surveyed counties in Washington State, Yakima and Thurston, Spokane County providers were least likely to accept new Medicare patients.

Access to Care in Kootenai County by Medicare Patients

Information on Medicare enrollees' access to physicians in Kootenai County is based on personal interviews with Joe Morris, CEO, Kootenai Medical Center and Arne Michaelson, M.D., President, KMC Medical Staff. It is consequently qualitative in nature. Access to primary care services for Medicare beneficiaries was generally poor and access to specialty services was adequate (Morris, August 2003). In August 2003, no family physician/primary care provider was accepting new Medicare patients.

In discussing possible reasons for not accepting new Medicare patients, Dr. Arne Michaelson (2003) suggested that it has been estimated that for a physician's practice to remain financially viable, only 28-30 percent of the patients can be Medicare insured. He also stated that primary care providers incur an \$11-\$17 out-of-pocket expense for each Medicare patient seen in their office.

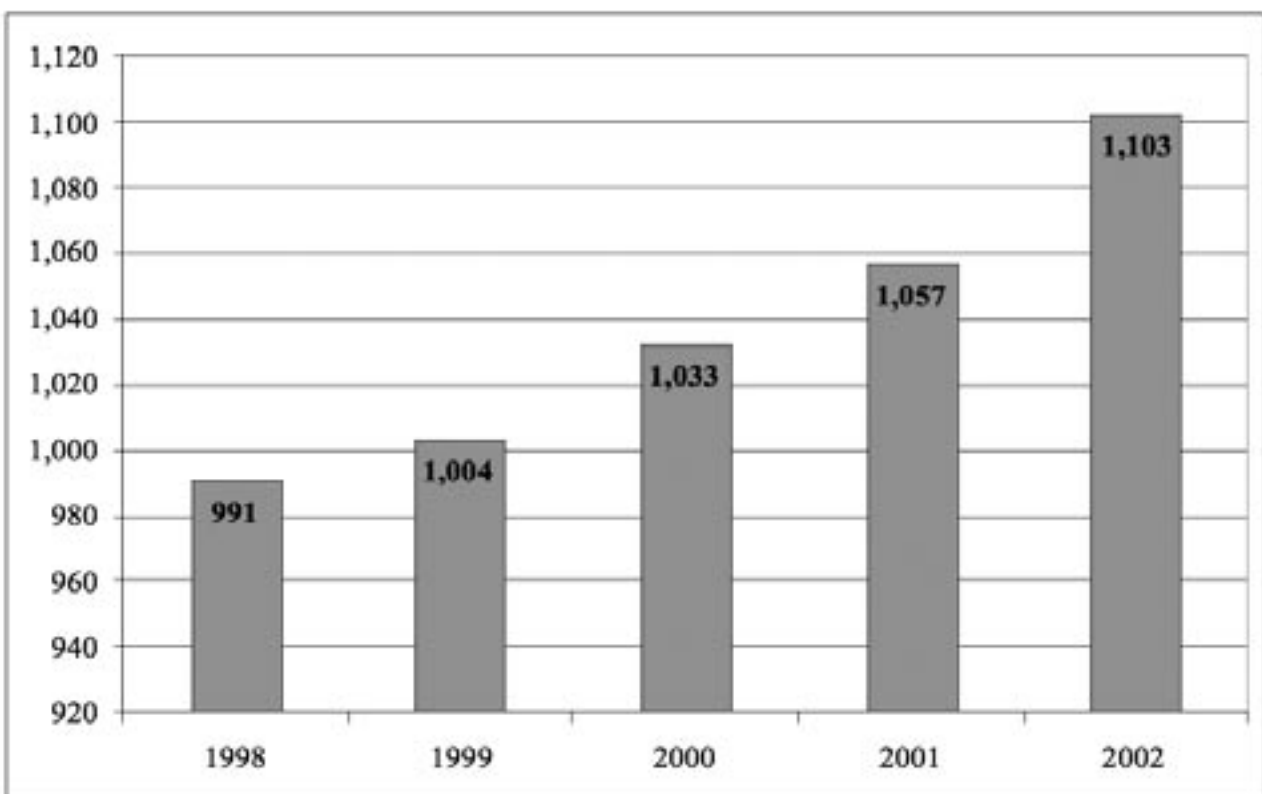
VI. Composition of the Physician Community in Spokane and Kootenai Counties

This section first looks at the total number of physicians at the county level and then examines rates of change in ten physician specialty areas at the county, state and national levels. The goal is to identify differences in growth patterns in the number of physicians in various specialty areas. That is, are some specialties faring better or worse than others? For example, according to a Washington State Medical Society report (WSMS 2002), Spokane County reported difficulties in recruiting and

keeping physicians in three particular specialties— anesthesiology, pediatrics, and family practice.

According to Figure 4, the total number of physicians, measured by the total number of licensees in Spokane County, experienced an 11.3 % increase over the 1998 to 2002 period, increasing from 991 to 1,103 during the period. Clearly, there was not a decrease in the number of licensees in any year. In contrast, the population increased from 413,455 to 425,600, an increase of 3% (Schueler et al., 2003).

Figure 4: Total Physician Licensees for Spokane County by Year, 1998 - 2002

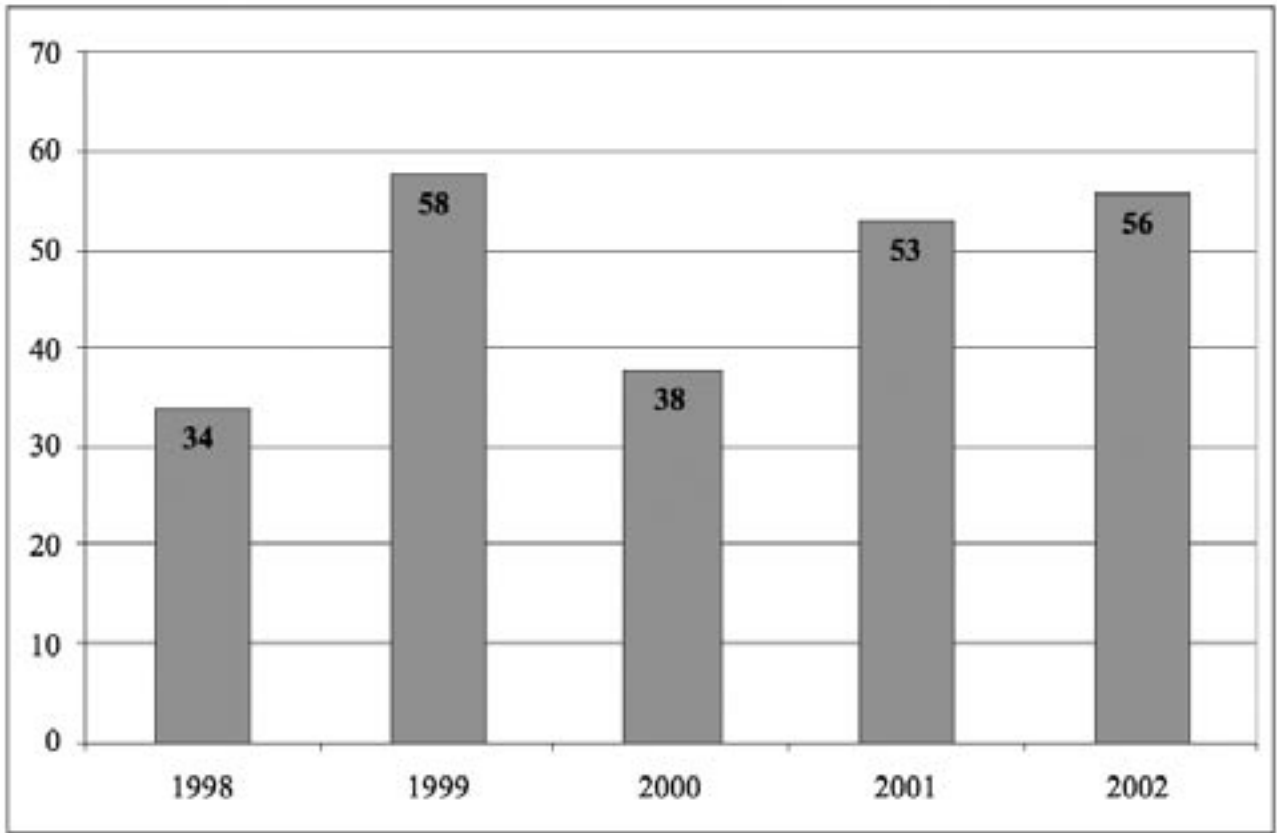


Source: Washington State Department of Health, Health Professions Quality Assurance

The number of new licensees by year varied over the same period (See Figure 5). From 1998 to 1999, there was a substantial increase (70.6 %) in new licensees. However, this was followed by a 34.5% decrease from

1999 to 2000. This was followed by a 39.5% increase from 2000 to 2001 and a 5.7% increase from 2001 to 2002.⁶

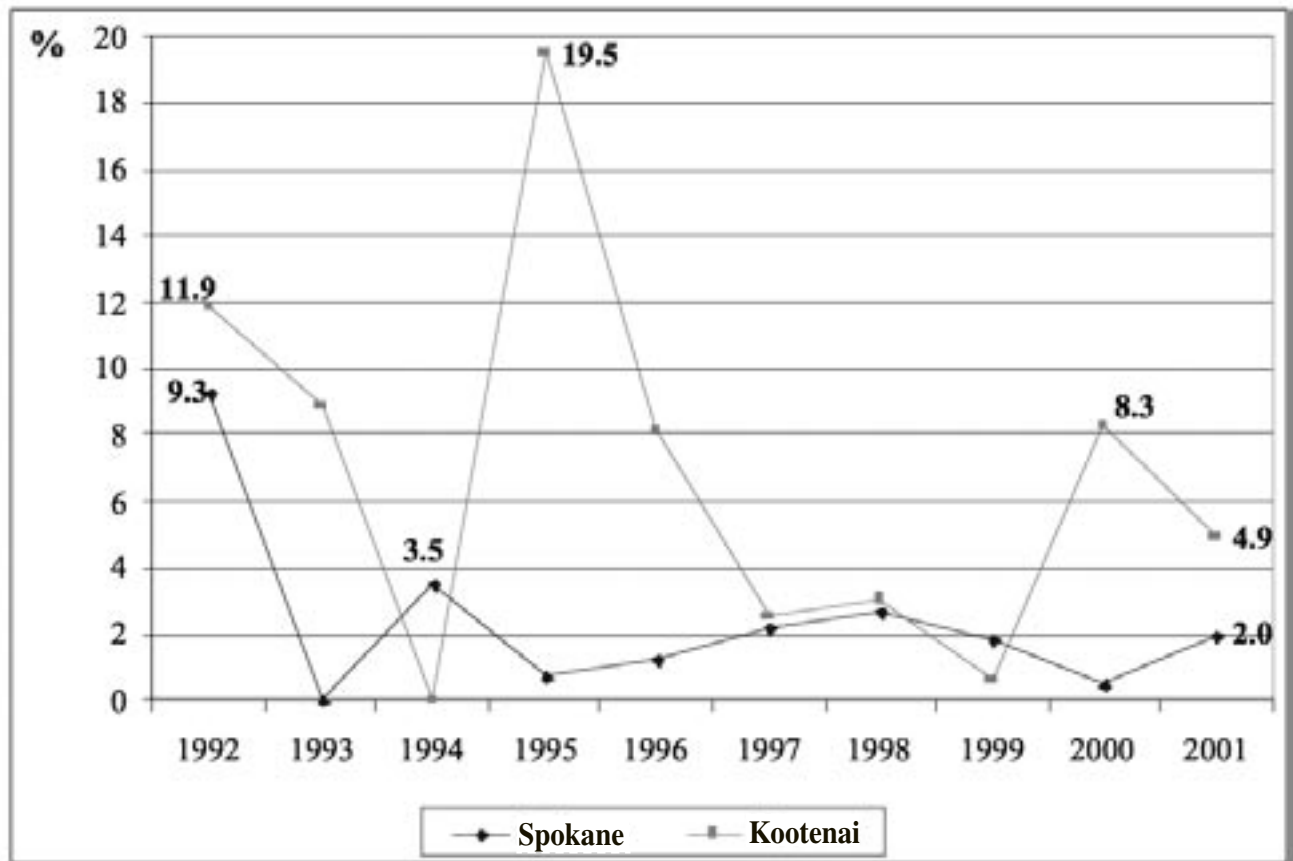
Figure 5: New Physician Licensees for Spokane County by Year, 1998 - 2002



Source: Washington State Department of Health, Health Professions Quality Assurance

What the above numbers do not show is whether the physicians are actively practicing or not. Figure 6 compares the annual growth rates in the number of active physicians in Kootenai and Spokane Counties from 1992 to 2001. While Kootenai County has experienced higher growth in more years than Spokane County⁷, it has also had much greater fluctuations in those rates. Spokane County, on the other hand, has had lower but relatively consistent growth since 1993.

Figure 6: Annual Growth Rates of Active Physicians by Year for Spokane and Kootenai Counties, 1992 - 2002.



Source: Area Resource File, February 2003, Bureau of Health Professions.

While the number of physicians has increased overall in Spokane County, there may be differences by specialty. This research took up changes in the number of physicians in specialties that are relevant to the population 65 years and older. The ten specialties examined were: General Practice, Family Practice, Cardiovascular Disease, General Internal Medicine, Pulmonary Disease, Obstetrics-Gynecology, Orthopedic Surgery, Anesthesiology, Neurology, and Radiology. (See the Appendix for definitions of specialties.)

In Table 2, growth rates of these specialties at the county, state, and national levels are compared. Since only data for 1995, 2000 and 2001 were available, the growth rates are annualized over 1995 to 2001 to give an average annual growth rate for the period. The rate of change for 2000 to 2001 is calculated and shown separately for comparative purposes. The year 2000 is

of particular interest, as this was a time of increasing concern by physicians in the state of Washington as well as in Spokane County.

Table 2: Total Growth Rates of Physicians by Specialty, 1995 - 2001 (in Percentages)

Specialty	Kootenai County		Idaho State		Spokane County		Washington State		United States	
	1995-2001	2000-2001	1995-2001	2000-2001	1995-2001	2000-2001	1995-2001	2000-2001	1995-2001	2000-2001
General Practice	1.2	2.3	3.0	3.8	1.5	-3.2	3.0	3.2	3.1	2.4
Family Practice	1.7	2.5	3.5	4.8	1.8	-1.1	3.9	0.1	4.1	4.3
Cardiovascular Disease	0.0	50.0	9.0	6.8	1.9	-2.6	3.1	6.7	2.5	3.3
General Internal Medicine	13.8*	18.2	6.0	9.0	2.0**	4.6	4.7	7.4	3.2	3.9
Pulmonary Disease	12.2*	0.0	9.2	0.0	2.0**	-10.0	5.3	4.9	3.7	5.8
Obstetrics-Gynecology	0.0	0.0	4.2	0.0	0.8	-2.3	2.9	1.8	1.9	2.5
Orthopedic Surgery	4.9*	14.3	3.5	-2.9	3.8	25.0	1.4	6.0	0.8	2.4
Anesthesiology	4.9	0.0	4.9	4.8	1.2**	7.1	1.8	4.1	2.0	2.9
Neurology	12.2*	0.0	1.9	-3.4	-3.6**	-7.8	3.1	8.4	2.2	4.5
Radiology	12.2*	0.0	4.1	7.7	3.4	4.8	2.5	7.5	1.6	1.1

Source: Area Resource File, February 2003, Bureau of Health Professions

* = Highest growth rate of a specialty **=Lowest growth rate of a specialty. Negative percentages in bold represent absolute loss in the number of physicians.

Over the 1995 - 2001 period, growth rates in all categories but one (neurology in Spokane County) were positive. That is, the physician workforce increased at all levels in all listed specialties with the one exception. During this time period, Kootenai had the highest growth rate in five out of the ten specialties, while Spokane County had the lowest growth rate in four of the specialties. All local categories had larger growth rates in the specialties of orthopedic surgery and radiology than the nation as a whole, while growth rates in family practice in all local categories were lower than those at the national level. This finding is corroborated by the *Occupational Outlook 2002-2012*, a report put out by the Washington State Employment Security Department's Labor Market and Economic Analysis Branch in 2004. According to this report, Family and

General Practitioners appear on a list of "occupations in demand" for Spokane County where the average annual total openings for this specialty for 2002-2012 is projected to be twenty-seven.

Between 2000 and 2001, negative growth rates (absolute loss in number of physicians) occurred in six specialties in Spokane County and in two specialties in Idaho at the state level. All other growth rates were positive between those two years. So, even though the total number of physicians in Spokane County grew, some specialties lost physicians. The losses occurred primarily from 2000 to 2001, except for neurology, which experienced losses over the entire time period. Other specialty areas in Spokane County that sustained losses over 2000 and 2001 were: General Practice, Family Practice, Cardiovascular Disease, Pulmonary Disease, and Obstetrics-Gynecology.

Losses in Idaho at the state level occurred in Orthopedic Surgery and Neurology.

Table 2 makes it clear that Spokane County growth rates were generally lower than those of Washington State and the U.S. We hypothesize that perceived inadequate Medicare reimbursement rates are only part of the problem. Another important issue is that of medical malpractice insurance rates relative to other areas. Another issue may be local market conditions for physicians, i.e., supply and demand in different specialties. And, finally, there is the issue of private payer reimbursement rates relative to Medicare rates and how they are determined. According to interviews with physicians in Family Practice, this is an important issue since private payers base their contract prices on Medicare rates.

Because numbers for Kootenai County were in many cases quite small, the rates of change cannot be used as a meaningful measure. For example, some increases doubled the number of physicians by increasing from one to two or from two to four. A zero indicates that there was no change. Nonetheless, rates of change remained positive, though some may be overstated.

An examination of Washington State relative to the U.S. reveals that for the ten specialties examined, the growth rate in Washington was no worse than the nation in general. From 1995 to 2001, the rates for General Practice, Family Practice, and Anesthesiology were virtually the same. For all other specialties examined, the growth rate in Washington exceeded that of the nation as a whole. From 2000 to 2001, three specialty areas saw lower rates relative to the nation—Family Practice, Pulmonary Disease, and Obstetrics-Gynecology, with Family Practice experiencing the lowest growth rate. All other specialties in Washington State exceeded the U.S. growth rates, several by almost double.

Seven specialty areas in Idaho experienced larger growth rates relative to the nation as a whole from 1995 to 2001. These were Cardiovascular Disease, General Internal Medicine, Pulmonary Disease, Obstetrics-Gynecology, Orthopedic Surgery, Anesthesiology and Radiology. The remaining three specialties were similar in growth to that of the nation. For all of these specialties except internal medicine, Idaho experienced higher growth rates than Washington State as well. However, from 2000 to

2001, Idaho experienced a fall in rates of growth in Pulmonary Disease and Obstetrics-Gynecology and an absolute loss of physicians in Orthopedic Surgery and Neurology. During the same time, Washington experienced relatively higher growth rates in Orthopedic Surgery and Neurology and relative lower rates in Family Practice.

Physician Flight

This study has shown that the loss to the community of what was defined above as physician “flight” holds the potential to pose serious consequences that reach beyond the medical community. The issue was publicized widely by physicians in the state—on both the west and the east sides. A report by the Washington State Medical-Education and Research foundation in 2002 (WSMS, 2002) described the problem vividly: an increase in number of bankruptcy of clinics and physicians’ practices; negative operating margins of practices; a net loss in the number of physicians in some communities; a growing number of medical practices unable to take Medicare patients due to the inability to continue to subsidize care provided to these patients; a growing exodus of physicians from practice in the state due to early retirement, leaving the state, leaving patient care; and increased difficulty in recruiting physicians to the area.

A stated cause for “flight” was the relatively low reimbursement rates received for provision of that care. This report does not offer clear evidence that physician flight correlates directly with Medicare reimbursement rates. But it is clear that geographic disparities persist. The Medicare Payment Advisory Committee (MEDPAC) is aware of the disparities and has recommended changes to address the problem. This is the committee that advises Congress on issues affecting the Medicare program. Since the Balanced Budget Act of 1997, payment to private providers has been a major policy issue of concern for the committee.

VII. Conclusions

We reach the following conclusions from our study:

- While growth rates of *total* Medicare payments to Spokane County, Kootenai County, Washington, Idaho, and the U.S. varied greatly prior to 1998, after 1999 there has been a steady upward trend and the growth rates are close in magnitude for all areas. The *average* payment rate to physicians for Medicare patients in the two counties and states has not decreased in the last five years. Payment rates have increased more than the rate of inflation in every year except 2000, where they remained at the 1999 level. Except for the year 2000, it seems unlikely that any physician flight in Spokane County can be attributed to Medicare reimbursement rates alone.
- Access for Medicare beneficiaries at all levels reveals some concerns. In Spokane County, a potential long-term problem looms because only 23 percent of primary care physicians were accepting new Medicare patients in 2002 compared to 75 percent accepting new private pay patients. Eighty-nine percent of Medicare fee-for-service and 98 percent of Medicare Managed Care is provided by private practice. There is evidence that access problems are on the rise at the national level also. Between 1997 and 2001, the percentage of all U.S. physicians accepting all new Medicare patients fell from 74.6 percent to 71.1 percent. A comparable figure at the county level was unavailable.⁸ Medicare managed care plans have very low penetration rates in Spokane County and all of Eastern Washington.
- In Spokane County, the absolute number of physicians increased by 11.3 percent from 1998 to 2002. There was a decrease of 34.5 percent in the number of newly-licensed physicians from 1999 to 2000 in Spokane County. All other years showed increases. From 2000 to 2001, Spokane County experienced an absolute loss of physicians in six specialties. The only absolute loss for the period 1995 to 2001 in Spokane County occurred in Neurology. In general, growth rates of the number of physicians in Washington State for the ten specialty areas examined were no worse than the nation as a whole. However, Spokane County's

growth rates were lower than Washington State's.

There is no doubt that this period was a troubling time for physicians in the area. It is also clear that Spokane County experienced relatively lower growth rates in the number of physicians than Kootenai County, Idaho, Washington, and the nation as a whole. Further study is required to determine more precisely causes and remedies for this situation. Changes in reimbursement mechanisms did lead to a redistribution of income among specialties. There was volatility and uncertainty associated with the changes. It appears that the Medicare Payment Advisory Commission has addressed some of the issues of concern.

VIII. Limitations of Data and Further Research

This study encountered several data problems. At the Spokane County level, the authors found only anecdotal information, no reliable local data about physician flight. Kootenai County seemed to have no agencies that monitored physician licensing. This, coupled with the small absolute numbers, made it virtually impossible to get any information at the local level other than word-of-mouth. Furthermore, in terms of access to care by Medicare enrollees, there are no historical data at the state or county level for comparison.

The limitations experienced in working on this project provide several avenues for further work. Because of the relative importance of the healthcare sector regionally, the authors suggest developing a database that tracks physicians in the area. Also, a database should track year-to-year changes in physicians' rate of accepting new patients, both public and private. This data work could be done with the respective medical societies and government agencies of each county and state.

Physician migration patterns and their willingness to see Medicare patients are affected by factors other than or in addition to Medicare reimbursement adequacy. Further steps in evaluating physician behavior relative to reimbursement issues should include examination of private insurance reimbursements and methods of determining rates. For example, how and to what extent are private payer rates related to Medicare rates? Input costs relative to reimbursements and malpractice issues at the various levels should also be examined. Other important factors include local physician and insurance market conditions, size and mix of Medicare patient caseloads, variation of payments by services and specialties, and administrative burden associated with Medicare patients.

APPENDIX

Abbreviations

ARF	Area Resource File
BBA	Balanced Budget Act
BBRA	Balanced Budget Refinement Act
BEA	Bureau of Economic Analysis
CMS	Centers for Medicare and Medicaid Services
FFS	Fee-For-Service
GDP	Gross Domestic Product
GPCI	Geographic Practice Cost Index
HMO	Health Maintenance Organization
MEDPAC	Medicare Payment Advisory Committee
MEI	Medicare Economic Index
MMA	Medicare Modernization Act
RBRVS	Resource Based Relative Value Scale
SGR	Sustainable Growth Rate

Definitions

Anesthesiology - “The anesthesiologist is a physician specialist who, following medical school graduation and at least four years of postgraduate training, has the principal task of providing pain relief and maintenance or restoration, of a stable condition during and immediately following an operation, an obstetric, or diagnostic procedure. The anesthesiologist assesses the risk of the patient undergoing surgery and optimizes the patient’s condition prior to, during, and after surgery” (American Board of Medical Specialties (ABMS), 1995).

Cardiovascular Disease - “Cardiologists subspecialize in diseases of the heart, lungs, and blood vessels and manage complex cardiac conditions such as heart attacks and life-threatening, abnormal heartbeat rhythms. They often perform complicated diagnostic procedures such as cardiac catheterization and consult with surgeons on heart surgery” (ABMS, 1995).

Family Practice - “Family physicians are trained to prevent, diagnose, and treat a wide variety of ailments in patients of all ages. They have received a broad range of training that includes surgery, psychiatry, internal

medicine, obstetrics and gynecology, pediatrics, and geriatrics. They place special emphasis on providing care to families on a continuing basis” (ABMS, 1995). Requires a three-year residency program beyond that of General Practice.

General Practice - A general practitioner is a family practice doctor (Signet, 1987). This specialty has largely been replaced by Family Practice (Weschler, 1976).

Internal Medicine - “The general internist is a personal physician who provides long term comprehensive care in the office and the hospital, managing both common illnesses and complex problems for adolescents, adults, and the elderly” (ABMS, 1995).

Neurology - “The specialty of neurology is concerned with the diagnosis and treatment of all categories of disease or impaired function of the brain, spinal cord, peripheral nerves, muscles, and autonomic nervous system, as well as the blood vessels that relate to these structures” (ABMS, 1995)

Obstetrics and Gynecology - “Obstetrician\ gynecologists are physicians who, by virtue of satisfactory completion of a defined course of graduate medical education and appropriate certification, possess special knowledge, skills and professional capability in the medical and surgical care of the female reproductive system and associated disorders, such that it distinguishes them from other physicians and enables them to serve as consultants to other physicians, and primary care physicians for women” (ABMS, 1995).

Orthopedic Surgery - “Orthopedic surgery is the medical specialty that includes the preservation, investigation and restoration of the form and function of the extremities, spine, and associated structures by medical, surgical and physical means. Orthopedic surgeons are involved with the care of patients whose musculoskeletal problems are present at birth or develop at any time during their lifetime” (ABMS, 1995).

Pulmonary Disease - “Pulmonary disease is the subspecialty concerned with diseases of the lungs and airways. The pulmonologist diagnoses and treats

cancer, pneumonia, pleurisy, asthma, occupational diseases, bronchitis, sleep disorders, emphysema and other complex disorders of the lungs. Pulmonologist test lung functions, endoscope the bronchial airways and prescribe and monitor mechanical assistance to ventilation. Many pulmonary disease experts are also expert in critical care” (ABMS, 1995).

Radiology - “A branch of medicine that utilizes radiologic methodologies in diagnosis and treatment of disease. The physician specialist practicing in the field of radiology most often specializes in radiology, diagnostic radiology, radiation oncology or radiological physics. Physician may subspecialize in neuroradiology, nuclear radiology, pediatric radiology, and vascular and interventional radiology” (ABMS, 1995).

Endnotes

¹ This figure does not distinguish between primary care and specialty physician.

² This rate does not include physicians who accept some but not all Medicare patients.

³ Medical malpractice costs are also at issue but are not included in this report.

⁴ Source: (Trude and Ginsburg, 2002)

⁵ *Access to Primary Care Providers for Medicaid and Medicare Patients In Spokane County*, Spokane Regional Health District, February 28, 2003.

⁶ Licensing information was not available for Kootenai County.

⁷ This is probably because of the much smaller number of physicians in Kootenai County compared to Spokane County.

⁸ The 23% figure includes only primary care physicians, leaving out specialty physicians.

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From One to Z, artist: Ms. Carla Bernsten



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