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Strategies to Address Physician Shortages in Rural and Underserved Communities

Congressional Staff Briefing

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Program

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Our Thanks to Our Briefing Sponsor: The Congressional Academic Medicine Caucus

CAMC Co-Chairs
Rep. Kathy Castor (D-FL) and Phil Roe, M.D. (R-TN)

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AAMC: Med. Schools, Hospitals, MDs

Membership includes:

• **141** U.S. medical schools (MD programs)
  - Nearly 300 major teaching hospitals
  - Each = 4+ approved/active residency programs
• **41** Department of Veterans Affairs medical centers
• **93** Academic and scientific societies

Over **300,000** “voices:

• **128,000** faculty members
  - Faculty in basic science and clinical departments
  - Staff of physician practice groups and hospitals
• **86,000** medical students and **110,000** residents
Examples of Federal Programs that Incentivize Physician Training and Practice in Rural and Underserved Areas

1. “New” Teaching Hospitals in Medicare
2. Medicare Rural Training Track
3. Federal Loan Forgiveness Programs such as NHSC
4. Federal Grant Programs such as Title VII
5. Conrad 30 J-1 Visa Program
Research Shows: Where Physicians Train Influences Where They Practice

Physicians who attend medical school and residency training in same state = more likely to stay to practice
  ▪ More than 66%

Physicians who receive $ support linked to practice location = more likely to stay in underserved areas
  ▪ E.g. NHSC

International medical graduates (IMGs) are as likely as USMGs to practice in underserved areas
  ▪ Eg: Conrad 30 J-1 Visa Program

We Can Help Hospitals to Become Teaching Hospitals but It’s Challenging

Major Teaching Hospitals = Only 5% of All Hospitals

Major teaching hospitals % of all hospitals varies by state. Eg:

- Kansas – 0.6%
- Texas – 2%
- Colorado – 2%

VS

- Mass. – 15%
- New York – 25%
- Wash., DC – 31%

Medicare law permits hospitals to become new teaching hospitals:

AAMC has prepared guide to help them and offers assistance

There is another way to see these numbers…
In pink states, less than 10% of hospitals are teaching hospitals.
States with Fewer GME Slots than UME Enrollment: Pink States Import Docs

Source: AMA Physician Masterfile, December 31, 2011
Data compiled by the AAMC Center for Workforce Studies
416 active physicians have missing GME state code or GME in the territories
Donor States: Rural States Depend on Other States to Train their Physicians

California is an example. It trains physicians for every state, including all rural states.
North Carolina Also Illustrates – It Imports 3,000+ More Residents from 23 States than It Exports

Figure 4. North Carolina’s trade surplus/deficit: resident physicians

Data Source: AMA 2009 Physician Masterfile.
Notes: Includes only clinically active, non-federal, non-resident in training, non-locum tenens physicians. Three physicians were missing practice state: 570 physicians practicing in North Carolina were missing residency state.
Produced by: Program on Health Workforce Research & Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill
Idaho: A Net Importer of Physicians

Source: AMA Physician Masterfile, December 31, 2010. Data compiled by the AAMC Center for Workforce Studies

Note: 130 active physicians have missing GME state code or GME in the territories
Wyoming: Net Importer of Physicians

Source: AMA Physician Masterfile, December 31, 2010. Data compiled by the AAMC Center for Workforce Studies
Note: 33 active physicians have missing GME state code or GME in the territories
The Medicare Rural Training Track

Rural and urban hospitals can team up to train more residents with Medicare support

Balanced Budget Act capped Medicare GME slots at 1996 levels.

- Unlike other hospitals, caps do not apply to “critical access hospitals.”
- Rural hospitals get a higher cap – 130% of their 1996 level. They can also expand their caps to add new programs.

Rural training track program enables rural & urban hospitals to partner for primary care training.

- Residents must train at rural site for more than half of training
- Urban hospitals allowed to receive additional Medicare GME funding above their cap.
- Rural hospitals also receive Medicare GME funding.
AAMC’s New Rural Training Track Guide

A guide to help hospitals take advantage of the Rural Training Track Option
National Health Service Corps (NHSC)

There are shortages of doctors in low-income, rural/urban areas - medically underserved areas

NHSC provides loan repayment to physicians who go to underserved areas after residency

- Also scholarships to medical students

NHSC proven to address maldistribution of docs

- 55% of NHSC clinicians stay in underserved areas at least 10 years

Congress renewed mandatory NHSC program for a minimum of 10 years.

- Yet to approve annual discretionary spending
Title VII Funding for Health Professionals

Title VII of PHSA helps address geographic distribution, specialty shortages by authorizing grants for education & training:

- Workforce **supply**, including primary care and interdisciplinary educational opportunities
- Workforce **distribution**, including training opportunities in rural and underserved settings
- Workforce **diversity**, including recruitment, retention, and faculty development


Separately AAMC recommends $300 million for CHGME.
Conrad 30 Waiver Program allows up to 30 J-1 visa docs per state to receive a waiver of the 2-year residence rule after completion of the J-1 exchange visitor program.

In order to receive such a waiver, the J-1 medical doctor must:

Agree to be employed full-time at a health care facility located in an area designated as a:

- Health Professional Shortage Area (HPSA)
- Medically Underserved Area (MUA), or
- Medically Underserved Population (MUP).

Many states currently max out their 30 waiver slots.
“Conrad 30” Program Has Big Impact

“Conrad 30 Program” vs. National Health Service Corps Field Strength

NHSC  Conrad 30
“Conrad 30” Program Has Big Impact on Both Primary and Specialty Care

New Conrad 30 Physicians by Discipline

Source: AAMC analysis of data from HRSA and Texas State Department of Health annual survey of state Conrad 30 programs
Today’s Presentations

Michelle A. Nuss, M.D., FACP
Campus Associate Dean for GME and Designated Institutional Official
Georgia Regents University/ University of Georgia Medical Partnership
Campus, Athens, GA

Connie Berry, M.A.
Manager, Texas Primary Care Office
Texas Department of State Health Services, Austin, TX
AAMC Recommendations For Federal Action

And Other Challenges...
How Do We Address Rural and Underserved Area Shortages of Physicians?

AAMC recommends a comprehensive strategy:

Promote innovations in health care delivery – new ways to deliver care – team-based care, technology, etc.

Strengthen federal investment in programs such as NHSC, Title VII that address maldistribution in rural, poor, underserved areas

Expand IMG visa waiver programs

Increase residency slots Medicare will support

- Help hospitals that want to become teaching or take advantage of rural training track
- Champion accountability for use of GME funds
- Lift Medicare GME cap modestly by 3,000 per year
Legislation to Lift Medicare Cap on # of Residents Medicare Will Pay for at Established Programs

The Resident Physician Shortage Reduction Act of 2015

- **H.R. 2124** by Reps. Joseph Crowley (D-NY) and Charles Boustany, Jr., M.D. (R-LA).
- **S. 1148** by Sens. Bill Nelson (D-FL), Chuck Schumer (D-NY), and Harry Reid (D-NV)
- **Lifts Cap** Increases, by 15,000 – 3,000 per year – the number of Medicare direct graduate medical education (DGME) and indirect medical education (IME) slots.
- **Report to Congress** Requires National Health Care Workforce Commission to submit report to Congress by 1/1/18, identifying physician shortage specialties.
- **GAO Study** Requires Government Accountability Office study on strategies for increasing health professional workforce diversity.
$$$ per Capita Not Necessarily a Wise Way to Analyze Policy
Other Challenges

"Recruiting physician faculty for new programs in community and ambulatory settings is challenging because the community physicians feel it is difficult to devote the time to teaching, at the expense of reduced practice income and decreased clinical productivity. Faculty members are also concerned that they lack the expertise in teaching methodologies to assure quality educational outcomes and support for self and learner needs."

22nd Report of the Council on Graduate Medical Education (COGME), November 2014
Challenges and Opportunities

- Educational pipeline
- Broader issues in recruiting to rural areas
- Short time for new teaching hospitals/RTTs to build to a new Medicare cap
- 18 year existing Medicare cap on support
- Challenges to other access approaches, e.g., telemedicine
Questions and Answers
Encourage Your Member of Congress to Join the Academic Medicine Caucus

Rep. Roe’s office:  
John.Martin@mail.house.gov

Rep. Castor’s office:  
Elizabeth.brown@mail.house.gov

*If your Representative was a member in the 113th Congress, he or she will automatically be rejoined. If they no longer wish to be a member, we ask that they opt-out of the caucus.

For more info on the caucus:  www.aamc.org/CAMC
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