TASK FORCE TO REVIEW PHYSICIAN SHORTAGES IN RURAL AREAS

Report of the Subcommittee on Options for Addressing Physician Shortages in Rural Areas (Revised September 19, 2008)

Background

- MHA/MedChi Physician Work Force Study shows Maryland has 16 percent fewer physicians available for clinical practice than the national average. (See attached charts).

- The physician shortages are most acute in three regions of the state—Eastern Shore, Southern Maryland, and Western Maryland.

- The shortages are projected to worsen over the next seven years.

- On August 11, 2008, the National Association of Community Health Centers released a new study on the primary care work force in the US. The study concluded that to provide a medical and health care home to all 56 million medically disenfranchised Americans and to continue to serve current patients, health centers will need up to 60,000 more primary care professionals, and up to 44,500 additional nurses. (Press release attached).

- If the shortages are not addressed, consumers will face problems gaining access to care; experience increased waiting times to see a physician; and, face greater reliance on already crowded emergency rooms.

- Further complicating the situation is the fact that Maryland physicians are reimbursed by commercial carriers at significantly lower rates when compared to their peers across the country, and must earn a living in one of the highest cost of living states.

General Approach

- No single strategy will work—a combination of strategies is needed to comprehensively address both primary and specialty care shortages across Maryland.

- Strategies are needed for the short, intermediate, and long term.

- Enhancing reimbursement is absolutely fundamental/critical/essential to the effort.

- Strategies need to apply to and focus on “shortage areas in Maryland”, not just the HPSA/MUA designated areas.

- Rural strategies need also to focus on all physician specialty shortages in rural areas—not just primary care.

- Where federal restrictions/barriers are in place, Maryland policymakers and other affected stakeholders should advocate for change at the federal level.

Recruitment

1. Establish/expand loan forgiveness programs targeted at "shortage areas."

   Rationale: Need to have multiple recruitment mechanisms when average debt of a medical school graduate is $147,000, and Maryland is a low reimbursement, high-cost of living state.

   The current program is only available for primary/ mental health care and only if the physician is practicing in a nonprofit setting in a federally designated shortage area.

2. Allow other "nonprofit" organizations, such as hospitals, nursing homes, clinics, hospices, etc., to sponsor a physician for loan assistance reimbursement program (LARP) purposes.

   Rationale: Requiring the physician to work in a "nonprofit setting" limits recruitment efforts by private practices in shortage areas. Allowing a nonprofit to "sponsor" the physician and permit the physician to work in a private practice setting would greatly expand the opportunities for retaining the physician in that community on a long term basis.

3. Adjust the current assessment on physician licenses to expand and/or increase flexibility of LARP.

   Rationale: Currently, 14 percent of the physician license fees *(12 percent beginning in FY 2009)* are dedicated and split between two programs: 1) grants under the Health Manpower Shortage Incentive Grant Program; and, 2) the Loan Assistance Repayment Program for primary care physicians. For FY 2008 the grants awarded under the Health Manpower Shortage Incentive Grant Program totaled $499,098 and were split between 39 different postsecondary institutions. The LARP for primary care physicians in FY 2008 totaled $432,500, with an average of $25,441 provided to 17 physicians. (Chart attached).

   Generating additional revenue for the state portion of LARP funding could be used to draw down additional federal funding and/or establish a state program with greater flexibility. *Further discussions with affected stakeholders are warranted to determine whether the grants awarded under the Health Manpower Incentive Grant Program are too small/diluted to have the impact originally intended, and whether that money could be used more effectively if dedicated entirely to LARP.*

4. Enhance outreach/administrative support for potential LARP/National Health Service Corps applicants.

   Rationale: Assisting with the paperwork required to qualify for these programs could be an attractive outreach and recruitment tool. Hospitals could develop expertise (individually or collectively) on the requirements of these programs to assist in recruiting.

5. Allow hospitals in shortage areas to establish loan forgiveness approaches under the all-payor system in exchange for a commitment to practice in the shortage area—similar to the Nurse Support Programs I and II.

   Rationale: Generating additional revenue from all payers for the state portion of LARP funding could be used to draw down additional federal funding and/or establish a state program with greater flexibility.

6. Encourage teaching programs to offer greater exposure to family practice settings, greater exposure to specialties in short supply, and rotations in shortage areas.

   Rationale: Focusing on the types of specialties in short supply, including family medicine, and exposure to shortage area practice settings could generate interest at the medical school level (before residencies/specialties are selected). Early identification of students with an interest in practicing in shortage areas would also be useful in earlier identification of students with an interest in those types of settings.

7. Expand existing AHECs in Western Maryland and the Eastern Shore to include a site in Southern Maryland.

   Rationale: AHECs provide rural clinical rotations for health professional students; provide health career education programs for elementary, middle, high school and college students in rural areas; promote interdisciplinary training and health practice; facilitate continuing education; and, provide training programs for regional health professionals.

8. Aggressively pursue additional HPSA/MUA designations for Maryland through the Office of Primary Care.

   Rationale: Locations or population groups that meet the criteria for federal designation are eligible for more than 30 federal program resources and benefits.

9. Encourage medical schools to generate additional interest/focus in family practice specialties and residencies.

   Rationale: There is currently a shortage of primary care physicians at the state and regional levels. All regions, except Central Maryland where supply is just meeting demand, are experiencing shortages.

10. Set aside a designated number of medical school slots in Maryland for those who commit to practice in a shortage area.

    Rationale: Creating an "incentive" in the admission criteria for students who agree to practice in a Maryland shortage area provides another mechanism for attracting medical school graduates into shortage areas.

11. Enhance efforts to collect data on physicians who have graduated from medical schools in Maryland; identify those graduates who are not currently practicing in Maryland; and, offer them incentives to return to Maryland to practice.

    Rationale: Provides mechanism to target recruitment of those who are already familiar with Maryland and its health care system.

12. Create partnerships of community, higher education, health care providers, and government bodies similar to the West Virginia Rural Health Education Partnerships.

    Rationale: Description attached.

13. Develop recruitment strategies focused on female and minority medical students.

    Rationale: Capitalize on the significant increase in the numbers of women and minorities enrolled in medical schools.

14. Create a Maryland Health Service Corps program.

    Rationale: Shortages exist in areas and specialties in Maryland beyond the limited focus of the national program.

Retention/Practice Support

1. Direct a portion of CMS electronic medical record demonstration monies to practices in shortage areas.

   Rationale: CMS recently awarded Maryland a five-year demonstration project to determine the potential of EHRs to transform quality and efficiency of health care. Approximately 200 small practices (under 20 employees) from Maryland

and DC will be eligible for bonus payments over a five-year period for making certain IT/EMR improvements and reporting clinical quality measures. (Additional information attached.)

2. Encourage/require insurers to provide incentive payments to practices in shortage areas for technology upgrades/medical home development/expanded hours, etc.

   Rationale: Providing upfront IT improvement funding (similar to the CMS demonstration above) eliminates a huge barrier to making these investments, will enhance quality improvement and patient safety initiatives, and may create leverage for additional federal funding under the CMS Medical Home Demonstration Project.

3. Enhance Medicaid/commercial carrier reimbursement in "shortage areas" similar to Medicare's reimbursement policies for HPSAs.

   Rationale: Consistent with existing Medicare policy.

4. Direct the Maryland Insurance Administration to monitor carrier network adequacy standards aggressively in shortage areas.

   Rationale: Effective this fall, Maryland Insurance Administration regulations will require carriers to demonstrate an adequate "network" of providers to meet the needs of their members.

5. Require medical liability insurers to provide additional mechanisms for Maryland physicians to institute risk management strategies in exchange for premium reductions; i.e., telemedicine, EMRs, chronic disease management, medical home designations, etc.

   Rationale: Investments for technology upgrades that enhance patient safety and improve patient outcomes reduce liability risk.

6. Require medical liability insurers to offer retired/part-time physician policies that do not require "tail" coverage.

   Rationale: Provides flexibility/incentives for retired physicians to practice part-time.

7. Provide tax credits for practicing and/or making technology investments in shortage areas.

   Rationale: Aligns tax policy to address an identified state health care need.

Grow Your Own

1. Allow shortage areas/regions to purchase one or more medical school slots in exchange for the student's commitment to practice in the region for a period of time.

   Rationale: Provides assistance to students with a strong connection and/or commitment to practicing in a Maryland shortage area.

2. Develop partnerships between teaching programs and hospitals in shortage areas to identify potential medical school students who could be encouraged to consider practicing in those areas.

   Rationale: Creates opportunities for linkages within Maryland to retain medical school graduates.

3. Develop additional health care careers education programs for elementary, middle, high school, and college students in shortage areas.

   Rationale: Generate interest in health care careers among students living in shortage areas.

4. Develop recruitment strategies focused on female and minority students.

   Rationale: Capitalize on the significant increase in the numbers of women and minorities enrolled in medical schools.

Telemedicine

1. At a minimum, require Medicaid and private third-party payors to reimburse for telemedicine services in accordance with Medicare policy.

   Rationale: Consistent with Medicare policy.

2. Encourage new uses for telemedicine.

   Rationale: Reimbursement should go beyond the Medicare limitation of "interactive clinical services that otherwise would be provided face-to-face." Monitoring chronic disease at home, providing continuing medical education to local providers in rural areas, clinical integration, improving coordination and communication among providers, payors, and patients, etc., all have the potential to significantly improve efficiency and effectiveness of health care delivery in shortage areas.

Federal

- Expand funding for the National Service Corp Scholarships and AHEC programs.
- Revise criteria for MUA/HPSA designations to qualify additional shortage areas for designation in Maryland.
- Provide flexibility in the federal LARP requirements to allow physicians in private practice settings in shortage areas to qualify for the program.
- Encourage continuation of the J-1 visa program and expand waivers on the responsibility to return to home country after graduation in return for serving in an underserved area.
- Remove barriers for hospitals/groups to require payback if J-1 or H-1 visa employee leaves practice early.
- Seek an increase in the number of residency slots in Maryland.
- Seek broader funding for Medicare reimbursement for telemedicine services.