



**The Immediate and Future Role
of the J-1 Visa Waiver Program for Physicians:
The Consequences of Change
for Rural Health Care Service Delivery**

**P2002-3
April 2002**

**Special J-1 Visa Waiver Program Task Force
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The RUPRI (Rural Policy Research Institute) Center for Rural Health Policy Analysis is one of six Rural Health Research Centers supported by the Federal Office of Rural Health Policy (ORHP), Grant No. 1 U1C RH 00025-01. This project is funded by ORHP, Health Resources and Services Administration, U.S. Department of Health and Human Services. The specific content of this *Paper* is the sole responsibility of the authors.

Preface

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PURPOSE

The longstanding and well-documented problem of maldistribution of physicians resulting in areas of shortage continues to plague much of rural America. The supply of physicians to those shortage areas currently includes physicians from nations other than the U.S.—international medical graduates (IMGs)—who obtain waivers on visa requirements (J-1 visas), allowing them to remain in the U.S. after their residency training. This *Policy Paper* addresses the question:

What are the consequences for the delivery of health care services in rural underserved areas if current policies governing the granting of J-1 visa waivers are changed (resulting in increases or decreases in the numbers of physicians affected)?

This *Policy Paper* will provide available information and analysis to help frame and examine policy options for placing physicians in rural underserved areas.

IMPACT OF THE J-1 VISA WAIVER PROGRAM ON RURAL UNDERSERVED AREAS

In September 1999, over 2,000 IMGs with J-1 visa waivers were practicing in shortage areas (urban and rural), as compared to 1,356 physicians in the National Health Service Corps (NHSC) (U.S. General Accounting Office, 2001). J-1 visa waiver physicians are currently providing care to over 4 million people living in underserved areas of rural America.⁵ A recent analysis of the geographic distribution of IMGs concluded: “If all IMGs currently in primary care

PHYSICIANS PLACED IN UNDERSERVED AREAS, BY TYPE, BY YEAR

J-1 VISA WAIVERS

USDA:¹

1994-1997:	2,317
1998-1999:	542
2000:	165
2001:	74

rural: all but 571 of the 8 year total of 3,098; most of the 571 occurred in 1994-1997

Conrad-20:²

1998:	432 - 522
1999:	423 - 513
2000:	459 - 549
2001:	469 - 559

rural: Estimated to be 62% of the total

Appalachian Regional Commission:³

1998:	100
1999:	92
2000:	58
2001:	64

NATIONAL HEALTH SERVICE CORPS⁴

1999:	436
2000:	365
2001:	375

rural: exact number not known, estimated to be 61%, based on percent of all NHSC placements

¹Per USDA program coordinator, March 2002.

²Data from a survey completed for the Federal Office of Rural Health Policy in April 2002 (37 participating Conrad-20 states provided data for the number of Conrad-20 physicians practicing as of April 2002). Missing state data were imputed by using the average number of state-reported Conrad-20 physician waiver recommendations obtained from: Berry, C., Dopp, A., and Caro-Justin, B. (2001). *J-1 visa waivers: Program update and “next steps.”* 2001 Primary Care Symposium. Bethesda, MD.

³Information provided by Appalachian Regional Commission, April 11, 2002.

⁴Data obtained from the NHSC by the Federal Office of Rural Health Policy, April 2002.

⁵This number is based on the median number of persons who are active patients under the care of a primary care physician (2,363), per data provided by Medical Group Management Association of America.

practice were removed from this calculation [of counties with shortages, 30% of all rural counties], one out of every five ‘adequately served’ nonmetropolitan counties would become underserved. In addition, the number of rural counties with no primary care physicians would rise from 161 to 212” (Baer, Konrad, and Slifkin, 2001, p. 1). In 1996, IMGs (most of whom would be J-1 visa waiver physicians) represented the following percentages of primary care physicians in counties classified by shortage status:

- in whole county Health Professional Shortage Areas (HPSAs), 18.7%;
- in partial county HPSAs, 15.2%; and
- in non-HPSA counties, 14.3% (Baer, Ricketts, Konrad, and Mick, 1998).

A study in New York state found that the contribution of IMGs on temporary waivers was not “as dramatic as was previously thought,” but nonetheless the percent of J-1 visa waiver IMGs planning to practice in shortage areas was triple that of U.S. medical graduates (USMGs) (Salsberg and Nolan, 2000). IMGs fill various safety net needs at a rate disproportionately higher than that for USMGs, including in areas with high infant mortality rates, low socioeconomic status, high non-white population, and states with high rural population percentages (Mick, Lee, and Wodchis, 2000).

IMGs are more likely to serve African-American and Hispanic patients and to practice in public settings (Blanco, Carvalho, Olfson, Finnerty, and Pincus, 1999). They are also more likely than USMGs to begin their pediatric practices in rural HPSAs (Randolph and Pathman, 2001). The same is true for general internists; IMGs are more than twice as likely to practice in rural underserved areas (Phillips, Fryer, and Fink, 2001). Finally, “new IMGs tend to locate in markets in which a large proportion of the population is of their own race/ethnicity” (Polsky, Kletke, Wozniak, and Escarce, 2000).

These impacts on rural underserved areas are clear from the evidence presented in the literature:

- IMGs are helping to fill a need for primary care physicians;
- IMGs are filling specific needs in pediatrics and general internal medicine; and
- IMGs are a resource for meeting the needs of new immigrant populations.

More information would be helpful to determine more detail about the impact of IMGs:

- locations of the patients seen by IMGs (urban or rural, in or out of shortage areas);
- precise placements of J-1 visa waiver physicians, by classification of county on the urban-rural continuum (or other measure of rurality);
- updated information on where IMGs practice after completing the J-1 visa waiver commitment; and
- patient mix seen by J-1 visa waiver physicians, including how many physicians not in Federally Qualified Health Centers accept sliding fee schedule payments, and the percent of Medicaid and uninsured patients cared for.

POLICY CHOICES

Participation of Federal Agencies in Requesting J-1 Visa Waivers

A description of the involvement of federal agencies, since 1998, can be found in the Appendix and in the data box on page one of this *Paper*. As of February 27, 2002, the USDA no longer requests placements for physicians seeking waivers from the J-1 visa requirement to return to their homeland. The USDA's decision was based on not having the staff to make sure security considerations were resolved (the USDA press secretary quoted in Dvorak, 2002). This decision has a disproportionate impact on some states that have a high number of physicians placed through the USDA process, which in 1994-2001 were: Texas (449), Louisiana (250), Michigan (242), California (232), and Florida (224). Other states, with smaller total numbers, saw most of their J-1 placements done through this process, including Kansas, Arkansas, and South Dakota. The total number of placements by the USDA, though, had already been falling each year. That decline followed a decision to limit any particular site to two placements, and coincided with increased participation by states in the Conrad-20 program. *The impact of the USDA decision is to remove one of several federal agency options that addressed the specific needs in rural areas in several states.*

Meeting Concerns for Homeland Security

The nation's renewed interest in evaluating the security risk of all immigrants has affected the J-1 Visa Waiver Program, even though physicians recommended for that status have already been screened for entry into the U.S. when they obtained their visas. Physicians recommended for waivers during the next several years will have undergone security clearance for visa purposes prior to the events of September 11, 2001. Security screening procedures have changed since that time, including identification of nations of origin that trigger special security reviews. For any temporary resident undergoing a change in status a new security check may be appropriate. There are reasons, however, to treat waivers for J-1 visa physicians differently:

- the physicians have already been in the U.S. for at least three years without manifestations of security risk;
- the ethical code of physicians would make them less likely to be terrorist threats; and
- the recommendations for waivers would have them remaining in the U.S. for the explicit purpose of serving residents of underserved communities.

Given the legal requirement that J-1 visa waiver physicians provide services in areas of great need, based upon a request by providers or governments in those areas, terminating the program, or requiring that all security checks be complete before a waiver can be granted, could adversely affect the health of residents in those areas. Therefore, a balance is required between security interests and the needs of underserved communities for which the only provision of primary health care will come from J-1 visa waiver physicians. For example, a presumption of non-risk could be used to allow placement in underserved areas, subject to revocation should an ongoing

investigation reveal a risk to national security. This would mean that physicians requesting waivers are subject to the same security clearance procedures, completed by the same agency, as any other foreign national changing visa status, but that the priority domestic need—providing health care services—would not go unmet while a security check is completed.

Once the question of how to be sure homeland security is protected while meeting the needs of underserved communities is resolved, the USDA may want to reconsider its decision to withdraw from the program. If not, other agencies could consider becoming more active in the J-1 Visa Waiver Program. Specifically, the Department of Health and Human Services is currently participating only to request waivers for physicians involved in research (per regulations published in 1984, 49 Federal Register 9900, March 16, 1984), and could fill the void left by the USDA. Another option would be for other regional commissions, in addition to the Appalachian Regional Commission (ARC), to participate in the program (such as the Mississippi Delta Commission). Increased involvement by federal agencies other than the USDA would help secure placements in those states not wanting to participate in the Conrad-20 state program, and those states in which the limit on how many waivers can be requested is below their need.

Status of the Conrad-20 Program: How Best to Use This State Option

As of March 25, 2002, 44 states participate in the Conrad-20 program, placing physicians in either HPSAs or Medically Underserved Areas (MUAs) (Berry, Dopp, and Caro-Justin, 2001, with states updated to include California and Arkansas). Approximately 62% of those physicians are placed in rural settings.⁶ Of states who currently place 20 or almost 20 physicians per year through this program, 21 said they could place more than 20 if the limit were not in place (Berry, Dopp, and Caro-Justin, 2001). Although experience with the program varies considerably across the states, some general points can be made:

- most states coordinate placement through the Conrad-20 program with other waiver placement efforts such as the USDA and ARC and with NHSC placements;
- the Conrad-20 program allows for targeting sites not included in other waiver programs or in the NHSC placements;
- staff time required to administer the program is minimal—less than one full time equivalent in almost all participating states;
- most states require that sites where J-1 visa waiver physicians will practice accept Medicaid, Medicare, and the uninsured;
- all but five states track the placements, with only 69 violations of J-1 requirements found in a five-year period (Berry, Dopp, and Caro-Justin, 2001); and
- because physicians admitted under the J-1 Visa Waiver Program (unlike those in the NHSC) are not required to be primary care physicians, the flexibility of the

⁶Data from a survey completed for the Federal Office of Rural Health Policy in April 2002 (37 participating Conrad-20 states provided data for the number of Conrad-20 physicians practicing as of April 2002).

option is particularly attractive to rural hospitals requiring physicians in critical specialties, such as general surgery, radiology, and anesthesiology, which are required to sustain community hospitals serving HPSAs and MUAs.

During the past few years, advocates of this program have suggested it be expanded to a limit of 40 placements per state per year. That proposal has been incorporated into legislation introduced in 2001 by Senator Brownback (with Senators Graham and Helms), the Rural and Urban Health Care Act of 2001 (S. 1259).

Alternative Sources of Physicians for Rural Underserved Areas

Currently, the number of J-1 visa waiver physicians meeting needs in rural HPSAs exceeds the number of NHSC physicians doing so. The President's fiscal year 2003 budget proposal would increase the NHSC recruitment budget from \$99 million (which was an increase from \$84 million the previous year) to \$143 million. This budget funds scholarships and loan repayments for primary care providers and dental and mental health professionals. The increased resources will not close the gap that would exist if positions currently filled by IMGs were vacated. There are considerations other than total numbers when suggesting the NHSC be a source for replacing J-1 visa waiver physicians:

- NHSC physicians can only be placed in HPSAs, not in MUAs.
- NHSC placements are used only for primary care physicians.
- The supply of NHSC physicians is a highly variable function of the size of graduating classes from U.S. medical schools, the composition of those classes in terms of their interest in primary care medicine, and the availability of alternative sources of financing medical school tuition and/or paying off debt incurred during the course of medical education. These factors will affect the percent of U.S. graduates making a commitment to the NHSC, and since there is not a history of expanding the program to meet all needs, the attraction to the program beyond the current supply is unknown.
- The demand for NHSC physicians will increase as the expansion of Community Health Centers continues, increasing the annual vacancies in those agencies from 700 to 1,100 physicians (estimate provided by the Bureau of Primary Health Care).

The demand for J-1 visa waiver physicians could be reduced by improved retention of physicians in HPSAs (and MUAs). For example, the supply of physicians in whole-county HPSAs who were neither NHSC- or J-1-related increased from 5,247 in 1988 to 7,371 in 1998; of those physicians, 2,782 and 3,841, respectively, were in primary care (family practice, general internal medicine, and general pediatrics). The number of J-1 visa waiver physicians in those areas was 414 in 1988 and 285 in 1998 (Mick, Fisher, and Davis, 2001). For partial county HPSAs, the number of "other" primary care physicians increased from 13,567 in 1988 to 20,039 in 1998; comparable numbers for J-1 visa waiver physicians were 520 and 623 (Mick, Fisher, and Davis, 2001), which means that the total number of J-1 waiver physicians serving in shortage areas has

increased even as the total number of physicians has increased.

Generating a sufficient supply of non-J-1 visa waiver physicians to replace those in practice, if set as a policy goal, will require attracting a significant percentage of USMGs and USIMGs completing residencies who are not already committed to practice in underserved areas. To illustrate, in 2000 there were 6,255 primary care residents who graduated from U.S. medical schools.⁷ To replace the approximately 727 J-1 physicians receiving waivers to practice in underserved areas would have required that 1/6 of all USMG primary care physicians would practice in underserved areas, in addition to those already doing so (including the 365 NHSC physicians).

There are state-based programs that use financial incentives, including scholarships and loan forgiveness, to attract physicians to shortage areas. In 1996, there were 82 programs in 41 states, with an estimated 1,306 physicians and 370 mid-level providers participating (Pathman et al., 2000). Medical schools and residency programs can implement programs to develop a work force more likely to practice in rural locations, including shortage areas.

The following strategies should be used to increase the general supply of physicians practicing in underserved areas:

- Significantly increase physician placements supported by the NHSC.
- Increase support for federal and state programs that increase the number of physicians who practice in rural underserved areas.
- Continue and strengthen programs authorized under Title VII of the Public Health Service Act.
- State governments should expand their activities in scholarships, loan repayment, and other financial incentives to attract physicians to underserved areas.
- State governments should encourage and support training programs in undergraduate medical curricula and residency programs that are designed to recruit students from rural areas, train them in rural areas, and secure their initial placement in underserved rural areas.

⁷National Resident Matching Program. *Positions offered and filled by U.S. seniors and total applicants from 1999 through 2001*. Received 3/22/02 from http://www.nrmp.org/res_match/table5.htm

RECOMMENDATIONS

1. Federal agencies should continue to participate in the J-1 Visa Waiver Program. This should include consideration by the Department of Health and Human Services to expand its J-1 visa waiver activities to include recommending waivers for physicians to practice in underserved areas. If multiple agencies are involved in recommending waivers in the same geographic area, coordination of effort should be assured, whether through the auspices of a federal agency, a national contract, or state governments.
2. Homeland security issues involving physicians immigrating to the U.S. for residency training, and staying in the U.S. under the authority of a J-1 visa waiver, should be handled the same as for any other foreign national in the same status. Physicians currently in residency should be required to request a security clearance at the same time they request a waiver. Physicians recommended for waivers should be allowed to begin their practice in the underserved area at the time requested by the recommending agency. The waiver would be revoked should any clearance process determine that a physician is a security risk.
3. The Conrad-20 program should be continued, with the current limit of 20 per state per year expanded to 40 per state per year.
4. State Offices of Rural Health should be encouraged to participate in the process of recommending waivers for J-1 visa physicians, particularly in reviewing and approving sites for placement. The 3R Net Program could be used to manage communication between state programs and potential J-1 visa waiver physicians.
5. Develop a national management information system to monitor placement of all federally-obligated physicians including J-1 visa waiver physicians and NHSC practitioners obligated under federal and joint state-federal scholarship and loan repayment programs. Appropriate data should include their location during the period of their service obligation and their practice location upon completion of that commitment.

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APPENDIX THE PROGRAM AND ITS RURAL APPLICATION

Foreign-born international medical graduates (IMGs) (henceforth the term IMG will assume foreign-born) can apply for a J-1 visa to pursue graduate medical education in the U.S. If the IMG is sponsored by the Educational Commission for Foreign Medical Graduates and has a contract from a U.S. accredited medical school, affiliated hospital, or other institution, the IMG is permitted to enter the U.S. and remain until the completion of her/his graduate medical education. The applying alien must:

- have graduated from a medical school listed in the “World Directory of Medical Schools” published by the World Health Organization;
- pass parts I and II of the National Board of Medical Examiners;
- have competency in oral and written English;
- be able to adapt to the educational and cultural environment in the training setting;
- have made a commitment to return to the country of nationality or last residence (Section 212(j), U.S. Immigration and Nationality Act); and
- pass the Clinical Skills Assessment examination administered by the Educational Commission for Foreign Medical Graduates.

The length-of-stay in the U.S. with a J-1 visa is limited to the time needed to train as a resident, to be no longer than seven years. IMGs will have cleared security procedures to enter the U.S. and will have been in the U.S. a minimum of three years while completing their residency training.

Upon completion of that training, the IMG is required to return to her or his home country for two years before seeking a different immigrant status. That requirement can be waived (J-1 visa waiver) if returning would result in persecution in the home country, create a hardship to a spouse or dependent child, or if a U.S. government agency or State Department of Public Health requests the waiver (Section 212(e), Immigration and Nationality Act). Requests are made to the U.S. Department of State, which makes a recommendation to the Immigration and Naturalization Service (stated in the statute as the U.S. Attorney General) for final ruling. Section 214(l) states that the Attorney General shall not grant a waiver unless:

- the government of the country to which the alien is otherwise contractually obligated to return furnishes a written statement that it has no objection to the waiver;
- the alien demonstrates a bona fide offer of full-time employment and agrees to begin employment in a facility or organization determined by the Attorney General to be in the public interest;

- the alien agrees to begin employment in the facility or organization within 90 days of receiving the waiver and agrees to continue for a total of not less than three years; and
- if an alien’s status is changed to a temporary work visa, the alien must agree to practice medicine for at least three years in the geographic area or areas designated as health professional shortage areas (except for Veterans Affairs facilities).

In addition, if the waiver is sought by a designated state agency, a waiver cannot be granted if that would cause the total number of waivers granted per that agency’s requests in that year to exceed 20.

Any U.S. government agency can request a waiver for any purpose that agency describes. State Departments of Health can also request waivers, up to 20 per year. The following J-1 Visa Waiver Programs have been established:

- U.S. Department of Health and Human Services—requests waivers for physicians who are participating in research projects.
- U.S. Department of Veterans Affairs—requests waivers for physicians who must be employed at least 50% by a Veterans Affairs facility and be participating in research, teaching, or patient care.
- U.S. Department of Agriculture—requested waivers for primary care physicians who will work in (or primarily serve) a rural health professional shortage area not otherwise “fully served.” The state health department must concur with the waiver. *The U.S. Department of Agriculture terminated its involvement in sponsoring foreign research scientists and recommending waivers of the home residency requirement for foreign physicians, effective February 27, 2002.*
- Appalachian Regional Commission—requests waivers for physicians who will work in a specified shortage area in the Appalachian region and who must practice primary care or psychiatric care for 40 hours per week for at least three years in a facility that serves Medicaid, Medicare, and indigent uninsured patients.
- State Departments of Health in 44 states—request waivers for physicians to work in either health professional shortage areas or medically underserved areas. Many states limit this to primary care physicians, although that is not a national requirement.

Recent Health Policy Documents

Inequitable Access: Medicare+Choice Program Fails to Serve Rural America. February 2002. (PB2002-2)

Comments on Regulatory and Contractor Reform Legislation. January 2002. (PB2002-1)

Comments on the June 2001 Report of the Medicare Payment Advisory Commission: "Medicare in Rural America." September 28, 2001. (P2001-14)

Redesigning Medicare : Considerations for Rural Beneficiaries and Health Systems. Special Monograph. May 15, 2001. (SM-1)

Can Payment Policies Attract M+C Plans to Rural Areas? May 2001. (PB2001-8)

An Update on Medicare+Choice: Rural Medicare Beneficiaries Enrolled in Medicare+Choice Plans through October 2000. March 2001. (PB2001-7)

Redesigning Medicare: Considerations for Rural Beneficiaries and Health Systems. February 2001. (PB2001-6)

Rural Implications of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000: Concerns, Legislation, and Next Steps. A Companion Brief to P2001-3. January 2001. (PB2001-4)

Rural Implications of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000: Final Bill: P.L. 106-554. A Consolidation of P2000-16 and PB2001-1. January 15, 2001. (P2001-3)

Designing a Prescription Drug Benefit for Rural Medicare Beneficiaries: Principles, Criteria, and Assessment. A Joint Policy Paper of the Maine Rural Health Research Center and the RUPRI Rural Health Panel. August 31, 2000. (P2000-14)

Redesigning the Medicare Program: An Opportunity to Improve Rural Health Care Systems? August 31, 2000. (P2000-13)

The Area Wage Index of The Medicare Inpatient Hospital Prospective Payment System: Perspectives, Policies, and Choices. August 27, 2000. (P2000-12)

Health Insurance in Rural America. August 2000. (PB2000-11)

Improving Prescription Drug Coverage for Rural Medicare Beneficiaries: Key Rural Considerations and Objectives For Legislative Proposals. June 30, 2000. (P2000-8)

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- Meet diverse clientele needs in a flexible and timely fashion.
- Foster and reward scientists who wish to contribute to the interplay between science and policy.
- Overcome institutional and geographic barriers.
- Make adjustments in the academic “product mix” to enhance relevancy and societal contributions.

2002 Program of Work

National Centers

Community Informatics Resource Center
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National Work Groups

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(CPAN)

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Rural Health
Rural Policy
Rural Welfare Reform
Rural Telecommunications

Topical Research

Rural Telecommunications
Rural Education
Rural Entrepreneurship
Rural Health
Rural Workforce
Census and Small Area Data Impacts
The Rural/Urban Dialectic