Office for Oregon Health Policy and Research

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MEMO

July 1, 2014
To: The Oregon Health Policy Board
From: Healthcare Workforce Committee

The Healthcare Workforce Committee is pleased to submit this policy options memo to the Health Policy Board. This memo fulfills the following deliverable request:

A policy options memo, developed in consultation with representatives from Oregon Health & Sciences University and the College of Osteopathic Medicine of the Pacific-Northwest, for increasing the number of family medicine and other primary care medical residencies in Oregon. The memo should consider options including but not limited to: the creation of new community-based primary care residency programs; a GME consortium approach to support regional primary care residencies; and strategies for increasing the proportion of primary care residences within the current GME residency cap for Oregon.

For ease of understanding, the Committee is including a matrix of the options and criteria against which the options are analyzed in Appendix A.

The Committee would like to highlight the recommendation that Oregon establish a Graduate Medical Education Primary Care Consortium. After speaking with many stakeholders, the energy and excitement generated by this idea is clear. A Consortium would allow stakeholders to share the cost, the risks and the rewards of a new residency program.

As further evidence of the viability of a GME Primary Care Consortium, the OEBB/Moda Health Grant program asked for a proposal for funding the startup and planning costs for a primary care residency program or consortium serving rural and underserved communities in Oregon. Although this funding has not been finalized, the chances are good that the OEBB/Moda Health Grant program will make a contribution. The Area Health Education Center Southwest has agreed to carry the fiduciary responsibility for the grant, should it be awarded, and will host meetings of stakeholders. It is expected that stakeholders will contract with a GME consultant to lead them through the complicated process of developing a business model for a GME Primary Care Consortium.

The Healthcare Workforce Committee believes there is an important role for the Board and for the Oregon Health Authority as the consortium concept moves forward. Involvement on the planning committee by OHA staff and possibly a voting membership for the Board or the Health Authority in the Consortium are appropriate given the impact a GME Primary Care Consortium could have on the triple aim of health reform in Oregon.

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OREGON HEALTH POLICY BOARD
Healthcare Workforce Committee

Expanding Graduate Medical Education

Policy Options Memo for the Oregon Health Policy Board

7/1/2014

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Executive Summary

The supply of primary care providers requires immediate action if Oregon's health reform efforts are to be successful. In addition to the general shortage, Oregon's rural areas are suffering even more acutely. One promising tactic is to train physicians in underserved or rural areas of the state by providing a primary care focused Graduate Medical Education residency program or programs in or near areas where more primary care physicians are needed.

In response, the Oregon Health Policy Board requested that the Healthcare Workforce Committee produce an analysis of options for expanding primary care GME in Oregon. The resulting policy options memo analyzes three categories of options:

1) Relying on hospitals in rural or underserved areas to create independent residency programs. This option requires a significant investment by the hospital putting an independent program out of reach of many rural hospitals.
2) Developing a GME Primary Care Consortium. Primary care consortia share the risks and costs of residency program development. There are several different options and business models for consortia from loosely connected, voluntary groups, to consortia established in statute.
3) Encouraging expansion of primary care residency FTE slots and more rural rotations within existing residency programs by shifting existing residency slots into primary care specialties. This can be accomplished voluntarily by the current programs or can be encouraged by tying incentive or accountability measures to any state funding for GME.

Expanding or establishing residency programs is expensive and is constrained by the requirements of the Balanced Budget Act of 1997. This Act put a cap on the number of residency slots a program is able to offer. Existing programs are effectively limited to the number of FTE they had in 1997. New programs have a three year window to develop a program before the cap is implemented.

New programs must go through a lengthy accreditation process, attract directors and faculty, and be able to convince students to attend the new program rather than a more established residency program. Because of the expense of developing new programs independently and the barriers in place to expanding existing programs, the Healthcare Workforce Committee recommends that a GME Primary Care Consortium be developed. Stakeholders would determine the business model for the Consortium but its functions would likely include recruiting faculty and residents, assisting with application for accreditation and could include running one or more residency programs. A GME Consortium would allow all those who would benefit from a community-based primary care residency program to participate, to share the risks and rewards and support each other through the process.

I. Background

The Oregon Health Policy Board charged the Healthcare Workforce Committee with producing a memo outlining options for increasing family medicine and other primary care medical residencies in Oregon. The Board asked the Committee to work in consultation with representatives from Oregon Health & Science University and the College of Osteopathic Medicine of the Pacific-Northwest. The Board asked that the options include a consortium approach to support primary care residencies, the creation of new community-based residency programs and strategies for increasing the proportion of primary care residencies.

To fulfill this charge, the Healthcare Workforce Committee reviewed current literature, met with experts in the field of Graduate Medical Education in Oregon, held a summit to discuss viable options and conducted phone interviews with representatives of GME consortium programs in five states that are using differing approaches to address the shortage of primary care residencies. The memo will outline five separate options and analyze them for administrative and financial feasibility, their potential impact on the problem, whether or not legislative action is needed, and essential partnerships.

The Healthcare Workforce Committee will also make a recommendation on which of the options the Board should endorse and provide an analysis of this option's strengths, weaknesses, opportunities and threats.

A. Brief history of GME nationally

The Accreditation Council for Graduate Medical Education (ACGME) certifies nearly 9,000 medical residency programs in the United States[i] with over 113,000 residents and fellows receiving training.[ii] According to the 2013 Osteopathic Medical Profession report, the American Osteopathic Association certifies 942 programs training 10,759 residents.[iii] This number will not meet future needs. Although there is variability in the predicted growth in demand for providers across the state, what is clear is that the current demand for providers outpaces the supply. There is variation geographically from a projected .7 to 5 percent across states and from 0 to 76 percent across primary care service areas. The variation is due to differing methodologies and to the unpredictability of the outcomes of health reform. The Association of American Medical Colleges (AAMC) estimates a shortage of 45,000 primary care physicians and 46,000 specialists by 2020 as a result of population growth, the aging and longer lifespan of baby boomers, and retiring physicians.[iv] The American Medical Association predicts that the national primary care workforce would need to grow 24 percent by 2015 to meet projected need.[v] In addition, most primary care

physicians are working in metropolitan areas, compounding the need in rural and underserved areas.

In Oregon, the baseline projection between 2013 and 2020 for physicians, nurse practitioners and physician assistants is 16 percent growth over current demand. There is variability across counties, from, for example, 9.3 percent growth rate in Umatilla County to 28.5 percent in Curry County. Growth in demand would also be affected by implementation of health information technologies, team based care and the state's commitment to reducing the growth of Medicaid.[vi]

Even if medical schools can increase the number of medical students choosing a primary care specialty, the number of residency positions in the United States is effectively limited by a cap on federal funding established by the Balanced Budget Act of 1997.[vii] Most graduate medical education is funded through payments from Medicare which totaled an estimated $9.5 billion in 2010. Of that amount, $3 billion was in the form of direct payments (DME) to hospitals for residents' and their supervising physicians' salaries and $6.5 billion were indirect payments (IME) to hospitals to cover the increased cost of running a teaching hospital.[viii] This funding is essential as it is estimated to cost $113,000 per year to train one resident in a primary care specialty.[ix]

Although the cap does not limit the development of new residency programs or preclude GME programs funded by other means, the Balanced Budget Act cap limits the number of residencies funded by Medicare in established programs to the number being trained in 1997. Furthermore, because most residency programs in 1997 were located on the East Coast, the cap has exacerbated the disparity in available residency positions between the western and eastern United States[x]. Additionally, the Budget Control Act of 2011 enacted a series of automatic budget cuts that included a 2% cut for IME payments that took effect on April 1, 2013.[xi] Some hospitals provide private funding for residencies in specialties the particular hospital wants to emphasize or in which there is a demand for services.

Some states, including Oregon, provide funding to residency programs within their state using Medicaid funds. These funds are not restricted by the cap in the Balanced Budget Act of 1997 but are small in comparison with Medicare funding.

Some hospitals and states, again including Oregon, are also providing rural rotations for residents, allowing them to practice for a period of time in a rural or underserved community. In Utah, for example, the state offers four week rural rotations in primary care medical specialties and pharmacy, providing housing, transportation and per diem for the residents. The state is tracking the success of these rotations in attracting physicians to rural Utah and is finding that family medicine residents who complete rural rotations are more likely to work in rural Utah than residents in other specialties completing rural rotations. [xii]

Anticipating a projected shortage of primary care physicians, the Affordable Care Act included a few provisions for GME. The Primary Care Residency Expansion program provided $168 million over five

years in grant funding to expand primary care residency programs using community-based health centers, called Teaching Health Centers. In the Teaching Health Centers programs, residents train primarily in community health centers rather than in hospitals. The new GME positions had to be over and above the current number of primary care GME positions even if they then exceeded the Medicare cap. It is projected that this program will support the training of 900 new residents in family medicine, general internal medicine and general pediatrics. This program expires in 2015.[xiii]

An attempt within the Affordable Care Act to increase GME in states with lower population was through the Graduate Medical Education Residency Redistribution (Section 5503 of the ACA). This section allowed 65 percent of unused residency slots to be given to hospitals meeting criteria outlined in Section 5503. Seventy percent of the unused slots were allocated to states in the lowest quartile of population and the remaining 30 percent were allocated to hospitals in rural areas or states with the highest percentage of their population living in Health Professional Shortage Areas. Although this well-intentioned provision was championed by primary care advocates, of the 58 qualifying hospitals, only five were located in a rural area.[xiv]

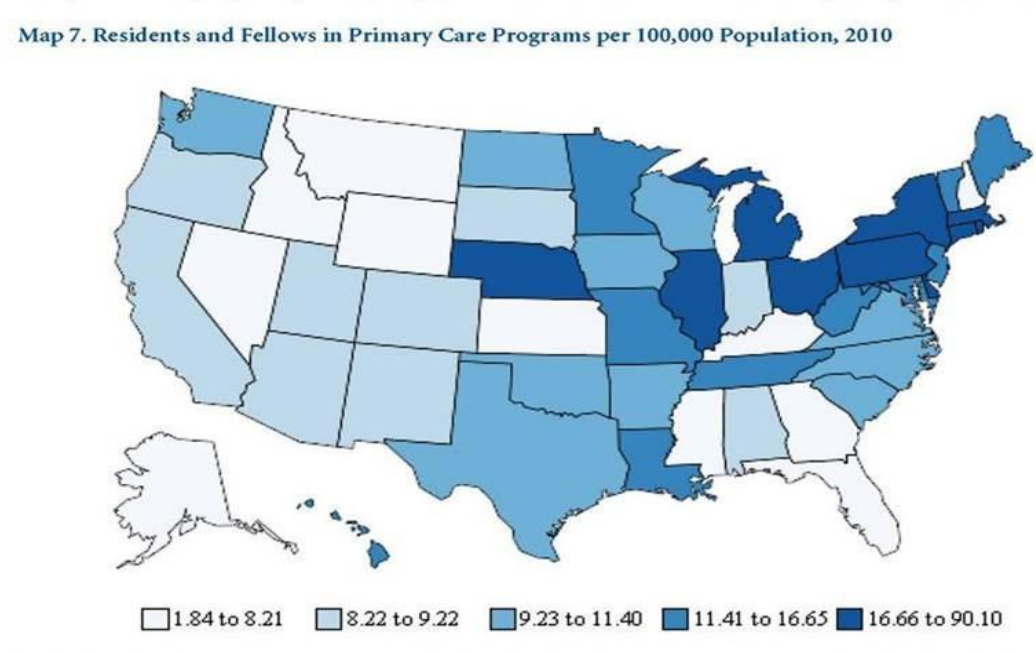
B. Oregon's GME history and current status

There are too few primary care physicians in rural and underserved areas in Oregon. Even if medical schools in the state increased the numbers of medical students graduating in these specialties, there aren't sufficient residency slots in which to place them. Insufficient family medicine residency slots results in the loss of Oregon's new physicians to states with available family medicine residency positions.

In addition, rural and underserved parts of Oregon have very few residency programs. This forces most new physicians who want to stay in Oregon and practice in primary care to complete their residencies in urban areas where the majority of them will eventually settle.

The Association of American Medical Colleges' Center for Workforce Studies reported that in 2011, Oregon had 861 residents or 22.3 residents per every 100,000 population. Oregon's ranking among states is 38th in residents per capita.[xv] The largest number of residencies in Oregon are concentrated at Oregon Health & Science University, however three health systems, Providence Health & Services, Legacy Health Services, and Samaritan Health Services, and one community-based health center, Virginia Garcia, offer residencies.

Oregon's primary care residencies are in even shorter supply. In 2011, there were only 8.4 primary care residencies per every 100,000 in population, putting Oregon at 40th in the nation.[xvi] This translates into only 27 first year primary care residency slots in three residency programs.[xvii]



Association of American Medical Colleges, 2013 State Physician Workforce Data Book

In response to the lack of primary care residencies in rural Oregon, Cascades East Family Medicine Center, cosponsored by OHSU, Sky Lakes Medical Center in Klamath Falls and Oregon's Area Health Education Center trains eight residents per year in family medicine. Most of the rotations are in Klamath Falls, but include rotations in Burns, Reedsport, Lakeview and Bend.

Providence Hood River Memorial Hospital launched a family medicine residency rural training track in partnership with One Community Health (formerly La Clinica). Two residents per year begin their training in Portland and see patients in Hood River a few days per month, but spend the last two years of their program in Hood River under the supervision of One Community Health.

There has been interest in the past several years in creating new residency programs. At least two hospitals and one health system have begun the planning process, but have stalled due to uncertainties in sustainable funding or shifts in leadership priorities. At least one collaborative, including representative from OHSU, AHEC, PeaceHealth /Sacred Heart in Eugene, Asante Health in Grants Pass/Medford, St. Charles Medical Center in Bend, Providence Health and Services and Salem Health has formed and begun planning, but again, had difficulties overcoming barriers due to funding.

In Oregon, Graduate Medical Education is funded primarily through Medicare IME payments and, to a lesser extent, Medicare DME payments. Oregon also provides $57 million per biennium in GME funding through Medicaid.

C. Recruitment and retention of family medicine providers

Increasing residencies in primary care specialties, particularly in family medicine, in rural or underserved parts of the state, addresses capacity problems in several ways. First, the residents practicing in underserved communities provide much needed access to health care for members of the community.

Second, physicians in rural residencies are much more likely to settle in those communities to build their practice.[xviii] According to the Physician Workforce Data Book, in Oregon, 46 percent of physicians who completed medical school in Oregon stayed in Oregon to practice and 53 percent of physicians who completed their residency in Oregon stayed in the state. However, 70 percent of physicians who completed both their medical school education and residency in Oregon remained in the state to practice.[xix]

Third, increasing residencies in primary care specialties increases opportunities for graduating medical students to practice in those specialties.

II. Policy Options

To address these problems, the Healthcare Workforce Committee investigated several options to increase the number of family medicine residencies in Oregon located in rural or underserved areas of the state. Options analyzed include:

- Establishing new, individual primary care residency programs: A hospital or health system takes on program development and funding individually.

- Creating a consortium: Stakeholders join to share costs and risks depending on the level of stakeholder involvement.
    - Consortium option 1: Voluntary member group that is loosely structured to provide support to residency programs
    - Consortium option 2: Independent nonprofit organization with 501(c)(3) status that can provide a broad range of support, from supplying assistance with accreditation and faculty development to actually developing a residency program or programs.
    - Consortium option 3: Statutorily established consortium with level of authority over funding and operational decisions granted by a state legislature.

- Increasing primary care residencies while staying within the cap: Changing the proportion of primary care residencies in the state.

- Existing residencies option 1: Current residency programs voluntarily increase the proportion of residencies they dedicate to primary care specialties.
- Existing residencies option 2: Attach accountability or incentive measures to the state's Medicaid GME funding to influence the proportion of residencies dedicated to primary care specialties.

The options are analyzed below for impact, feasibility, cost, partners required and whether or not legislative action would be necessary. The Committee asked staff to speak with GME program representatives in other states to determine how they have addressed the problem and identify lessons learned. Information learned from these conversations is detailed below.

A. New individual primary care residency programs – without consortium support

To avoid the constraints of the cap imposed by the Balanced Budget Act of 1997, hospitals without current residency programs can establish new residency programs. The programs then have three years to expand before a cap is placed on the number of residency slots for which they will receive Medicare funding.

Impact on problem- High, depending on scope: New family medicine residency programs established in rural or underserved communities could increase the total number of residency slots in family medicine and assist in remedying the health professional shortages in those communities. The overall impact would depend on the number of slots created and the effectiveness of the recruitment effort for graduating medical students.

Financial and administrative feasibility - Low: Creating new residency programs entails significant financial and administrative investment. To meet accreditation standards, residency programs must have a high level of appropriate oversight, an education faculty in place, a medical director on board, and a structure for receiving and distributing federal funds, to name just a few. Family medicine residency programs are also required to operate or have access to a primary care clinic. These requirements, and high start-up costs, estimated at a minimum of $2 million by stakeholders exploring establishing an independent family medicine residency in Roseburg, Oregon, make this option unfeasible for most local community hospitals or clinics.

In addition, many rural hospitals are designated by the Centers for Medicare and Medicaid Services (CMS) Sole Community Hospitals. A hospital paid under the Medicare IPPS is eligible to be classified as a SCH if it is located at least 35 miles from "other like hospitals" or it is rural (located in a rural

area), located between 25 and 35 miles from other like hospitals AND meets one of the following criteria:

- No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital or, if larger, within its service area; or
- The hospital has fewer than 50 beds and would meet the 25 percent criterion above if not for the fact that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital;
- The hospital is rural and located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years; or
- The hospital is rural and because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

Since Sole Community Hospitals are eligible to receive Medicare reimbursement at their hospital-specific rate, rather than the rate established by the Inpatient Prospective Payment System (IPPS), they are not eligible to receive IME payments for their residents.[xx] The current list of communities ineligible for IME payments because their hospitals are receiving enhanced payments from the Centers for Medicare and Medicaid Services are: Coos Bay, Bend, The Dalles, Corvallis, Klamath Falls, Redmond and Roseburg.

Partnerships – Clinic partner, Medical schools, area hospital

Legislative action - None required: Given the high cost of establishing an independent residency program, however, stakeholders may want to ask for funding from the state for start-up costs which would require legislative action.

B. Consortia and Networks

Many states have taken advantage of the consortium model provided as an option for new program funding through the Balanced Budget Act of 1997 to establish residency programs. The description of a consortium in the Balanced Budget Act follows:

> *"The Secretary shall establish a demonstration project under which DGME payments would be made to "qualifying consortia." A qualifying consortium is defined as a teaching hospital with one or more approved medical residency training programs and one or more of the following entities:*
>
> - *A school of allopathic or osteopathic medicine;*

- *Another teaching hospital, which may be a children's hospital;*
- *A federally qualified health center;*
- *A medical group practice;*
- *A managed care entity;*
- *An entity furnishing outpatient services; or*
- *Another entity deemed appropriate by the Secretary.*

The members of the consortium must agree to participate in the training programs that are operated by the entities in the consortium, and must agree on a method for allocating the payment among the members. The members also must agree to any additional conditions established by the Secretary. The total payment to a qualifying consortium for a fiscal year cannot exceed the amount that would have been paid to the teaching hospital(s) in the consortium. Payments will be made in proportion from each of the Medicare trust funds as the Secretary specifies." [xxi]

There are many variations of this model, a few of which are detailed below.

1. Voluntary member group/ Network

Some states have created less formal networks or councils that may not have funding authority, but have informal authority over certain aspects of residencies, provide centralized or coordinated operations for multiple residency programs, act as collectors of workforce data, offer trainings or materials and, in some cases, act as advocates for increased funding or attention from their state government, hospitals or medical schools.

Impact on problem – Moderate to low**,** depending on strength of partnerships: Although some voluntary partnerships have resulted in an increase of residency slots through advocacy for funding, most networks provide only indirect support of already established residencies.

Financial and administrative feasibility – High: Support and coordination can be achieved through established programs such as the state's Area Health Education Centers (AHEC) or the Office of Rural Health, capitalizing on infrastructure already in place. This reduces the administrative burden and reduces funding needed for start-up.

Partnerships – The benefits of a network accrue primarily to members of the network, so the network is improved as partners come to the table. Ideally, all entities with a stake in primary care Graduate Medical Education and increasing family medicine and other primary care physicians in underserved areas would participate. Partners could include FQHC's, teaching hospitals, other clinic partners, medical schools, and health professional training programs.

Legislative action – None needed

State example – Montana: The Montana Graduate Medical Education Council (MGMEC)

Montana, with a relatively small population, had only one GME program located in Billings, and a difficult time recruiting physicians. In 2011, the state convened the MGMEC using the resources of the state's AHEC to administer and staff the Council. The Council is charged with tracking and measuring the health care workforce, coordinating the development of new residency programs and nurturing relationships with providers.

Although the Council has no authority over GME decisions or funding streams, they have been very successful at bringing together influential partners. Council members include the Provost of Montana State University, the Dean of Medical Education at the University of Montana, representatives from the hospital and health care provider association and the American Medical Association, the residency directors, hospital administrators and representatives from the regional AHECs, state AHEC and Office of Rural Health. These partners successfully lobbied the state legislature for increased funding for new family medicine residency programs located in more rural areas of the state.

The Council has increased available residency slots from six per year in Billings alone to 22 per year in Billings and Missoula. All the residencies are in primary care, including family medicine, with three specifically dedicated to internal medicine. The Council has achieved this with no direct budget for the consortium. The state's AHEC director is hoping for some state funding for at least a .5 FTE to help coordinate the Council and conduct data analysis, for a total funding request of between $60,000 and $100,000.

2. Independent, Nonprofit (501(c)(3)) Consortium

Impact on problem – Moderate to high, depending on funding and support from partners and stakeholders – A consortium approach through a nonprofit organization has the potential to create new residency slots and locate them where the members of the consortium want them. This type of approach gives decision-making authority to consortium members.

Financial and administrative feasibility – Moderate (compared to establishing an independent residency program) – As noted above, start-up costs for new residency programs are high and the administrative burden is great. However, with a consortium approach, these burdens are shared among members. Consortia organized as nonprofit organizations are required to have governance boards with fiduciary and operations accountability and oversight. A nonprofit organization can also function as a financial umbrella organization, receiving funds from various partners and distributing the funds as agreed upon by the Board. Although the burden is still heavy, sharing the cost and administration among partners makes this option much more feasible than establishing a new, independent residency program.

Partnerships- All organizations benefitting from the residency program need to be involved in the initial planning and creation of the organization. In some cases, Board members of a 501(c)(3) contribute equally to the organization. In this model, Board membership is often limited to representatives of organizations that have provided funding or who are major stakeholders.

Legislative action – None needed - The basic authority to establish a nonprofit entity comes from the state and federal government; however, no legislative action is necessary to establish the consortium Board and bylaws. Legislative action would only be required if the consortium needed additional state funding or if members of the consortium or stakeholders wanted to mandate participation.

State example – Modesto, California: The Valley Consortium for Medical Education

The Valley Consortium was developed in response to the closing of the only family medicine residency program in the county. Closing the program meant not only losing the physician recruitment benefits of a residency program, but also leaving 70,000 low-income residents of the county without access to the care that had been provided by the residents.

The crisis spurred the formation of a consortium of traditionally competitive partners including a for-profit health center, a not-for-profit health center, the county community health center and a Federally Qualified Health Center look-alike which provided care to the county's very low-income residents. Consortium members provided startup funding through an assessment on all partners. Initial administrative and legal fees were approximately $70,000. This amount included hiring consultants to work with state and federal partners and facilitate the newly-formed partner group and establishing a nonprofit organization.

Subsequent costs for the establishment of a residency program included the cost of accreditation, hiring faculty and staff, hiring the first residents and further legal and administrative costs. These costs were paid for with a $200,000 annual investment from each of three partners as well as a $2.5 million Teaching Health Center grant. It is anticipated that all future costs of running the program will be paid for with federal GME funds; however, consortium partners have committed to contribute in the event of a shortfall.

The result is a consortium that provides 30 family medicine residents to the consortium partners and the community. All business operations of the residency program, and any future residency programs, are run through the consortium, including all Medicare GME payments and any state or grant funding. [xxii]

3. Statutorily-established consortium

Impact on problem – Moderate to high, depending on level of authority. A consortium established in statute could have control over new funding, over any potential accountability and incentive measures tied to state money and could bring influential members to the table. These factors could create an environment where impact on the problem would be high.

Financial and administrative feasibility - Moderate This option requires establishing a new bureaucratic entity with all of the administrative constraints a government entity imposes. Although this type of structure would not support establishing and running a residency program, it would need to comply with government hiring regulations, oversight measures and other administrative rules and procedures.

The costs for establishing this type of consortium would be restricted to establishing and maintaining the consortium structure as this entity would not be operating the actual residency program.

Partnerships – Health systems, hospitals and clinics, medical schools

Legislative action – Yes

State example – Utah: The Utah Medical Council

The Utah Medical Council was established by statute in 1997 and created as a quasi-public entity. The Board has eight Governor-appointed members including representatives from teaching hospitals, private and public hospitals, representatives from health insurance plans and three at large members. The Council functions as a neutral body where these potentially competitive members can collaborate.

The Council's charge is three-fold: 1) To increase funding to GME and to advise on how to spend those funds; 2) To conduct studies on the health care workforce; and 3) To operate a rural rotation program for medical and pharmacy students.

The Council has been successful on all three fronts. By looking closely at every rotation and tracking each resident's time, they were able to increase the reimbursements from Medicare to the teaching hospitals. They have produced workforce reports that have guided GME policy in Utah. The rural rotation program is fully operational and the Council is tracking how many of those residents eventually practice in rural Utah.

At this time, the Utah Medical Council is not charged with increasing residency slots, however they are looking into increasing state and federal funding and acknowledge that to make a real difference, they need to find new sources of funding for residency FTEs.

The Council is funded at about $1 million per year, half coming from the state legislature and half coming from the teaching hospitals. The investment by the hospitals is voluntary, so the Council needs to demonstrate value in order to maintain that funding source.

C. Expanding current family medicine residency FTEs

Expanding current family medicine residency FTEs is an option available to states whether or not new residency programs or consortia are established. In fact, Options 1 and 2 could provide momentum for individual or consortium-based programs to develop.

1. Requesting that currently operating GME programs voluntarily allocate more of their residency slots to primary care

Impact on Problem – Low to moderate – The impact depends on the willingness of existing programs to commit significant resources. Since the reallocation would be completely voluntary, some institutions may not follow through. In addition, although allocating more slots to primary care would address the need for more primary care residencies, it wouldn't necessarily address the issue of meeting the needs of rural or underserved areas of the state.

Financial and administrative feasibility – Administratively easy, financially challenging – Since these programs are already operating, infrastructure is in place, faculty is trained (although additional training in family medicine or other primary care specialty may be needed) and financial systems are functioning. However, institutions receive significant revenue from certain residency specialties and may be unwilling to shift resident FTEs into less lucrative specialties such as primary care.

Partnerships – None needed

Legislative action – None needed

2. Directing Medicaid funds to programs meeting accountability or incentive measures

Currently Oregon allocates $57 million per year in Medicaid payments to the state's teaching hospitals.[xxiii] Unlike payments from the Medicare program to the teaching hospitals, the state has control over the spending of Medicaid funds and could tie those funds to measures such as number of residency slots allocated to family medicine or other primary care specialty, or the number located in a rural community.

Impact on problem – Moderate to high – Although the Medicaid funding is a small part of overall GME funding, it is still a significant amount. Training primary care residents costs approximately

$113,000 per year and Medicaid funding makes a valuable contribution. Tying this money to statewide objectives and appropriate physician workforce development could have high impact on the state.

Financial and administrative feasibility – Easy – A process and administrative structure for allocating these funds already exists. Although some investment of time and resources would be needed to develop the new measures and funding formula as well as an evaluation plan, the investment is minimal compared to the other options above.

Partnerships – Hospitals currently receiving GME, health policy experts, health system representatives – Stakeholder engagement needed if current funding formula is to be changed.

Legislative action – None needed

State Examples: *In 2009, ten states linked their Medicaid DME and/or IME payments to state policy goals for the health care workforce. These goals included encouraging training in specific specialties or settings, increasing the supply of health professionals serving Medicaid beneficiaries and improving the geographic distribution of the healthcare workforce. In one state, Kansas, Medicaid payments were also linked to funding teaching programs that have experienced Medicare GME cuts. Since 2009, some states have reduced or eliminated Medicaid GME funding.*

The table below shows the ten states using Medicaid DME/IME funds to encourage meeting state policy goals and which goals they are emphasizing.

States Linking Medicaid Direct and Indirect GME Payments to State Policy Goals, 2009

State	State Policy Goals that apply to Medicaid DGME and/or IME payments	Applicable to Fee-for-Service or Managed Care?
Alaska	• Encourage training in certain specialties (e.g. primary care) • Encourage training in certain settings (e.g. ambulatory sites, rural locations, medically underserved communities) • Increase the supply of health professionals serving Medicaid beneficiaries • Improve the geographic distribution of the health care workforce	Fee-for Service
Arizona	• Increase the supply of health professionals serving Medicaid beneficiaries	Both
Florida	• Encourage training in certain specialties (e.g. primary care) • Encourage training in certain settings (e.g. ambulatory sites, rural locations, medically underserved communities)	Fee-for-Service
Kansas	• Encourage training in certain specialties (e.g. primary care) • Encourage training in certain settings (e.g. ambulatory sites, rural locations, medically underserved communities) • Increase the supply of health professionals serving Medicaid beneficiaries • Improve the geographic distribution of the health care workforce • Help fund teaching programs that have experienced Medicare GME cuts	Both
Maryland	• Encourage training in certain specialties (e.g. primary care and pharmacy care) • Encourage training in certain settings (e.g. ambulatory sites, rural locations, medically underserved communities)	Both
Michigan	• Encourage training in certain specialties (e.g. primary care) • Encourage training in certain settings (e.g. ambulatory sites, rural locations, medically underserved communities) • Increase the supply of health professionals serving Medicaid beneficiaries • Improve the geographic distribution of the health care workforce	Both
New York	• Encourage training in certain specialties/professions – such as those in short supply	Both
Tennessee	• Encourage training in certain specialties (e.g. primary care) • Encourage training in certain settings (e.g. ambulatory sites, rural locations, medically underserved communities) • Increase the supply of health professionals serving Medicaid beneficiaries • Improve the geographic distribution of the health care workforce	Managed Care
Utah	• Encourage training in certain specialties (e.g. primary care) • Encourage training in certain settings (e.g. ambulatory sites, rural locations, medically underserved communities) • Increase the supply of health professionals serving Medicaid beneficiaries • Improve the geographic distribution of the health care workforce	Fee-for-Service
West Virginia	• Encourage training in certain specialties/professions – such as those in short supply	Fee-for-Service

Source: From a survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges[xxiv]

III. Recommendation

Based on the analysis above, conversations with other states and GME consultants and the emerging literature, the Healthcare Workforce Committee recommends establishing a consortium that would be used to develop and support new primary care residency programs in Oregon. There are three to five health care institutions and areas of the state that may—with the resources of a consortium—be able to launch new residency programs in the next five years. Although the specific form and functions can only be determined through a rigorous planning process with stakeholders, it is likely that the consortium would establish an independent nonprofit organization for administrative operations, faculty recruitment and development, and receipt and distribution of funds.

The consortium should focus operations in underserved areas of the state and pay particular attention to the potential to recruit and retain primary care physicians in those underserved areas. The consortium would begin by focusing on development of primary care residency programs only, but could grow to encompass other priority specialties as well (e.g. psychiatry, general surgery). Local hospitals and health systems, federally qualified health centers, county medical centers and Oregon's two medical schools would be the primary stakeholders for the initial planning phases with the eventual consortium members to be determined.

Strengths: The strength of the consortium model lies primarily in optimizing shared resources. When stakeholders join together to create a residency program, no one institution bears the financial and administrative burden. All stakeholders share the benefits of having residents and increased numbers of physicians practicing in their communities.

Establishing a new residency program allows new GME slots to be built over three years before being capped by the federal government. Creating a new residency program for primary care allows new physicians increased opportunities to select a primary care practice, filling an urgent need in Oregon. Placing residency programs in rural or underserved parts of the state encourages physicians to build practices in those communities.

Weaknesses: Establishing new residency programs requires a significant investment of resources, whether they are created through a consortium or individual hospitals. Finding sufficient funding until GME payments from Medicare begin is challenging.

Additionally, a consortium established as a nonprofit organization operates under the mission and bylaws created and amended by the stakeholders. Depending on the stakeholders involved and their individual needs, the mission may not reflect the best interests of the state.

Opportunities: Recently, some individual members of the Healthcare Workforce Committee were contacted by representatives of an OEBB/ModaHealth Grant program about the potential of

funding for a new primary care residency program or consortium serving rural or underserved communities in Oregon. The funding would be enough to cover the planning phase and some of the initial startup costs. A proposal was submitted to ModaHealth on June 10, 2014. Although this funding has not been finalized, the chances are good that the OEBB/ModaHealth Grant program will make a contribution. This opportunity required immediate action. The Healthcare Workforce Committee has been researching the issue of expanding primary care residencies in Oregon since the initial GME Summit in February 2014, and was well prepared to submit a serious proposal to ModaHealth.

Other opportunities include Oregon's work on health reform, which has encouraged innovation, and increased emphasis on primary care through the patient-centered primary care home model. Also important is the work already done in Roseburg, Salem and Eugene, investigating the potential of creating a new individual family medicine residency programs. Many partners are already engaged and ready to move forward.

Threats: Developing a consortium generally requires the participation and agreement of traditionally competitive institutions, which can be a difficult task. Competing interests of the various stakeholders could threaten the organization.

IV. Conclusion

The shortage of primary care physicians in Oregon, especially in rural or underserved areas, is acute and growing worse. A best practice for recruiting and retaining primary care physicians is having primary care residency options available for medical school graduates in areas where more physicians are needed. This memo analyzed three main categories of policy options for expanding primary care residency options in Oregon including establishing residency programs in individual hospitals and creating a consortium of stakeholders that would encourage, support and share the risk and rewards of establishing one or more residency programs. The third category, not mutually exclusive from the first two, would be encouraging voluntary or incentivized redistribution of the residency FTE already in Oregon.

The Healthcare Workforce Committee recommends establishing a consortium model with stakeholders and community members involved. Stakeholders are enthusiastic about this option and start-up funding is potentially available. In addition, the Oregon Health Policy Board could begin researching how best to use the funding the state provides for GME through Medicaid to support statewide policy goals.

In this way, Oregon could begin reversing the trend of primary care physician shortages and be better prepared to meet the goals of better health and better care at lower cost in the decades to come.

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Appendix A: Matrix of GME family medicine/primary care expansion options

Approved Charter deliverable #3 (due July 1, 2014): *A policy options memo, developed in consultation with representatives from Oregon Health & Sciences University and the College of Osteopathic Medicine of the Pacific-Northwest, for increasing the number of family medicine and other primary care medical residencies in Oregon. The memo should consider options including but not limited to: the creation of new community-based primary care residency programs; a GME consortium approach to support regional primary care residencies; and strategies for increasing the proportion of primary care residences within the current GME residency cap for Oregon.*

	Description of Option	**Administrative feasibility and governance issues - list**	**Financial feasibility – High, Medium, Low Cost**	**Impact on problem**	**Political considerations - list**	**Partnerships needed - list**	**Legislative action needed - Yes or No**	**Minimum time to first residents**	**Other considerations**
New Individual Residency Programs	Hospital or medical center establishes a family medicine residency program.	▪ Difficult to develop administratively – one institution bears the responsibility of faculty development, relationships with federal partners, accreditation, etc. ▪ Governance easier to establish as one entity is in control	▪ High cost borne by one institution ▪ Some rural hospitals have Sole Community Hospital designation, making them ineligible for GME IME payments	High impact in one area of the state, if successful	None, since the responsibility is all on one institution.	It would be preferable to involve community partners, but not necessary as the authority rests with one institution.	No – unless the institution wanted to ask for state funds.	2 years	Needs to be some sort of incentive to draw residents and faculty to location. This is true of ALL options below.
Consortium to support residencies									
Option #1 – Network or council	Voluntary member group that serves to convene residency programs and other partners, provide educational opportunities and to communicate with members.	▪ Easy to form ▪ Governance would be voluntary	Low Cost	Impact is related to the influence of the partners in the network; group would have no authority to require changes.	None, however, the network could have considerable political influence depending on the partners involved.	All residency programs, hospitals, medical centers, OMA, AHHS, medical schools, AHEC	No	Depends on programs involved – 1 year minimum for accreditation	

	Description of Option	Administrative feasibility and governance issues - list	Financial feasibility – High, Medium, Low Cost	Impact on problem	Political considerations - list	Partnerships needed - list	Legislative action needed - Yes or No	Minimum time to first residents	Other considerations
Option #2 – Independent 501C3: not for profit consortium with member-determined authority	Group of stakeholders join and commit resources to establish a residency program (s). These stakeholders are usually formerly competitive medical centers, hospitals and educational institutions that are required to collaborate.	▪ Difficult administratively as the consortium would take on all development tasks such as accreditation, etc., however, burden is shared ▪ 501C3 governance determined by Board of Directors and bylaws ▪ Consortium can act as fiscal agent for members	High cost – however, establishing a residency program under any mechanism is costly. In a consortium model, costs are shared.	High impact on problem, if successful	Political considerations are internal to the members of the consortium, unless the members are advocating for state funding or unless membership is mandated.	Members would include those entities that benefit from having a family medicine residency program in the area.	No	2 years	Consortium could host residency programs, or support programs in community hospitals, teaching health centers, FQHCs, etc.
Option #3 – statutorily established consortium with legislatively-determined authority	Group established in statute or by Executive Order to coordinate GME in the state. This group may or may not be given control over funding and location of new residencies. Members would be in statute.	▪ Difficult – would require new government administrative unit with staff, etc. ▪ Governance would be determined by statute	Moderate to High cost – this would depend on level of authority and function of the group. If the group was to set up and run a program, the cost would be high, if not, moderate.	Moderate impact – if residency funding and location decisions were made based on evidence and best practice.	If the group were advisory only, there might not be any opposition. However, as the consortium's authority over resources increased, so would political considerations.	For this group to function successfully, all entities benefiting from a residency program should be involved.	Yes	Depends on authority and members involved.	Legislative involvement extends timeline.
Increasing/improving residencies within the cap – no consortium									
Option #1 -	Organizations currently operating residency programs voluntarily allocate more slot/resources to family medicine or other	Very feasible since the programs are already operating.	Low cost – minimal start up is needed, however, reallocation might divert support from specialties	Moderate to high – depending on willingness to commit significant resources.	None other than internal, as decisions on reallocations were made.	None	No	1 year	Sustainability - priorities could shift and residencies be reallocated

	Description of Option	Administrative feasibility and governance issues - list	Financial feasibility – High, Medium, Low Cost	Impact on problem	Political considerations - list	Partnerships needed - list	Legislative action needed - Yes or No	Minimum time to first residents	Other considerations
	primary care specialties.		that generate more revenue.						
Option #2 -	Give Oregon Health Authority Medicaid Assistance Program (MAP) authority to attach incentive/accountability measures to the Medicaid GME payments (approx $57 million per biennium according to the 2010 AAMC survey report).	▪ Moderate ▪ Governance – OHA	Medium cost – agency is already established and is already passing through the dollars	Moderate impact – amount of money is comparatively small, however, could encourage movement toward redistribution goals	Possibly moderate opposition, given the amount of money. Could be seen as an attempt at “good government”. Support could come from communities receiving the benefits.	All benefitting institutions, preferably, state health agency, MAP	No	Uncertain	This option is not exclusive - could be exercised along with other options.

Appendix B:
Oregon Health Policy Board
Health Care Workforce Committee Members
June 2014

Ann Buchele, M.Ed, PhD - Chair
Dean, Health Occupations and Workforce Education, Linn-Benton Community College, Albany, OR

Position of Vice-Chair - Vacant

Agnes Balassa
Workforce Policy Advisor, Governor's Office, State of Oregon

Jordana Barclay
Executive Director, Oregon Workforce Partnership, Oregon City

Sharmila Bose
Workforce Planning Consultant, Kaiser Permanente

Lita Colligan
Associate Vice President Strategic Partnerships, Oregon Institute of Technology, Portland, OR

Dr. Robyn Dreibelbis,
Vice Chair, Department of Family Medicine, Western University of Health Sciences

Mary Rita Hurley, RN, MPA
Executive Director, Oregon Center for Nursing, Portland, OR

Dr. Andrew Janssen, MD
Family Physician, Strawberry Wilderness Community Clinic & Blue Mountain Hospital, John Day, OR

Theresa Mazzaro, RN, CHCR
Workforce Planning Consultant, Nursing, Peacehealth Center of Expertise

David Nardone, MD
Retired Physician, Veteran's Administration, Portland, OR

David Pollack, MD
Professor for Public Policy, Departments of Psychiatry and Public Health and Preventive Medicine, Oregon Health & Science University, Portland, OR

Daniel Saucy, DMD
Dentist, Private Practice, Salem, OR

Jennifer Valentine, MPH
Consultant, Bend, OR

Representative from Oregon Health Policy Board

Dr Carla McKelvey, MD, Coos Bay

Staff / Consultants

Cathryn Cushing
Workforce Policy Lead, Office for Oregon Health Policy and Research

Lisa Angus
Policy Director, Office for Oregon Health Policy and Research

Jo Isgrigg, PhD
Executive Director, Oregon Healthcare Workforce Institute

Chad Johnson
Oregon Healthcare Workforce Institute

Marc Overbeck
Director, Primary Care Office, Office of Oregon Health Policy and Research

Mailing Address:

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1225 Ferry Street SE, 1st Floor
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Appendix C:
Consortium for Expansion of Primary Care
Graduate Medical Education Summit, Lebanon Oregon
February 25, 2014

Attendance List

Nancy Bell, RN, MPH
Vice President for Academic Affairs
Samaritan Health Services

Dr. Patrick Brunett, MD, FACEP
Associate Dean for Graduate Medical Education, OHSU

Dr. Geoffrey Hayden Carden, MD
Virginia Garcia Memorial Health Center
(Unable to attend this meeting)

Dr. Lisa Dodson, MD
Chair, OHPB Healthcare Workforce Committee
Family Medicine, OHSU

Dr. Robyn L Dreibelbis, DO
Assistant Professor, Department of Family Medicine
Western University of Health Sciences
COMP-NW

Dr. Robert L Dannenhoffer, MD
Mercy Medical Center, Roseburg

Brian G Eichman
PACS Administrator, Mercy Medical Center

Dr. Michael Finley, DO
Associate Dean, Western University
College of the Osteopathic Medicine of the Pacific
Western University of Health Sciences
COMP-NW

Dr. Katherine L Fisher, DO
Internal Medicine
Adventist Health

Dr. Roger Garvin, MD
Director, Family Medicine Residency, OHSU

Dr. Gary Halvorson, MD
Medical Director, Peace Health, Sacred Health Medical Center

Dr. Joyce C Hollander-Rodriquez, MD
Program Director
Cascade East Family Medicine Clinic, OHSU

Dr. Andrew G Janssen, MD
Blue Mountain Hospital, Family Medicine
(Unable to attend this meeting)

Dr. Edward Junkins, MD, MPH, FAAP
Associate Dean of Academic Affairs
Western University of Health Sciences
COMP-NW

Dr. Rowena L Manalo, MD
Family Medicine, Kaiser Medical Center Rockwood

Dr. Lance McQuillan, MD
Program Director, Family Medicine Residency Program
Samaritan Health Services

Dr. David Nardone, MD
Portland VA Medical Center

Dr. David Pollack, MD
Professor of Public Policy, OHSU

Dr. Mari Ricker, MD
Primary Care Physician, Providence Medical Group

Dr. David E. Schmidt, MD
Director of Graduate Medical Education
Kaiser Permanente Medical Center, NW

Chris Traver
Director, Center for Medical Education and Research
Peace Health, Sacred Health Medical Center

OHA Staff: Lisa Angus

Follow up GME meeting 5-14-14

Lisa Dodson, MD
Chair, OHPB Healthcare Workforce Committee
Family Medicine, OHSU

Joan Kapowich, PEBB/OEBB

Pat Brunett, MD, FACEP
Associate Dean for Graduate Medical Education, OHSU

Chris Swide
OHSU

David Nardone, MD
Portland VA Medical Center

Nancy Bell, RN, MPH
Vice President for Academic Affairs
Samaritan Health Services

Lance McQuillan
Samaritan Health Services
Corvallis

Robert L Dannenhoffer, MD
Mercy Medical Center, Roseburg (submitted info for meeting via email)

Lucy Andersen
Manager for GME at Kaiser – calling for David Schmits

Douglas Carr
PeaceHealth

OHA Staff: Lisa Angus, Cathryn Cushing