



ASPE

ISSUE BRIEF

Building the Nation's Health Care Workforce July 2, 2015

Introduction

The Affordable Care Act is working to expand health insurance coverage to millions of Americans, including many gaining coverage and access to health care for the first time. As of March 2015, about 14.1 million adults had gained insurance coverage since October 1, 2013. An additional 2.3 million young adults had gained coverage between 2010 and October 1, 2013 as a result of its provision that allowed young adults aged 19-25 to remain on a parent's policy. The Department of Health and Human Services (the Department) has proposed a package of workforce policies that builds on the successes of the Affordable Care Act by making strategic investments in the nation's health care workforce to improve the delivery of health care across the country.

The Department's workforce policy initiatives address issues that have troubled the nation for a long time: there is insufficient emphasis on primary care; the supply of primary care providers may be inadequate; the workforce is unevenly distributed geographically and its composition does not adequately reflect or serve the country's evolving demographics and diversity; and the workforce needs of an evolving delivery system emphasizing care access, quality, cost reduction, and population health may require new provider skills and team compositions.

HHS Major Workforce Proposals

The Department's major workforce proposals directly address current problems facing the national health workforce. (Additional detail on these and other 2016 workforce budget proposals is found in the Appendix.) The recently enacted Medicare Access and CHIP Reauthorization Act of 2015 included several provisions that address the evolving nature of the health care workforce, which is an encouraging step in advancing the vision found in the Department's FY 2016 budget proposals. While the focus of this law is to move Medicare toward a more value-based payment system and encourage the development of alternative payment models, the law also extends mandatory

KEY HHS FY 2016 BUDGET PROPOSALS

(Details in Appendix)

Extend Medicaid primary care payment increases through CY 2016 and include additional providers

Make permanent the Medicare Primary Care Incentive Payment

Encourage new approaches to residency training by targeting \$5.23 billion in mandatory funds over 10 years to a new results-oriented grant program

Expand the National Health Service Corps

funding for the National Health Service Corps for Fiscal Years 2016 and 2017 and extends the Teaching Health Center Graduate Medical Education program for those two years.

The Department's package of proposals is rooted in common sense and supported by an emerging research base drawn from studies conducted within the Department, by its contractors, and by external parties.

- **Primary Care Incentive Payments**

- Medicaid primary care incentive payment*

Background: There is face validity to the premise that if health practitioners are paid more, more will participate in Medicaid, which is borne out by past researchⁱ. Building on this premise, the Medicaid primary care incentive payment, requiring that Medicaid primary care doctors be paid at rates no less than those paid doctors in Medicare went into effect in January 2013 and extended through December 2014ⁱⁱ. While costs associated with this increase were borne entirely by the Federal government, states faced challenges in its implementation, largely tied to its application in Medicaid managed care and fears that two years would not be long enough to affect physician behavior.

Research: A recent *New England Journal of Medicine* articleⁱⁱⁱ reports promising initial findings tied to this Medicaid "bump". A study by researchers from the University of Pennsylvania and the Urban Institute examined the impact of the Medicaid primary care reimbursement increase on the availability of primary care appointments and waiting times for Medicaid participants in ten states, including both Medicaid expansion and non-expansion states. The researchers interviewed providers at two points in time -- late 2012 and early 2013 before the incentive was in place and in mid-2014 after the payment incentive was implemented, and compared results for Medicaid participants to individuals with private insurance. The Medicaid "fee bump" led to an average increase in the availability of primary care appointments for Medicaid enrollees across states of nearly 8 percentage points. Those states that saw an above average increase in Medicaid reimbursement tended to see the greatest increases in the availability of care to Medicaid beneficiaries. No similar changes were observed in the private insurance group and waiting times remained constant.

Proposal: The Department's proposal would extend this provision for calendar years 2015 and 2016, and expand eligibility to nurse practitioners and physician assistants.

- Medicare primary care incentive payment*

Background: The Affordable Care Act included a five-year supplement to Medicare payments for certain primary care practitioners and services. Its intent was to encourage the provision of primary care by lessening the disparity in earnings between primary care doctors and those of many other specialists. (For example, The Medical Group Management Association reports that the median starting salary for family medicine is \$100,000 as opposed to \$284,000 for non-invasive cardiology and \$300,000 for general surgery).^{iv} Practitioners specializing in general internal medicine, family practice, pediatrics, and geriatrics) who have at least 60 percent of their allowable charges for primary care evaluation

and management services receive the 10 percent Primary Care Incentive Payment. This provision expires at the end of 2015.

Research: The Office of the Assistant Secretary for Planning and Evaluation (ASPE) has sponsored research by The Lewin Group to examine the impact of the Primary Care Incentive Payment on primary care services by examining Medicare claims over the period 2005-2011. This analysis suggests that the number of Medicare providers with a Primary Care Incentive Payment bonus-eligible specialty and at least one Primary Care Incentive Payment eligible claim increased annually by about 2.8 providers per county in 2010 (after the incentive was enacted) and 2011 (when incentive payments went into effect) due to the Medicare Primary Care Incentive Payment bonus policy^v. While the number of primary care providers increased, the number of primary care claims per provider decreased. Although the average number of claims per provider decreased overall, there was a 7 percent increase in the number of claims for longer (25 minute) office visits due to the Primary Care Incentive Payment policy.

This study contained only one year of Primary Care Incentive Payment implementation data and the experience of later years may differ. Still, these early findings suggest that the Primary Care Incentive Payment has been associated with a greater volume of primary care services delivered to the Medicare population.

Proposal: The Department's FY 2016 budget request would make the Primary Care Incentive Payment permanent in a budget neutral way.

- **Targeted Support for Graduate Medical Education**

Background: In 2010, the Medicare Payment Advisory Commission (MedPAC) recommended more accountability for Medicare payments for graduate medical education (GME) and a recalibration of how these payments should be determined^{vi}. Their recommendations reiterated findings from previous ASPE research that suggested that indirect medical education (IME) payments^{vii} exceeded analytically justified levels^{viii}. This year, the Department again proposes to reduce IME funding by 10 percent while giving the Secretary the authority to set standards for teaching hospitals that receive this funding, a proposal that addresses both of these points.

IOM Report: In the summer of 2014, the Institute of Medicine (IOM) issued a report on GME funding which proposed major changes in the structure and oversight of GME support^{ix}. The IOM recommends keeping the aggregate amount of GME funding but increasing accountability for how it is used by standardizing direct medical education payments and establishing a "transformation fund" to determine and validate appropriate metrics, pilot innovative payment approaches and establish new residency positions in priority disciplines. The report also recommended the establishment of a GME Policy Council within the Office of the Secretary to guide policy and a new center within the Centers for Medicare & Medicaid Services (CMS) to manage operational aspects of GME funding.

Proposal: The Department is proposing a new program, Targeted Support for Graduate Medical Education, to be administered by the Health Resources and Services Administration (HRSA), and funded with mandatory funds, totaling \$5.25 billion over ten years. Its purpose

is to train more doctors in primary care and other shortage specialties, emphasize training in new delivery models and in rural and underserved locations, and strengthen resident training around team-based care, effective incorporation of health information technology into clinical practice, population health, and telemedicine. The overall effect of this is to bring increased accountability to Federal spending on graduate medical education. As a grant program it will be able to target funds and track grantee performance in ways not available within CMS GME funding mechanisms. It builds on the experience of the Affordable Care Act's Teaching Health Center GME program^x whose awardees will be eligible to compete for this program.

- **National Health Service Corps**

Background: For over 40 years, the National Health Service Corps (NHSC) has provided scholarships and loan forgiveness to primary care and certain other needed health professionals in exchange for service in a Health Professional Shortage Area (HPSA). As of September 2014, there were 9,242 NHSC practitioners in the field providing care to 9.7 million people. The NHSC is an important source for Health Center clinicians: approximately half of NHSC participants meet their service obligations in Federally-Qualified Health Centers.

Research: There have been earlier studies of retention in the NHSC that relied on participant surveys. A FY 2012 study, the NHSC found a 55 percent retention rate for clinicians remaining in service to the underserved 10 years after completing their NHSC commitment. A FY 2014 NHSC Participant Satisfaction Study reported a short-term retention (defined as up to two years after service completion) rate of 86 percent^{xi}.

ASPE contracted with The Lewin Group to further explore retention issues in the NHSC. The ASPE sponsored work took a data driven approach, drawing on NHSC administrative data from Provider 360 (a proprietary data base) and Medicare claims data to examine the experience of persons exiting from the NHSC in the years 2000 through 2013. The files constructed for this project provided descriptive data on NHSC provider mobility and practice location by age, sex, and discipline, and also allowed comparisons with similar non-NHSC providers^{xii}. Analysis corroborated findings from past NHSC survey research which found that a high proportion of NHSC participants remain in practice in HPSAs post-NHSC service, although not always in the same one. For example, while 39 percent of primary care NHSC participants who left the NHSC between 2000 and 2012 remained in practice in the same HPSA^{xiii} in the same county as when they left the NHSC at the close of 2013, an additional 35 percent were practicing in a HPSA in a different county^{xiv}. One item of particular interest from the descriptive data is that of those NHSC participants who met their service obligation in a Federally Qualified Health Center and left the NHSC between the years 2000 and 2013, 88 percent were practicing in the same zip code at the close of 2013. This is in great contrast to NHSC participants who did not practice in a Federally Qualified Health Center, where only 22 percent remained in practice in the same zip code^{xv}.

NHSC participants are less likely to practice in HPSAs beyond their obligation than those who chose to practice in HPSAs without this incentive. This is not surprising given that the non-participants were not induced to practice in HPSAs and may have had strong personal

reasons for their choice of practice site. This finding suggests that the NHSC incentive resulted in many individuals practicing in HPSAs post-NHSC service who otherwise would not have chosen to practice in a HPSA area. The implication is that the program is successful in inducing providers to HPSAs who would not have otherwise chosen to serve in these areas^{xvi}.

Proposal: For FY 2016, the Department proposes a projected \$2.6 billion investment in mandatory funding for the NHSC between FY 2016 and FY 2020. The Medicare Access and CHIP Reauthorization Act of 2015 provides \$310 million in mandatory funds for the NHSC for both FY 2016 and FY 2017, a welcome first step in meeting the Department's request and addressing primary care needs in underserved areas. Funding at the Department's proposed level through 2020 will result in a sustainable NHSC field strength of more than 15,000, providing care to nearly 16 million people.

Additional Research

- Nurse Practitioner Scope of Practice

Background: The Department, through the American Recovery and Reinvestment Act and the Affordable Care Act, infused additional funds into existing programs training nurse practitioners and physician assistants. The FY 2016 budget request maintains funding for these programs at FY 2015 levels. Given the emerging emphasis on team-based care, continuing poor distribution of primary care providers and emerging models of service delivery, the Department has a continuing interest in these practitioners and how they are used. In 2014, HRSA's National Center for Health Workforce Analysis released key findings from its 2012 survey of nurse practitioners which provided information on the nation's over 150,000 nurse practitioners^{xvii}. The survey indicated that over half of nurse practitioners practiced in primary care, a much larger percentage than among doctors. Previous work by HRSA has suggested that rapid projected growth in the numbers of nurse practitioners and physician assistants would partially alleviate an anticipated shortage of primary care doctors in 2020, if these providers were more fully utilized^{xviii}.

Research: Recently completed work commissioned by ASPE identified factors that constrain nurse practitioner practice, particularly in primary care settings. The study, performed by Westat, found that full practice authority is associated with greater nurse practitioner in primary care, with the impact being greater in rural areas. The study also found that central to full practice is prescriptive authority. Beyond scope of practice limitations, organizational culture is also a key factor in the extent to which nurse practitioners are fully utilized^{xix}. These findings support the Department's efforts to encourage team-based care, where each team member is performing to extent of their education, training, and licensure capabilities.

Proposal: The FY 2016 budget request continues to support training for advanced practice nurses. Nurse practitioners can participate in the NHSC: as of September 2014, nurse practitioners and nurse midwives made up 19 percent of the NHSC field strength. In addition, this budget through HRSA continues to fund the NURSE Corps which provides scholarships and loan repayment in exchange for service in a facility with a critical shortage of nurses. In FY 2016, up to 50 percent of the \$80 million in requested funds will be targeted

to nurse practitioners. The program is open to baccalaureate level nurses, advanced practice nurses and nursing faculty.

Data Development

New workforce data efforts within the Department will encourage a better understanding of the nation's health care workforce, its attributes, and how it is configured.

An important component of the Affordable Care Act was the establishment of the National Center for Health Workforce Analysis in HRSA which now provides supply and demand projections for the health workforce at both the national and state level through a microsimulation model. In the past, such projections were available only intermittently. This work is increasingly a useful tool for planning both within and outside the Department, and is a nuanced supplement to projections from other Federal and non-Federal sources.

Beginning with the survey fielded in 2013, the physician induction questionnaire component of the National Ambulatory Medical Care Survey has included additional questions describing the composition of the surveyed practice, more information on which type of practitioner is responsible for particular activities, whether the practice is recognized as a Patient Centered Medical Home, and other aspects of the practice such as 24/7 access to medical records. The data from 2013 is expected later this year and it should provide a useful benchmark against which to observe changes in health care delivery during a time of rapid system-level reform. A new data set, Medicare Data on Provider Practice and Specialty (MD-PPAS), developed by CMS and ASPE, has recently become publicly available. MD-PPAS assigns Medicare providers to medical practices based on the tax identification numbers (TIN) and elaborates on the CMS provider specialty classification. This provider-level dataset is built around two identifiers: the national provider identifier (NPI) and TIN. Other variables include age, sex, metropolitan area, and tax ID name. For 2013 MD-PPAS, which is derived entirely from CMS administrative data, has about 600,000 doctors and other providers).^{xx} As the practice of medicine becomes increasingly concentrated in large medical practices, this new data source will be helpful in examining some of the effects of changes in the health care delivery system.

Conclusion

The Department's package of workforce proposals is designed to address the nation's longstanding workforce problems. It focuses on increasing the availability of primary care providers and services and helping better assure access to care in underserved communities. A trained, well-deployed health care workforce is critical to meeting the needs of the nation and achieving the promise inherent in the expanded insurance coverage provided by the Affordable Care Act. The Department is committed to sustained efforts to monitor workforce trends, support innovative service delivery, evaluate program performance and, ultimately, use its policy levers to address workforce needs for the benefit of the nation.

APPENDIX

FY 2016 HHS Workforce Budget Detail and Related Activities

The President's FY 2016 workforce budget initiative builds on proposals offered for FY 2015. Key components include:

- **Primary Care Incentive Payments:**

Extend the Medicaid primary care payment increase and include additional providers. The budget provides \$6.3 billion over the 10-year Budget window total for calendar years 2015 and 2016 to extend the Affordable Care Act's provision that Medicaid primary care providers be paid at comparable rates to Medicare providers. The FY 2016 President's budget reports by fiscal year and the FY 2016 score for this proposal is \$5.01 billion. This budget proposal would also extend the primary care incentive payment to obstetricians, gynecologists and certain non-physician providers such as nurse practitioners and physician assistants. To better target primary care, the proposal would also exclude emergency room codes.

Make permanent the Medicare Primary Care Incentive Payment. The Affordable Care Act provided a 10 percent incentive payment for qualifying primary care Medicare providers for calendar years 2011-2015. To qualify for the bonus, a practitioner must be in a primary care specialty (general internal medicine, family practice, pediatrics, and geriatrics) and a substantial portion—at least 60 percent—of their allowable charges must be for designated primary care services. The Department's FY 2016 budget request would make this incentive payment permanent.

- **Targeted Support for Graduate Medical Education:**

Create a new approach to training by targeting \$5.23 billion in mandatory funds to a new competitive grant program. Beginning in FY 2016, HRSA will, over ten years, develop and implement a new grant program aimed at supporting medical residency positions across the country that advance key workforce goals, including the training of more doctors in primary care, and other specialties with shortages, and encouraging doctors to practice in rural and other underserved areas.

Under this proposal, the Teaching Health Center GME program would be absorbed into this effort, with current grantees eligible to apply. The Medicare Access and CHIP Reauthorization Act of 2015 provides \$60 million for each of Fiscal Years 2016 and 2017 for this effort.

- **National Health Service Corps (NHSC):**

Expand the Corps to increase the availability of providers in those areas across the country most in need. For FY 2016, the Department proposes reinstating discretionary funding for the NHSC at \$287 million, the same level that the Affordable Care Act provided for FY

2015. An additional \$523 million is being sought in mandatory funds, for a total of \$810 million. The FY 2016 mandatory funds are the first installment in a proposed \$2.6 billion investment in mandatory funding for the NHSC between FY 2016 and FY 2020. Funding at the proposed FY 2016 level NHSC will result in a sustainable NHSC field strength of more than 15,000, increasing access to care in many of the Nation's neediest inner city and rural areas. If funded at the requested amount for FY 2016, nearly 16 million people would receive care from NHSC providers in that year.

The Medicare Access and CHIP Reauthorization Act of 2015 provides \$310 million in mandatory funds for the NHSC in both FY 2016 and FY 2017.

- **Other Health Workforce Budget Requests:**

Building on MedPAC's past findings that Medicare's IME payments overstate the actual added expenses associated with medical training, this budget again proposes a 10 percent reduction in Medicare IME payments, while giving the Secretary the authority to set standards for teaching hospitals receiving this funding that encourage training in primary care and the development of skills needed for the delivery of high quality medicine in an evolving environment.

The budget sustains HRSA's workforce training programs largely at FY 2015 appropriated levels and continues funding for the National Center for Workforce Analysis. As in FY 2015, this budget proposes two new HRSA programs. The first, a program authorized in the Affordable Care Act, but to date not funded, is designed to recruit and train medical students to practice in rural America. The second is a new program, Clinical Training in Inter-professional Practice. HRSA has been emphasizing the importance of team-based care in all its training programs: this new program will help develop the academic infrastructure to support training in team-based service delivery. A third program is also new this year: the Health Workforce Diversity Program replaces the Health Careers Opportunity Program. Funding from this new program will help recruit and support students from disadvantaged backgrounds as they pursue training for health professions careers.

The Indian Health Service (IHS) maintains a program of health professions scholarships, loan repayments, health professions training grants and recruitment and retention activities. The FY2015 appropriation of \$48 million restored funding for this set of activities to earlier levels and the same level is requested for FY 2016. Most funds (\$30 million) are devoted to the loan repayment program. In the past, demand for loan repayment funding has exceeded available funds. In FY 2014, there were 118 health care providers who matched to an IHS site but could not be funded. The IHS works with HRSA to increase the number of IHS and tribal delivery sites eligible for placement of NHSC practitioners: currently 641 such sites have been deemed eligible and 376 NHSC scholarship and loan repayment participants are serving in Indian Health Service, urban Indian and tribal facilities.

ⁱ Sandra L. Decker, Two-Thirds of Primary Care Physicians Accepted New Medicaid Patients in 2011-2012: A Baseline to Measure Future Acceptance Rates, *Health Affairs*, 32, No. 7 (2013): 1183-1187.

<http://content.healthaffairs.org/content/32/7/1183.full.html>

Decker cites four studies from 2000 through 2012 to make this point.

ⁱⁱ Congress did not accept the Department's proposed one-year extension of the incentive payment for 2015. This year's proposal, as noted above, would extend the incentive payment to calendar years 2015 and 2016, make it available to nurse practitioners and physician assistants, and bar its use in hospital emergency rooms.

ⁱⁱⁱ Daniel Polsky, Michael Richards, Simon Basseyn, Douglas Wissoker, Genevieve Kenney, Stephen Zuckerman, and Karin Rhodes, Appointment Availability after Increases in Medicaid Payments for Primary Care. *New England Journal of Medicine*, (January 21, 2015)

<http://www.nejm.org/doi/full/10.1056/NEJMsa1413299#t=articleBackground> .

^{iv} See Medscape 2014 Physician Compensation Report.

<http://www.medscape.com/features/slideshow/compensation/2014/public/overview#2> In 2013 Family Medicine (\$176,000) and Internal Medicine (\$188,000) practitioners were at the low end of the annual compensation range while cardiologists, urologists, and gastroenterologists clustered near \$350,000.

^v The Lewin Group, Health Practitioner Bonuses and Their Impact on the Availability and Utilization of Primary Care Services, January 2015, . See also, pps. 35-36. Internet posting pending.

^{vi} Medicare Payment Advisory Commission, June 2010 Report to Congress, Chapter 4: Graduate Medical Education Financing: Focusing on Educational Priorities. P. 102 et seq. <http://goo.gl/SKvztY> Accessed February 5, 2015

^{vii} An IME payment is an adjustment that is made to each teaching hospital inpatient Medicare case to account for the additional costs associated with training residents.

^{viii} Barbara Wynn et al. Working Paper: Alternative ways of financing medical education. Office of the Assistant Secretary for Planning and Evaluation, May 2006. <http://goo.gl/LcN4FX> Accessed February 5, 2015

^{ix} IOM (Institute of Medicine. 2014. *Graduate medical education that meets the nation's health needs*. Washington, DC: The National Academies Press. <http://www.iom.edu/Reports/2014/Graduate-Medical-Education-That-Meets-the-Nations-Health-Needs.aspx> Accessed February 5, 2005.

^x The Teaching Health Center Graduate Medical Education Program was extended for FYs 2016 and 2017 by the Medicare Access and CHIP Reauthorization Act of 2015 with funding of \$60 million each year.

^{xi} Health Resources and Services Administration, Justification of Estimates for Appropriations Committees, FY 2016, p. 77. <http://www.hrsa.gov/about/budget/budgetjustification2016.pdf> accessed February 7, 2015.

^{xii} Sebastian Negrusa, Projesh Ghosh and John T. Warner. Provider Retention in High Need Areas. The Lewin Group. December 2014. Pps 1-2. Internet posting pending.

^{xiii} Geographic HPSAs must be a rational service area for primary care services and can be single counties, contiguous counties, a portion or portions of counties, or established neighborhoods or communities in metropolitan areas.

^{xiv} *Ibid.*, p. 22.

^{xv} *Ibid.*, pps 27-28.

^{xvi} *Ibid.*, pps 20-22

^{xvii} Highlights from the 2012 National Sample Survey of Nurse Practitioners, National Center for Health Workforce Analysis, 2014 <http://bhpr.hrsa.gov/healthworkforce/supplydemand/nursing/nursepractitionersurvey/> Accessed February 11, 2015

^{xviii} Projecting the Supply and Demand for Primary Care Practitioners through 2020. National Center for Health Workforce Analysis, 2013, <http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/> accessed February 12, 2015.

^{xix} Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners, Weststat, 2015. Internet posting pending.

^{xx} Version 2.0 was released in March. Files for 2008 through 2013 and user documentation are available through ResDAC: <http://www.resdac.org/cms-data/files/md-ppas> DUA restrictions apply.