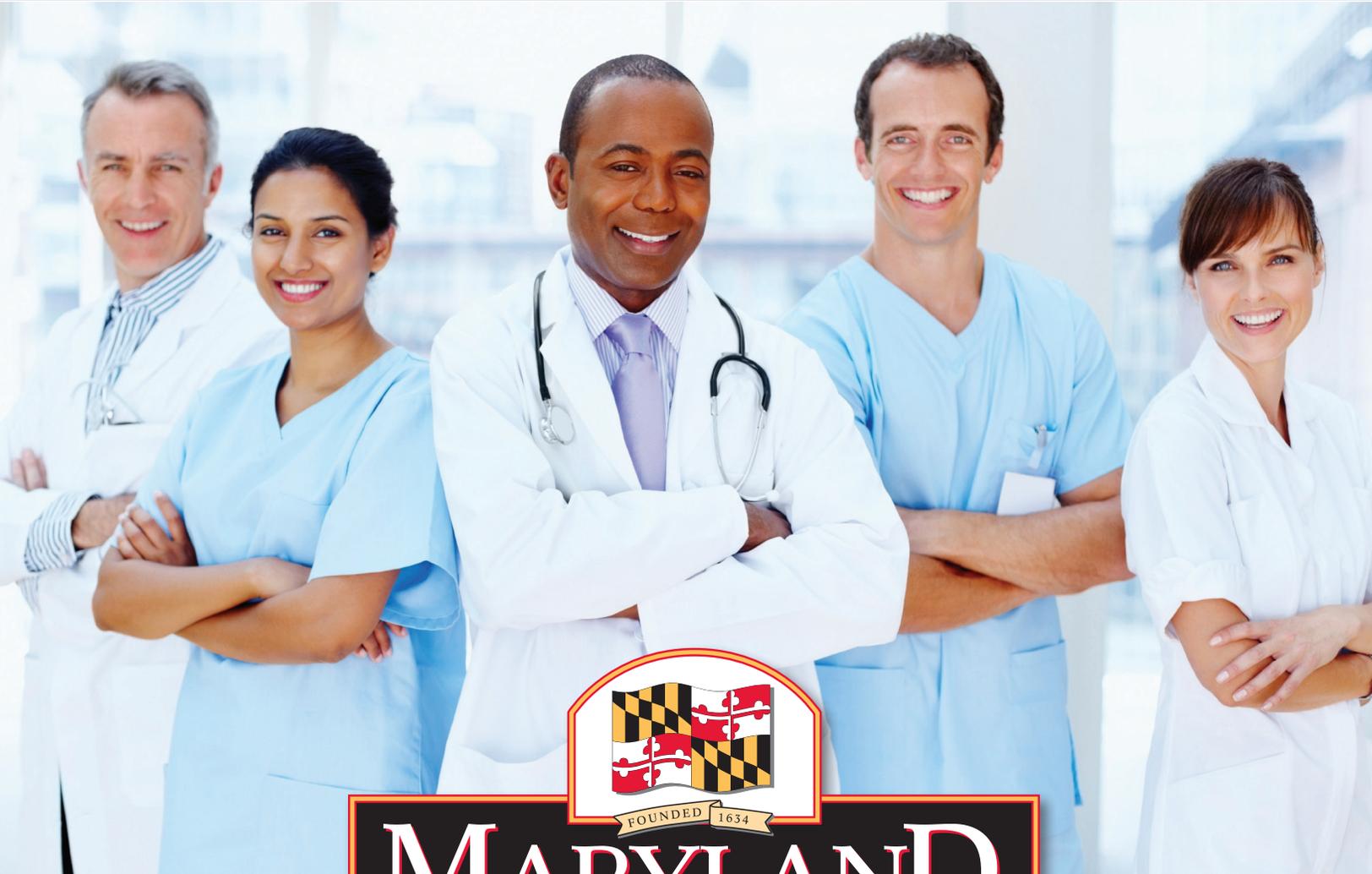


PREPARING MARYLAND'S WORKFORCE FOR HEALTH REFORM:

HEALTH CARE 2020




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MARYLAND

GOVERNOR'S WORKFORCE
INVESTMENT BOARD

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NOVEMBER 2011

Funded by U.S. Department of Health & Human Services

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LETTER FROM LT. GOVERNOR ANTHONY G. BROWN

Dear Friends,

I am excited to help the Governor's Workforce Investment Board release the "Health Care 2020" action plan to grow Maryland's health care workforce by up to 25 percent before 2020. This plan will go a long way to help us reach our goal of developing a national model for the implementation of federal health care reform.

We understand that implementing federal reform is a state obligation. Under Governor Martin O'Malley's leadership, we've taken that work very seriously. Since taking office in 2007, we have expanded access to coverage for 290,000 uninsured Marylanders and passed important legislation to create patient centered medical homes that improve the quality of care and provide incentives for physicians and providers to choose primary care.

Federal health care reform will save Maryland \$829 million in 10 years and cut the number of uninsured by half. But to successfully implement reform and make good on our promise to expand coverage, lower costs and improve the quality of care for all Marylanders, we need a robust health care workforce.

This plan sets four broad goals to provide comprehensive primary care workforce planning and analysis, strengthen primary care workforce capacity, address primary care workforce distribution and reduce service shortage areas and reexamine practitioner compensation for high-quality care. The plan specifically recommends that the state establish a primary care workforce website that includes data, maps and job opportunities, support educational and training mechanisms to expand Maryland's health care workforce pipeline and expand the state's patient-centered medical home program.

I applaud the Governor's Workforce Investment Board and the leadership of its chair, Bill Robertson, and look forward to working closely with the GWIB to monitor our progress in building a health care workforce for 2020.

Sincerely,

Anthony G. Brown

Anthony G. Brown

Lt. Governor

Chair, Maryland Health Care

Reform Coordinating Council



Anthony G. Brown
Lt. Governor

PREPARING MARYLAND'S WORKFORCE FOR HEALTH REFORM: HEALTH CARE 2020

By 2020, roughly 360,000 newly insured individuals in Maryland will be utilizing primary care services as a result of Affordable Care Act (ACA) coverage expansions.¹ In order to plan for an expanded health care workforce to respond to their needs, the Governor's Workforce Investment Board (GWIB) pursued and was awarded a \$150,000 health care workforce development planning grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). This strategic action plan is the product of the planning grant and will serve as the starting point in preparing Maryland for the expected and accelerated increase in primary care utilization.

A high-level health care workforce steering committee comprised of GWIB board members led the planning process. Building on the Governor's Health Care Reform Coordinating Council's (HCRCC) Workforce Workgroup options paper and final recommendations, the GWIB:

- Conducted regional listening tours (*Baltimore Metropolitan Area, Washington Metropolitan Area, Eastern Maryland, Southern Maryland, and Western Maryland*) to capture primary care workforce concerns from various private and public-sector stakeholders;
- Solicited input/guidance/comments from the following identified healthcare stakeholders directly tied to primary care education, pre-practice training, recruitment, retention, compensation, and distribution; and

- ★ **The Health Care Reform Coordinating Council**

- ★ **Governor's Office of Health Reform**

- ★ **Department of Health and Mental Hygiene**

- Office of the Secretary**

- Health Care Financing**

- Office of Health Services

- Office of Planning

- Family Health Administration**

- Office of Health Policy and Planning

- Office of Primary Care

- Community Health Resources Commission**

- Office of Population Health Improvement**

- Office of Health Care Workforce**

- Maryland Board of Nursing**

- Maryland Board of Physicians**

- ★ **Maryland Higher Education Commission**

- ★ **Department of Legislative Services**

- ★ **Maryland Health Care Commission**

- ★ **Health Services Cost Review Commission**

- ★ **CareFirst, Blue Cross Blue Shield**

- ★ **Maryland Hospital Association**

- ★ **Johns Hopkins University**

- Prepared to convene the "Health Care 2020" Summit on September 19, 2011, with private and public-sector stakeholders to validate the strategic action plan.

The HCRCC's final report in January 2011 included several workforce recommendations which underpin this strategic plan.² These include:

Recommendation #8: Institute Comprehensive Workforce Development Planning;

Recommendation #9: Promote and Support Education and Training to Expand Maryland's Health Care Workforce Pipeline;

Recommendation #10: Explore Improvements in Professional Licensing and Administrative Policies and Processes; and

Recommendation #11: Explore Changes in Maryland's Health Care Workforce Liability Policies.

The final recommendations in this strategic plan build on work of the HCRCC's Health Care Workforce Workgroup whose white paper was submitted to the Council on October 31, 2010. The Workgroup's short- and long-term objectives provide the framework of objectives for this strategic action plan.³ The white paper objectives encompass:

Short-term Activities

- Revisiting Maryland Loan Assistance Repayment Program Funding;
- Comprehensive Workforce Planning;
- Improve Coordination of Existing Resources;
- Explore Licensure Process Improvements;

- Pursue Demonstration Program to Evaluate Alternatives to Current Medical Tort Litigation; and
- Facilitate Medical Malpractice Coverage for Volunteers.

Long-term Activities

- Streamline Credentialing;
- Facilitate Clinical Training in the Community;
- Maximize Opportunities for Non-Traditional Paths to Health Workforce Development; and
- Continue to Improve Medicaid Reimbursement Rates.

Information gathered during the regional listening tours and key discussions has been augmented by the information derived from a review of health care workforce analyses previously performed and consolidated into the four following areas of focus for the strategic action plan:

- Comprehensive Primary Care Workforce Planning and Analysis;
- Strengthen Primary Care Workforce Capacity;
- Primary Care Workforce Distribution and Reduction in Service Shortage Areas; and
- Practitioner Compensation for High-Quality Care.

Comprehensive Primary Care Workforce Planning and Analysis

A critical component in assessing Maryland's primary care capacity is the ability to accurately (and systematically) quantify the number and need of primary care providers in Maryland. Currently, the main sources of health care workforce supply and demand analyses originate from:

- Maryland Department of Labor, Licensing, and Regulation (DLLR);
- The Health Resources and Services Administration (HRSA) physician requirements model;
- The Maryland State Medical Society (MedChi)/ Maryland Hospital Association (MHA) physician requirements modification; and
- MHCC analysis of the HRSA physician requirements model, MedChi/MHA modification, and American Association of Medical Colleges (AAMC) projections.

None of these analyses are sufficient to accurately project future supply and demand of primary care workers. DLLR's projections are solely based on trended licensure data—detailing decreasing vacancy rates for physicians, physician assistants, and nurse practitioners between 2005 and 2009.⁴ HRSA's physician requirements model, though showing Maryland in relatively good standing in terms of physician supply, does not factor in need or demand for non-physician clinicians who are an increasingly large share of Maryland's primary care provider workforce.⁵

The MedChi/MHA analysis modifies the HRSA physician requirements model to include non-physician clinicians.⁶ However, as noted in the MHCC report, the physician component of the estimates presents a shortage compared with the original HRSA model forecast.⁷

This disparity in supply and demand estimates underscores the importance of forging partnerships among data gatherers and users from the public and private sectors to create an annualized method for evaluating the success of comprehensive health care workforce planning. In addition to tabulating the primary care workforce, future analysis must include links between the number of primary care providers in an area and their effectiveness in reaching populations with high needs. A study conducted by the RAND Corporation for Baltimore City correlated the availability of primary care to emergency room (ER) visits and hospitalizations for ambulatory care sensitive (ACS) conditions.⁸ This form of analysis would enhance any estimate of primary care shortfall by emphasizing measurable health goals and outcomes attributable to primary care.

Strengthen Primary Care Workforce Capacity

In order to expand Maryland's primary care workforce, more emphasis needs to be given to educational and pre-practice training opportunities. Key discussions and listening tour participants consistently pointed to the lack of instructors for advanced practice nursing and physician assistant programs and incentives for community-based preceptors. Federal Graduate Medical Education (GME) funding is not typically allocated to clinical settings in the community. In addition, the Community Health Center and Academic Medical Partnership (CHAMP) program, an important community-based clinical opportunity, does not include pre-practice training opportunities for advanced practice nurses and physician assistants. There are several new programs initiated by the ACA that would greatly facilitate the expansion of pre-practice training.

Primary Care Workforce Distribution and Reduction in Service Shortage Areas

Maryland has 51 medically underserved areas or populations (MUA/Ps) and 137 health professional shortage areas (HPSAs)—51 in primary care, 42 in mental health care and 39 in dental care.⁹ A key issue emphasized through discussions and listening tours was the lack of funding for the Maryland Loan Assistance and Repayment Program (MLARP). Respondents suggested it would be beneficial to have a dedicated funding stream to support educational loans for primary care workers. Current funding activities are not necessarily coordinated and the allocation of funding may not ensure primary care workforce capacity and distribution as effectively

as it could. An urgent need is to create the capacity to use data to guide educational loan decisions. Developing working partnerships around primary care between those administering loans and the higher education institutions where the loans are used would also be beneficial. Scope of practice changes can be instituted in the form of (1) allowing physician assistants to bill independently in Medicaid and (2) creating a mechanism when one or more professional boards cannot come to an agreement on amending scopes of practice.

COMPENSATION FOR PRIMARY CARE PRACTITIONERS

The most frequently cited concern of those practicing or interested in primary care was the pay discrepancy between primary care and specialty care. Through ACA, the Medicaid reimbursement rate is increased between 2013 and 2014 for primary care physicians.¹⁰ Also, primary care practitioners are provided with a 10 percent Medicare payment bonus for five years for specified primary care services.¹¹ Maryland must investigate workable strategies for sustaining this reimbursement level in subsequent years. Allowing physician assistants to bill Medicaid independently of their supervising physician could (1) attract more physician assistants into the field of primary care and (2) make physician assistants a more quantifiable component of the primary care workforce. Finally, payment structures within accountable care organizations (ACOs — federally incentivized) and patient-centered medical homes (PCMHs — offered through MHCC and CareFirst) offer the opportunities for lowering administrative costs and for increasing compensation for primary care through cost-sharing and quality incentive payments.

Strategic Goals and Objectives

Building off of the (1) Health Care Reform Coordinating Council's Workforce Workgroup white paper, (2) regional listening tours and (3) key discussions, GWIB presents the following strategic goals and objectives for review:

★ GOAL 1: Comprehensive primary care workforce planning and analysis

OBJECTIVE 1A: By January 2012, designate a new or existing agency or organization with responsibility for primary care workforce data collection, analysis, and reporting.

- Establish an advisory board of key stakeholders representing data gatherers and users from the public and private sectors to facilitate collaboration and communication dedicated to comprehensive workforce planning and to assure that primary care

workforce data and evaluation needs are addressed through comprehensive workforce planning.

- Identify ways to support the designated agency/organization in these tasks.

OBJECTIVE 1B: By July 2012, develop and implement a statewide program for data collection, analysis, and reporting to inform comprehensive and coordinated primary care workforce planning and development.

- Identify minimum data elements that are both consistent with national guidelines and sufficient to accommodate state-specific needs.
- Identify relevant data sources.
- Integrate data collection from several sources, including the health professions licensure boards and health care services providers.
- Develop a comprehensive quarterly dashboard for ongoing assessment of Maryland's primary care workforce.

OBJECTIVE 1C: By January 2013, issue an initial annual report on primary care workforce planning and development.

- Report on the numbers, types and diversity of primary care practitioners currently employed, where they are employed, and in what roles and what types of activities they perform.
- Describe the numbers, types and diversity of health professional students in the educational pipeline, including allied health training programs.
- Assess primary care workforce adequacy.
- Evaluate primary care workforce developmental projects and special initiatives funded by state, federal and private sector organizations and agencies.
- Review primary care workforce-related legislation, regulations, policies and practices.

OBJECTIVE 1D: By January 2013, establish a comprehensive primary care workforce website that includes data, maps, training education tools, recruitment and retention incentives and job opportunities.

- Explore coupling new primary care workforce data analysis with existing mapping tools, such as Maryland's StateStat or the geo-mapping initiative through DHMH.

★ GOAL 2: Strengthening primary care workforce capacity

OBJECTIVE 2A: By January 2014, develop and implement a program that promotes and sustains opportunities for nontraditional paths to primary care workforce development.

- Explore the feasibility of designing and implementing a “Grow Your Own Program” in Maryland.
- Determine the feasibility of enhancing CHAMP to include pre-practice training opportunities for advanced practice nurses and physician assistants.

OBJECTIVE 2B: By July 2014, devise mechanisms to expand and support Maryland’s health care workforce pipeline.

- Investigate ways to develop and periodically update a comprehensive repository of federal and state education and training program opportunities.
- Consider ways to utilize GME payments for community-based primary care workforce pre-practice training.
- Explore the development of a statewide CHAMP program in Maryland that includes community health centers in urban and rural areas.

★ GOAL 3: Address Primary Care Workforce Distribution and Support Service Shortage Areas

OBJECTIVE 3A: By January 2013, conduct a comprehensive assessment of the state’s health professions shortage areas with the goal of determining how best to maximize support for their primary care workforce through loan assistance repayment and other strategies.

- Complete the first annual assessment of state and federally authorized health professions educational and training opportunities for those who wish to enter the primary care field.
- Coordinate existing Loan Assistance Repayment Programs (LARPs.)
- Align the goals, objectives, policies, and procedures of existing LARP with the goals and objectives of this strategic plan whenever possible.

OBJECTIVE 3B: By July 2012 explore feasible mechanisms to ensure full use of innovative state and federal opportunities for primary care workforce development.

- Investigate options for fully funding the Maryland LARP (MLARP), as authorized by the Maryland state legislature in 2009.
- Explore the feasibility of expanding MLARP to include all state-designated primary care professionals.
- Initiate a statewide volunteer program geared to

augment the primary care workforce in designated shortage areas and designed to provide medical malpractice coverage for volunteer providers in community settings.

- Work with the legislature to develop a mechanism to address scope of practice expeditiously when two or more professional boards cannot come to an agreement. This mechanism should include input from the relevant boards, expert review and public comment.
- Consider scope of practice legislation that would permit physician assistants to bill Medicaid independently for primary care service delivery.
- Facilitate independent practice among advanced practice nurses in accordance with recent Maryland legislative authorization.
- Consider other creative solutions to increasing the number of primary care professionals in underserved areas.

OBJECTIVE 3C: By January 2013, launch an initiative to reduce and/or eliminate practice barriers.

- Review health professional licensure processes to identify greater efficiencies, taking care to protect patient safety and standards of quality.
- Explore options for developing reciprocity agreements with other states for all primary care disciplines.
- Review current credentialing practices and identify opportunities to minimize unnecessary administrative burdens.
- Evaluate alternatives to current medical tort litigation.

★ GOAL 4: Practitioner compensation for high-quality care

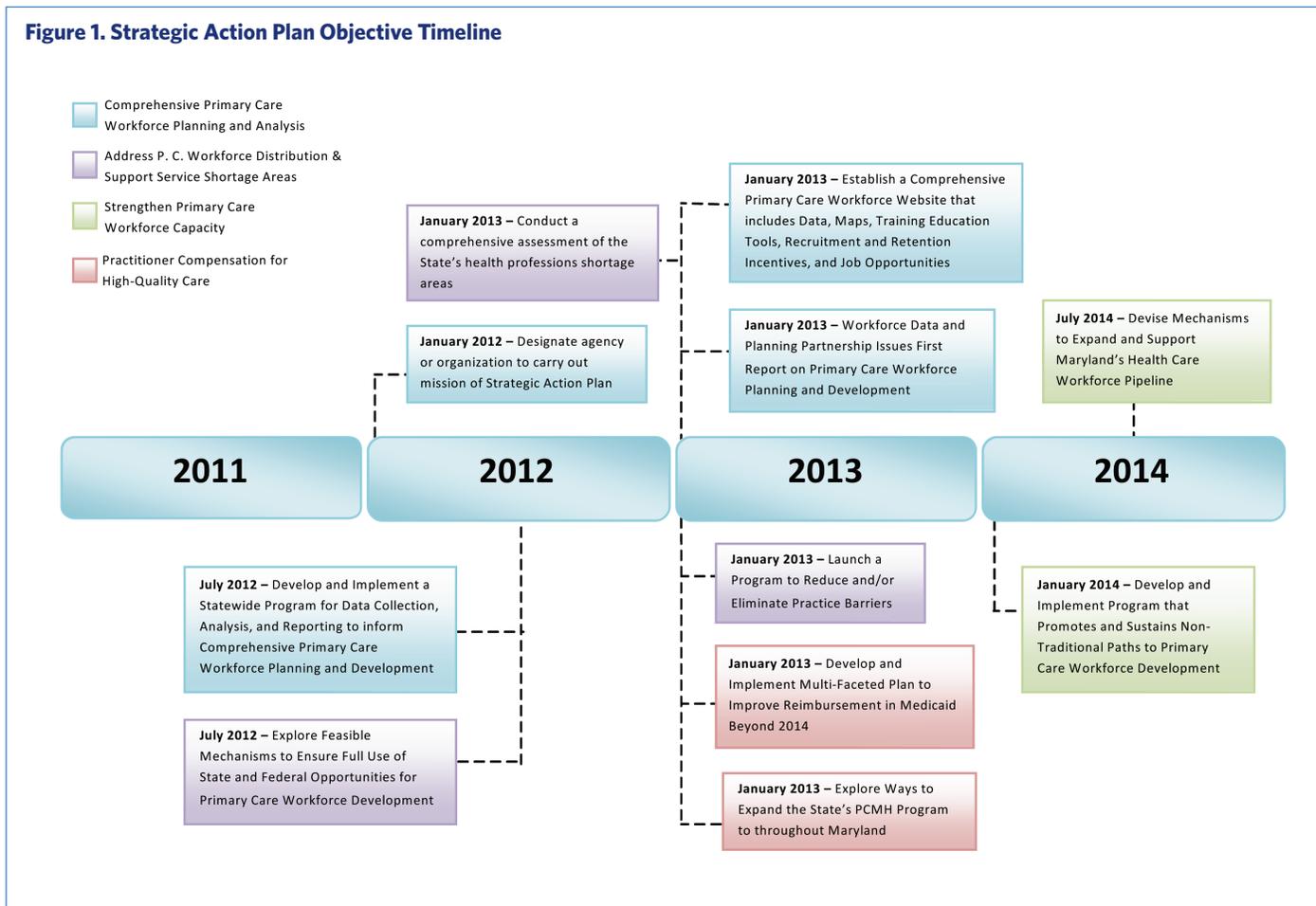
OBJECTIVE 4A: By January 2013, explore ways to expand the state’s patient-centered medical home programs throughout Maryland.

- Review the outcome data from two models in the state: the programs overseen by the Maryland Health Care Commission and CareFirst. Based on this review, consider expansion to all state primary care providers.

OBJECTIVE 4B: By January 2013, develop and implement a multifaceted plan to improve primary care compensation and reimbursement under Medicaid beyond 2014.

- Investigate ways to sustain the anticipated rate increase beyond 2014.
- Explore ways to incorporate the anticipated rate increase into payment models that go beyond fee-for-service.
- Determine the feasibility and appropriateness of permitting physician assistants to bill Medicaid directly.

Figure 1 below outlines the above objectives by calendar year, placing emphasis on workforce data collection and analysis before Exchange operation and Medicaid expansion.



INTRODUCTION

Preparing for Health Reform: Health Care 2020 has been prepared for the purpose of describing the ways and means by which the current capacity of the primary care workforce in Maryland will be increased over the next 10 years. By 2020, roughly 360,000 newly insured individuals in Maryland will be utilizing primary care services as a result of Affordable Care Act (ACA) coverage expansions.¹² In order to plan for an expanded health care workforce to respond to the needs of these individuals, the Governor's Workforce Investment Board (GWIB) pursued and was awarded a \$150,000 health care workforce development planning grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). In this context, increased capacity refers to the number of primary care workers—the headcount—but also to the distribution of workers across the state and to their ability to provide quality care to prevent disease and promote health. This plan has been developed by the GWIB. It is intended for use by the Governor's Health Care Reform Coordinating Council (HCRCC), co-chaired by Lt. Governor Anthony G. Brown and Department of Health and Mental Hygiene (DHMH) Secretary Joshua Sharfstein, and the many stakeholder agencies and organizations involved in strengthening Maryland's primary care workforce. This strategic action plan presents a proposed approach for accomplishing the workforce goal that reflects the HCRCC's commitment to assure that all Maryland residents have access to needed health care services. It has been especially designed to address the immediate and shorter term objectives, but in so doing sets a suggested course of action for the longer term.

STATED GOAL

Increase primary care workforce capacity by 10 to 25 percent over the next 10 years

For purposes of this plan, the primary care workforce is defined as primary care physicians (family practitioners, internists, pediatricians, gerontologists, obstetrician/gynecologist, and general practitioners), advanced practice nurses (nurse practitioners and certified nurse midwives), and physician assistants. This definition was provided by HRSA and adopted by the GWIB's Health Care Workforce Planning Grant Steering Committee at its meeting on May 5, 2011.

VISION

"The State of Maryland has a primary care workforce that meets the needs of all Maryland residents."

MISSION

"To improve the access for all Marylanders to health care in the state by supporting policy making and programs that assure the necessary supply and distribution of quality trained primary care clinicians."

GWIB CHARGE

The strategic plan will be used by the HCRCC in developing the policies and strategies for carrying out a coordinated workforce system that meets the needs of the health care industry and its users. Key participants in the planning and implementation of this work include the following:

- **Governor's Workforce Investment Board (GWIB):** Accountable for the development of the 2020 plan,
- **Health Care Reform Coordinating Council (HCRCC):** Facilitates and oversees the workforce planning initiative with other agreed upon health care reform activities,
- **Governor's Office of Health Care Reform:** Coordinates the various activities of health reform; staffs the HCRCC.

BACKGROUND AND CONTEXT

The GWIB serves as the state's lead entity for developing a primary care workforce expansion plan. To assist in its work, the GWIB established a high-level health care workforce steering committee composed of GWIB Board members and other experts. Building on its well-established, nationally recognized, sector-based approach to workforce development, GWIB collaborated with a broad network of health care industry leaders, the education community—including two- and four-year institutions of higher education— and the public workforce system.

GWIB used its Center for Industry Initiatives methodology to fulfill its charge. This methodology involved a five-phase structured process for convening private and public sector healthcare stakeholders to develop goals, strategies and deliverables that advance the workforce needs of the health care industry over the next 10 years. The phases (get organized, research and assess the industry, conduct healthcare industry sum-

mit, develop action plan, implement action plan) provided a working template to develop, implement, and sustain a demand-driven, industry sector approach for assessing and addressing healthcare workforce needs and issues. This sector-based methodology connects the workforce needs of the health care industry with the state workforce development and education systems.¹³ The culmination of the planning activity is a summit designed to validate the proposed plan and move toward implementation.

Health care workforce capacity has been studied previously in Maryland, through multiple past task forces and reports. A chronology of prior state and organizational efforts follows:

- **Governor's Health Care Workforce Summit:** August 2003—To deliberate on strategies to increase the number of health care workers.
- **Statewide Commission on the Shortage in the Health Care Workforce:** 2007—Report that highlighted the importance of coordination and reiterated the need to develop faculty, consider reciprocity, and promote diversity in the health care workforce. The Commission ended in 2008.
- **Maryland Commission on the Shortage in the Health Care Workforce:** Established by legislation effective July 1, 2006, and ended June 30, 2008; developed recommendations and strategies to reverse the growing shortage of health care workers.
- **Access to Care and Physician Workforce Requirements:** January 2008—Report presented to the Governor's Task Force on Health Care Access and Reimbursement. Report showed that the physician supply in Maryland is well above national levels; wide differences in estimates of supply between the Maryland Hospital Administration (MHA)/Maryland Medical Society (MedChi) study and the nationally collected data.
- **Task Force on Health Care Access and Reimbursement:** December 2008—Report covered recommendations focused on the need for greater administrative simplicity, increased practice efficiency and new models of realigned reimbursement that reward primary care in general.
- **Rural Maryland Council's Rural Health Roundtable on Maryland's Health Care Workforce Shortages in Rural Areas:** October 2008—Report noted rural areas and outer suburban areas require special attention to primary care and specialty care capacity.
- **Health Care Workforce Workgroup White Paper:** October 2010—Governor's Health Care Reform Coordinating Council—Identified short-term and long-term options for strengthening Maryland's health care workforce capacity.¹⁴

- **Health Care Reform Coordinating Council—Final Report and Recommendations:** January 2011—Recommendation #8 initiated the work on the GWIB's strategic action plan. Additional framework for workforce development planning was provided through Recommendations #9 (Promote and support education and training to expand Maryland's health care workforce pipeline), #10 (Explore improvements in professional licensing and administrative policies and processes) and #11 (Explore changes in Maryland's health care workforce liability policies).¹⁵

As noted earlier, the HCRCC Workforce Workgroup issued a White Paper on October 31, 2010, which presented options to the Council for strengthening Maryland's health care workforce capacity. Some of the options entailed specific activities that could begin in the short-term, and others required further input from stakeholders and additional review. The options were organized around these two categories and were *not* prioritized. The options are summarized next.

Short-term options included the following:

- 1. Revisit Maryland Loan Assistance Repayment Program Funding**
Providing financial assistance incentives through a state-funded loan assistance repayment program for physicians with an interest in primary care; expanding loan repayment programs beyond physicians to other health care professional students; exploring the use of licensure fees as additional sources of funding for these programs.
- 2. Comprehensive Workforce Planning**
Expanding the focus of health care workforce needs assessments beyond specific categories of health professionals or geographic areas; provide data on the numbers, types and diversity of health professionals currently employed, where they are employed, and in what roles and what types of activities they perform; provide data on the numbers, types and diversity of health professional students in the educational pipeline, including allied health training programs.
- 3. Improve Coordination of Existing Resources**
Coordinating efforts to address health care workforce issues by facilitating the development of viable partnerships among both governmental and nongovernmental entities engaged in health care workforce initiatives.
- 4. Explore Licensure Process Improvements**
Reviewing professional licensure laws to explore options for greater efficiencies in licensure processes; incentivizing health care professionals

who volunteer in underserved areas; requiring cultural competency training to address disparities in health experienced by racial and ethnic minorities.

5. Pursue Demonstration Program to Evaluate Alternatives to Current Medical Tort Litigation

Participating in a state demonstration program authorized by the ACA to evaluate alternatives to current medical tort litigation; improving medical tort litigation processes and procedures by strengthening apology provisions, enacting Good Samaritan provisions and creating a pilot medical care track within the judicial system.

6. Facilitate Medical Malpractice Coverage for Volunteers

Encouraging hospitals, health systems, and insurance carriers to provide coverage for volunteer providers in community settings on a consistent basis to increase the volume of volunteer providers in underserved areas.

Longer-term options included the following:

7. Streamline Credentialing

Convening public and private insurers with provider groups to review current credentialing practices and identify opportunities to further minimize unnecessary administrative burdens.

8. Facilitate Clinical Training in the Community

Taking steps to increase community-based clinical training and residency opportunities; encouraging partnerships between schools of nursing and health organizations to expand training options for advance practice nurses; ensuring that training programs include education and clinical experience that facilitate the development of skills in cultural competency and sensitivity, as well as the ability to navigate patient-provider discordance in language and health literacy; encouraging the use of inter-professional training models; ensuring that such clinical training opportunities are extended to health profession students who reside in rural and other medically underserved areas and students who are from racial and ethnic minority communities.

9. Maximize Opportunities for Nontraditional Paths to Health Care Workforce Development

Increasing efforts to identify and maximize the use of nontraditional channels to increase the health professions pipeline and practicing workforce.

10. Continue to Improve Medicaid Reimbursement Rates

Building on progress that has been made in recent years to increase levels of Maryland's Medicaid reimbursement rates, in both the fee-for-service

and managed care systems; devising a plan for improving Medicaid reimbursement rates as the economy improves.

These articulated issue areas provide the essential framework for GWIB's strategic action plan.

ASSESSMENT OF CURRENT AND PROJECTED PRIMARY CARE

This section is meant to provide the environmental context within which the strategic action plan is framed. It includes both quantitative and qualitative assessments of the primary care workforce in Maryland, as well as a summary of the key resources that are expected to be available.

Building from the HCRCC Workforce Workgroup options, and recognizing the need for reliable and readily accessible health care workforce data, the HCRCC recommended improved data collection to enable a more accurate assessment of primary care workforce needs and to enhance coordination of various workforce development efforts throughout the State.

Currently, the main sources of health care workforce supply and demand analyses derive from:

- The Maryland Department of Labor, Licensing and Regulation (DLLR);
- The Health Resources and Services Administration (HRSA) physician requirements model;
- The Maryland Medical Society (MedChi)/Maryland Hospital Association (MHA) modification; and
- The Maryland Health Care Commission (MHCC) analysis of the HRSA, MedChi/MHA and American Association of Medical Colleges (AAMC) projections.

These analyses serve as a valuable starting point in evaluating Maryland's current primary care workforce and expected demand in the wake of federal health reform implementation.

Department of Labor, Licensing, and Regulation

DLLR's supply and demand analysis (based on licensure data trends) details the gap between the need for primary care providers and the number of graduates in those occupations for Maryland. This observance is not exclusive to primary care, as current projections for overall healthcare occupations are projected to grow at more than double the rate of the State's overall economy during the next several years. Between 2008 and 2018, DLLR estimates that employment in healthcare occupations in Maryland will grow from 219,160 jobs to 263,905 jobs, an increase of 20.4 percent. By comparison, overall jobs in the state are projected to grow by approximately 9.1 percent during the same time period.

Table 1 below shows the growth by health care industry sector.

Table 1. Employment and Payroll Data for Maryland's Health Care Sector, CY 2008–2010¹⁶

INDUSTRY SECTOR	JOB IN Q4, 2008	JOB IN Q4, 2009	JOB IN Q4, 2010	EMPLOYMENT CHANGE, Q4 2008 TO Q4, 2010	EMPLOYMENT CHANGE (%), Q4 2008 TO Q4, 2010
Ambulatory health care services	103,381	108,500	112,234	8,853	8.6
Offices of physicians (Subset of Ambulatory Health Care)	45,241	46,666	47,301	2,060	4.6
Hospitals	108,848	111,580	110,959	2,111	1.9
Nursing and residential care facilities	68,452	70,360	71,312	2,860	4.2
Total—Health Care Sector	280,681	290,440	294,505	13,824	4.9

Table 2 illustrates the projected growth for primary care occupations in Maryland between calendar year (CY) 2008–2018.

Table 2. Occupational Projections for Select Health Care Occupations in Maryland, CY 2008–2018¹⁷

OCCUPATION	ESTIMATED 2008 EMPLOYMENT	REPLACEMENT OPENINGS	GROWTH OPENINGS	GROWTH RATE
Family and general practitioners	3,040	535	465	15.3%
Internists, general	1,055	185	160	15.2%
Obstetricians and gynecologists	255	45	35	13.7%
Pediatricians, general	540	95	80	14.8%
Physician assistants	2,285	415	665	29.1%
Total	7,175	1,275	1,405	19.5%

In addition to looking at projected openings, DLLR recognizes the importance of evaluating unmet demand for certain healthcare professionals. One indicator is the vacancy rate for health care positions at hospitals. Table 3 provides the vacancy rate for primary care positions at Maryland hospitals over the past five years.

Table 3. Vacancy Rate for Select Health Care Positions at Maryland Hospitals¹⁸

POSITION	2005	2006	2007	2008	2009
Nurse midwife	7.4%	11.8%	19.3%	9.2%	12.0%
Nurse practitioner (RNP)	8.9%	8.6%	13.6%	8.0%	7.3%
Physician (MD)	4.3%	7.3%	6.7%	3.0%	2.1%
Physicians assistant	13.5%	13.1%	15.9%	10.5%	9.7%

Funding from public and private sources in Maryland supports incentive programs that impact practitioner recruitment, retention, and attrition in the state. Table 4 provides the most recent information on the level of funds the state is spending on health care projects and programs.

Table 4. State Expenditures on Health Care Projects and Programs¹⁹

PROGRAM/PROJECT TITLE	STATE'S CURRENT SPENDING
Nurse Support Program (NSP) I (Maryland Higher Education Commission [MHEC])	\$11.9 million (FY 2010)
NSP II (MHEC)	\$13.2 million (FY 2010)
Teach for the Health of It (DLLR)	\$1.5 million (completed 2008)
Who Will Care? Maryland Hospital Association (MHA)	\$11.1 million (phases 1 and 2)
Health Personnel Shortage Incentive Grant (MHEC)	\$450,000 (FY 2010)
Workforce Shortage Student Assistance Grants (MHEC)	Unfunded FY 2011
Loan Assistance Repayment Programs (primary care, dental, and nursing practitioners) (MHEC)	\$1,204,614 (FY 2009)
Tuition Reduction Programs (MHEC)	\$320,641 (FY 2009)
Foreign-Trained Health/Nursing Professionals (Montgomery County, MHA, and DLLR)	\$443,561 (FY 2010)
Nursing Workforce Commission (Department of Health and Mental Hygiene [DHMH])	N/A
Military Health Care Personnel Staffing Initiative	N/A
Maryland Statewide Commission on the Shortage in the Health Care Workforce (Maryland State Assembly)	N/A
Healthcare Workforce Diversity and Cultural Competency Initiative (DHMH)	N/A - Federally Funded

HRSA Physician Requirements Model

The HRSA Physician Requirements Model calculates national estimates of physician supply and demand using medical license renewals and the American Medical Association (AMA) Physician Master file to (1) assess the current supply of physicians by discipline and (2) anticipate the amount required to meet future projected need. An illustration of the physician requirements model is shown in Figure 1.²⁰

Figure 2. Physician Requirements Model Overview

HRSA has calculated supply and demand projections for active primary care physicians in the United States. Based on its model, overall primary care physician supply will exceed demand by 11,800 full-time equivalents (HRSA, 2008), as indicated in Table 5.²¹

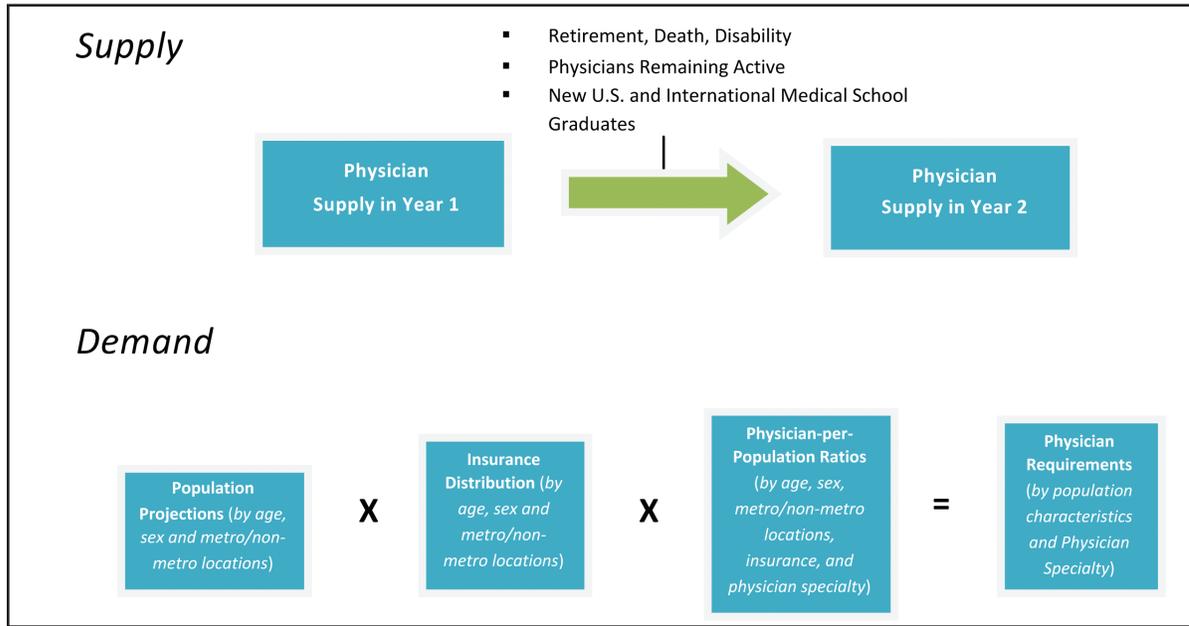


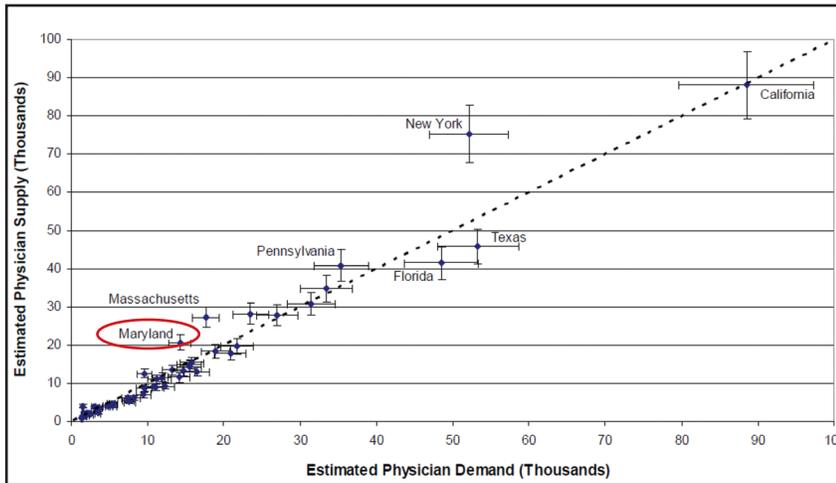
Table 5. HRSA Baseline Full-Time Equivalent (FTE) Supply Projections of Active Physicians

HRSA BASELINE FTE SUPPLY PROJECTIONS OF ACTIVE PHYSICIANS (U.S.)					
PRIMARY CARE	BASE YEAR	PROJECTED			
	2000	2005	2010	2015	2020
General family practice	107,700	114,000	121,400	128,600	134,700
General internal medicine	107,500	121,900	131,400	138,800	143,900
Pediatrics	51,900	56,200	60,400	63,700	66,100
OB/GYN	41,500	45,300	48,000	50,100	51,600
Total	308,600	337,400	361,200	381,200	396,300

HRSA BASELINE FTE DEMAND PROJECTIONS OF ACTIVE PHYSICIANS (U.S.)					
PRIMARY CARE	BASE YEAR	PROJECTED			
	2000	2005	2010	2015	2020
General family practice	107,700	113,900	120,600	127,900	135,900
General internal medicine	107,500	115,000	123,400	132,900	143,500
Pediatrics	51,900	52,900	53,500	55,500	57,900
OB/GYN	41,500	43,100	44,800	46,000	47,200
Total	308,600	324,900	342,300	362,300	384,500

According to the HRSA analysis, Maryland fares quite well in comparison with other states. The 2001 analysis in Figure 3 shows Maryland with an estimated physician demand of 16,000 compared with roughly 20,000 in physician supply.²²

Figure 3. HRSA Physician Requirements Model by State



MedChi/MHA Physician Workforce Study²³

The Physician Workforce Study conducted in 2008 took a modified approach to the HRSA model, adding in other elements of the primary care workforce not initially factored—residents, nurse practitioners and physician assistants. In addition to the data sources used by the original HRSA model, the study used data sources on advanced practice nurses and physician assistants from the American Academy of Physician Assistants, American College of Nurse-Midwives, Maryland Nurse Practitioner Association and the Board of Nursing. This study estimated that, with the exception of the Baltimore and Washington metropolitan area, Maryland would experience a primary care physician shortage by 2015. Factoring in the non-physician clinicians however, limited the shortfall to Southern Maryland. The study also estimated that 41 percent of the primary care workforce will be non-physician clinicians by 2015.

The Maryland Health Care Commission (MHCC)²⁴

The MHCC’s May 2011 presentation of its ongoing physician workforce study explores some of the discrepancies between the methodologies used by HRSA and the MedChi/MHA studies, specific to physicians. The MedChi/MHA study states that physician supply in Maryland is 15 percent below the national average, whereas the HRSA study shows that Maryland is 25 percent above the national average. The comparison is presented in Table 6.

Table 6. Comparison of Maryland Physician Estimate

METHODOLOGY	PUBLISHED	MARYLAND PHYSICIAN ESTIMATE (VS. NATIONAL AVERAGE)
HRSA	2008	25% Above ¹²
AAMC	2009	29% Above
MedChi/MHA	2008	15% Below

Additionally, when analyzed by region using the HRSA methodology, the data show that Maryland meets the primary care supply need in four of five regions:

Table 7. Comparison of Maryland Physician Estimate to HRSA Standard

REGION	PERCENT MORE (LESS) TOTAL PHYSICIANS THAN HRSA STANDARD REQUIRES	PERCENT MORE (LESS) PRIMARY CARE PHYSICIANS THAN HRSA STANDARD REQUIRES
Entire State	27% ¹	11%
Baltimore Metro	44%	21%
Eastern Shore	4%	0%
National Capital	18%	4%
Western	20%	12%
Southern	-26%	-19%

The MHCC presented findings from its most recent physician workforce study in May 2011. The study compared two completely different sources of data: (1) the American Medical Association (AMA) Physician Master file used by HRSA and (2) Maryland license renewals used by MedChi/MHA. After adjusting for hospital residents and file completeness to make the two data sets comparable, the MHCC study found that its estimates of physician supply in Maryland agreed most closely with the HRSA analysis. The report showed that Maryland overall has 27 percent more active non-federal patient-care physicians per capita than the U.S. year 2000 average (HRSA's benchmark) and that these physicians supply about as many patient-care hours per provider as the U.S. average. Significant differences were apparent by specialty and region, however; most notably in Southern Maryland. The study emphasized the need to focus on sub-regional areas and less broad classes of physicians to better delineate, for example, primary care physician network adequacy.²⁵

None of the methodologies discussed is sufficient in accurately projecting future supply and demand of primary care practitioners. Rather, they provide a foundation for moving toward an accurate assessment of Maryland's current primary care workforce and its ability to meet the increase in demand for primary care services that is anticipated upon initiation of the Exchange and Medicaid expansion. The methods included are not an all-inclusive list, but rather a standard by which important federal funding opportunities such as medically underserved and health profession shortage areas are designated.

Primary Care Adequacy

In addition to annualized tabulations of primary care practitioners, there is the need for analysis of primary care network adequacy. The RAND Corporation published a study in 2009 on ambulatory care-sensitive (ACS) hospitalizations and emergency room (ER) visits in Baltimore City. The study showed that although a range of factors contributes to ACS rates, a key determinant is the availability of primary care. The study estimated that Baltimore City may need an additional 130,000 to 159,000 primary care visits, with concentrations in areas where primary care capacity is particularly constrained and for populations for which capacity is constrained—which may include Medicaid enrollees and the uninsured. A key limitation of the study is worth noting: the investigators had no data from which to develop additional estimates of the primary care shortfall that would serve to validate their findings or to determine the impact that other factors, such as the availability of adequate urgent care (walk-in capacity during the day and evening/weekend capacity) and better coordination of care, might have on their estimates.²⁶

For the 2020 Blueprint to fulfill its outlined objectives, an effective evaluation and mechanism must be in place. This mechanism must be rooted in proven, annualized data analysis.

In developing the strategic plan, the GWIB complemented its review of qualitative data sources with information gathered from primary care workforce stakeholders. These individuals represented agencies and organizations with responsibility for primary care workforce planning and participated in regional listening tours and discussion sessions to identify and describe both challenges and opportunities. A synopsis of the information gathered during these tours and discussion sessions follows.

REGIONAL LISTENING TOURS AND KEY DISCUSSIONS

In developing a plan to increase the primary care workforce pool statewide in the next decade, it is important to note the regional differences that exist throughout Maryland. For this purpose, GWIB convened five regional listening tours to gather region-specific primary care concerns, as well as cross-cutting issues. The regional listening tours were held at the following locations:

- Baltimore Metropolitan Area
- Washington, DC Metropolitan Area
- Eastern Shore
- Southern Maryland
- Western Maryland

During these tours, the HCRCC's final recommendations were presented as a baseline of consensus, as well as statewide data from DLLR/GWIB on projected trends in Maryland's health care workforce capacity, and an overview of the HRSA planning grant. The regional discussion was guided by the following questions proposed by GWIB:

- What are the most critical challenges impeding the state's ability to grow its primary care workforce?
- How are you addressing these challenges? With whom are you partnering?
- What steps should Maryland take to ensure sufficient capacity in the health care delivery system to meet demand?
- Do you have any current initiatives designed to recruit and retain workers?
- How can Maryland plan for future primary care provider workforce needs?
- How do you respond to worker shortages?
- Where does your organization find its best talent?
- To what extent should Maryland use a broad range of tools to increase capacity and assure an adequate workforce, including fostering education and training programs designed for the workforce of the future, changing licensing policies, supporting recruitment and retention strategies and changing liability laws and regulations?
- What are the workforce challenges and potential solutions for meeting the needs of different special populations you serve?

Over the course of the five listening tours, input included broad statewide concerns, as well as region-specific issues. Initiatives inside Maryland, as well as national and international models were highlighted as models to replicate. Recurring themes are described next.

Educational Capacity and Pre-Practice Training Opportunities

Panelists agreed that more pre-practice and early educational opportunities across the primary care provider spectrum are needed for expansion of the primary care workforce in Maryland. Barriers cited include difficulty attracting and retaining faculty given that teaching salaries are not competitive with clinical practice, limited physical capacity at schools and clinical training sites and lack of reimbursement for preceptors. There is a financial disincentive for providers to take on the role of preceptor as services provided by students are not billable and teaching activity decreases a provider's billing productivity. Federal Graduate Medical Education (GME) funding is not typically allocated to clinical settings in the community. Lastly, panelists emphasized how the Community Health Center and Academic Medical Partnership (CHAMP) program does not include pre-practice training opportunities for advanced practice nurses and physician assistants.

Practitioner Compensation for High-Quality Care

The role of reimbursement in creating an adequate primary care workforce was a major topic of discussion. One issue is the income gap between primary care and specialist physicians, which is created by the current procedure-driven fee-for-service payment system. Another issue is inequity in reimbursement levels between nurse practitioners or physician assistants relative to primary care physicians, even when rendering the same services. For example, this inequity in reimbursement limits the ability of nurse practitioners to practice at their full capacity by operating a financially viable primary care practice. Financial issues are exacerbated for providers in publicly funded settings, such as local health departments, or in settings with a large uninsured population.

Given the loan burden of graduating health professionals and the primary care income gap, there was support for funding and expanding the Maryland Loan Assistance Repayment Program (LARP).²⁷ Wider reimbursement for telemedicine was also discussed as a potential solution to some provider shortages.

Practice Environment

Panelists from the five listening tours discussed the relation of practice environment to recruitment and retention. Themes included the high expenses of practice overhead, medical liability insurance, administrative burdens of billing and credentialing, the inability of providers to practice at the full capacity of their training, and the perceived safety and desirability of working in some of the highest need areas. The advent of health information technology and electronic health records gives the potential to improve quality and

increase efficiency. However, the acquisition costs of these technologies (to include effective billing systems) can be prohibitive for small private practices.

Challenges for Special Populations

Participants were asked about challenges for ensuring an adequate workforce to provide care for special populations. Some newly insured Marylanders will need extensive assistance in navigating the health care system. Critical barriers involve limited education and health literacy, enrollees' low socioeconomic status, prevalence of substance abuse and limited English proficiency. Recruitment of students from underserved areas is viewed as a successful strategy for developing a pipeline of providers for underserved areas.

Team approaches were discussed as more successful models of care delivery for the general population, as well as for special populations. Other approaches to meeting the needs of special populations include mobile clinics and community health workers.

Key Discussions

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) and the GWIB staff conducted informal interviews with representatives of state agencies and other stakeholders whose organizations influence, implement, or evaluate primary care workforce policy. The purpose of the interviews was to gain additional insight into issues identified in the Health Care Workforce Workgroup White Paper and included as recommendations in the HCRCC Final Report. During the interviews, individuals offered their perspectives on primary care workforce priorities, suggested strategies for meeting primary care workforce needs and identified barriers that impede progress.

Interviews were conducted with:

- CareFirst Blue Cross Blue Shield of Maryland
- Maryland Board of Nursing
- Maryland Board of Physicians
- Maryland Community Health Resources Commission
- Maryland Department of Legislative Services
- Maryland Health Care Coordinating Council
- Maryland Health Care Commission
- Maryland Health Services Cost Review Commission
- Maryland Higher Education Commission
- Maryland Hospital Association
- Maryland Office of Primary Care
- Maryland Office of Health Care Financing
- Maryland Office of Population Health Improvement
- Maryland Primary Care Coalition

- Maryland State Medical Society
- Montgomery County Department of Health and Human Services

Identified Themes

Themes identified in support of comprehensive primary care workforce planning and data analysis: A strategy essential for gathering data for statewide comprehensive primary care workforce planning is using license renewal processes more effectively.

The Governor's Health Care Coordinating Council (MHCC) and the Maryland Board of Physicians are working together to develop questions that can provide timely information on the characteristics of primary care physicians. The MHCC can analyze data generated through renewal forms and connect those data to other data sources for purposes of workforce planning. Questions such as race, ethnicity, and location are especially useful in thinking about distribution and diversity issues. Consistent connections among data agencies and licensure boards would lead to more accurate year-to-year data comparisons. Additional partnerships between the MHCC (and other data agencies) and licensing boards, especially connections with the Board of Nursing, should be created and sustained. Currently, there is no accurate count of nurses in primary care practice because that information is not provided when licenses are renewed. Collaboration between the Board of Nursing and data agencies is essential to designing questions that would elicit accurate and valid information and that could be used for analytical purposes.

As a support for comprehensive primary care workforce planning, Maryland's State Health Improvement Plan will serve as a springboard for local and regional action. Maryland's State Health Improvement Plan (SHIP), released in the fall of 2011, sets forth objectives for health improvement, provides data for use by individuals and groups, and identifies metrics to connect goals and outcomes. The SHIP provides a framework for local and regional plans aimed at bolstering access to healthy communities and to health care. Oral health is a more significant problem on the Eastern Shore than in other parts of the state, and solutions, including workforce solutions, can best be developed regionally. Similarly, issues associated with cultural competency of providers, access to family planning services, and language access are unevenly distributed across the state. Alignment of resources to tackle these issues, including recruitment and training of primary care providers, will proceed differently in various sections of Maryland.

Theme identified in support of enhanced educational capacity and pre-practice training opportunities:

The primary care workforce will be strengthened through additional education of the public and professionals about expanded independent practice opportunities available to advanced practice nurses through legislation enacted in Maryland in 2010.

Provisions included in HB 319/SB 484 clarified the interpretation of independent practice for advanced practice nurses. Previous law had required physician supervision of advanced practice nurses. Now advanced practice nurses practicing independently are required to collaborate with physicians. An advanced practice nurse develops a collaborative plan with a physician and attests to that collaboration on a form submitted to the Board of Nursing. Attestation forms must be resubmitted regularly. Maryland's approach to independent nursing practice suggests that nurse-led patient-centered medical homes could be successfully brought to scale in the state. Respondents suggested looking at nurse-led medical homes in Pennsylvania as a model. Although hard data are not available, independent practice by advanced practice nurses appears to be more successful in rural areas of Maryland than in urban areas. Another nursing issue of interest to some respondents was the lack of a program in Maryland for training nurse midwives. In some parts of the state there are insufficient obstetrics/gynecology providers for persons covered by Medicaid. Nurse midwives may be part of the solution to that problem and additional data on the need for new nurse midwives would be useful.

Theme identified in support of improved primary care workforce distribution and reduction of service shortage areas:

Making a more robust connection between primary care needs and educational loan policy is important to reduce variation in distribution across the state.

Respondents suggested it would be beneficial to have a dedicated funding stream to support educational loans for primary care workers. Current funding streams are spread out and not well organized and do not give preference to individuals who intend to provide primary care. An urgent need is to create the capacity to use data to guide educational loan decisions. Developing working partnerships around primary care between those administering loans and the higher education institutions receiving them would also be beneficial. An infrastructure for administering loans is already in place at the Maryland Higher Education Commission (MHEC). Partnerships among MHEC, educational institutions, data agencies, and licensure boards, coupled with additional funding and building on MHEC's current administrative capabilities, would

advance healthcare workforce growth. The Workforce Shortage Advisory Council will meet this fall to consider shortages in various fields and could be asked to consider some of these issues during its deliberations. Policymakers could also look at Maryland legislation creating loan assistance programs for green technology jobs as a guidepost for primary care workforce activities.

Theme identified in support of increased primary care practitioner compensation for high-quality care:

As a support for appropriate compensation of primary care providers, patient-centered medical home initiatives underway in Maryland provide an essential frame.

Both public and private payers are implementing patient-centered medical home models. With their emphasis on primary care provision, illness prevention and payment reform, these initiatives may provide important incentives for doctors and nurses to enter primary care practice. Federally qualified health centers, now eagerly moving toward patient-centered medical home models, provide a good infrastructure for primary care growth in underserved areas. Currently, upwards of 20 percent of primary care providers serving Medicaid beneficiaries are in Federally Qualified Health Centers.

Theme identified in support of all areas noted above:

Resources available through federal grant sources and through Maryland grant-making agencies can jumpstart action on the primary care workforce.

Although federal appropriations for some authorized health reform initiatives remain uncertain, opportunities for receiving federal funding exist. Targeting funding available through Maryland agencies such as the Community Health Resources Commission (CHRC) is also essential. Short-term grants from CHRC could allow a safety net agency to buy technical expertise or develop a long-range plan for workforce capacity building. Assuring grants are used to assist with comprehensive workforce planning is an important strategic activity. CHRC plans to give priority to bolstering activities identified in the SHIP, including the development of regional or local primary care plans.

MATRICES

New or Existing Federal Primary Care Workforce Funding Opportunities

The matrix below includes existing federal funding streams, as well as new opportunities for primary care workforce enhancement. All of the new opportunities are authorized; some have received appropriations.

PRACTITIONER COMPENSATION FOR HIGH-QUALITY CARE

- A Primary Care Extension Program** (grants from the Agency for Health Research and Quality) to establish “state hubs” and local extension agencies to support local primary care physicians and implement Medical Home programs and improve community health: \$120 million for FY 2011 and FY 2012.
- B Medical Homes under Medicare:** Pilot program by 2013 and Medicaid expansion with funding for planning grants (ACA §3502).
- C Health Workforce Needs and Action Plans:** Grants to states for planning and implementation of health workforce development initiatives.
- D Bonus payments of 10 percent** for primary care physicians whose Medicare charges for office, nursing home care, and home visits comprise 60 percent of their total Medicare charges. The bonus runs through 2016 (ACA §5501).
- E Increase in Medicaid payments** to primary care physicians (restricted to family medicine, general internal medicine, and pediatrics) to no less than 100 percent of Medicare rate in 2013 and 2014 with the costs covered by the federal government (ACA §1202).
- F Accountable Care Organizations** (ACOs) participating in the Medicare Shared Savings Program could, through enhanced collaboration and coordination, achieve and retain savings if ACO is able to keep costs lower than the per capita Medicare expenditure average (ACA §3302).
- G Pediatric Accountable Care Organization Demonstration** project would allow pediatricians who meet certain requirements to be recognized as accountable care organizations for the purposes of incentive payments. Demonstration period is from FY 2012 to FY2016 (ACA §2706).

PRIMARY CARE WORKFORCE DISTRIBUTION AND REDUCTION OF SERVICE SHORTAGE AREAS

- A Revises the required length of service** in primary care from equal to the life of the loan to a total of 10 years, including the three- to four-year period of graduate medical education for physicians (ACA §5201).
- B Reduces the noncompliance interest rate** from 18 percent to 7 percent (ACA §5311).
- C Nurse Education Loan Repayment Program** (ACA §5311).
- D Secretary of HHS has discretion**, beginning July 1, 2011, to redistribute residency positions that have been unfilled for the prior three cost reports and direct those slots toward primary care (ACA §5503).
- E Secretary HHS has discretion to redistribute residency slots** from hospitals that closed on or after March 23, 2008 (ACA §5506).

STRENGTHEN PRIMARY CARE WORKFORCE CAPACITY

- A Family nurse practitioner training programs** to receive three-year grants through Federally Qualified Community Health Clinics and Nurse Managed Health Centers for one-year training program for primary care nurse practitioners (\$10501).
- B Grants to five eligible hospitals** to support the development of expansion of Advanced Practice Nurse Training Programs under Medicare (\$50 million per year from 2012 to 2015) (ACA §5208).
- C Advanced practice nursing students:** \$31 million for financial assistance enabling 600 part-time nurse practitioner and nurse midwifery students to enroll on a full-time basis and complete their degrees more rapidly.
- D U.S. Department of Health and Human Services** funds Experiences and Rotations in Community Health (SEARCH). Programs are state-based and provide health professions students with primary care rotations in rural, frontier, and urban health professional shortage areas (HPSAs).
- E Nurse managed clinics:** \$15 million for nurse-managed clinics to provide clinical education for nurse practitioner students.
- F Primary care medical residency positions:** \$167 million for more than 500 additional medical residence positions in primary care specialties (i.e., family practice, general internal medicine, and general pediatrics).
- G Physician assistants:** \$30 million to educate 700 additional physician assistants, with funding drawn from the Prevention and Public Health Fund established by ACA.
- H Increase the authorized funding** for the National Health Service Corps by 360 percent to \$1.15 billion by 2015 (ACA §5207).
- I Establishes a Community Health Centers Fund** for the Community Health Centers and the National Health Service Corps authorizing DHHS to provide additional increase of \$1 billion in FY 2010 up to \$3.6 billion in 2015 and \$1.5 billion for construction and/or renovation of Community Health Centers (ACA §10503 as modified by ACA §2303).
- J Authorizes funding to Federally Qualified Health Centers** (community health centers that receive federal grants) from \$3 billion in 2010 to \$8 billion in 2015, along with enhanced reimbursement from Medicare and Medicaid and special protection from tort action (ACA §10503).
- K Changes in Medicare reimbursement for graduate medical education (GME):** Grants for creation and expansion of teaching health centers, removing disincentives to train residents in non-hospital settings, and redistributing unused specialty residency positions to primary care residency programs.
- L “Teaching Health Centers”** for training primary care residents at Community Health Centers. Authorizes and appropriates such sums for direct and indirect costs of training residents up to \$230 million for FY 2011 to FY 2015 (ACA §5508).
- M Rural-focused physician education:** Grant to improve/expand rural-focused “tracks” with admissions criteria that give priority to students from underserved rural areas. Reauthorizes AREA Health Education Centers (AHECs) to “maintain and improve” existing AHECs.
- N Students and faculty from disadvantaged backgrounds:** These programs aimed at increase the number of health professionals from underrepresented minorities and disadvantaged backgrounds.

Best Practices from States

Several states have made progress on various aspects of primary care workforce development. Their experiences are summarized below.

COMPREHENSIVE PRIMARY CARE WORKFORCE PLANNING AND ANALYSIS

- A Virginia:** HRSA Health Care Workforce Implementation funding supports collaboration of Virginia's Health Workforce Development Authority with the state's Department of Health, Workforce Council, Health Care Foundation, Medical School Roundtable, Area Health Education Center Program, and Health Workforce Incentive Program, resulting in (1) increased staffing for the Health Workforce Authority, (2) an ad hoc committee under the Workforce Council, and (3) the creation and implementation of regional data pilot projects.
- B New Hampshire:** The New Hampshire Department of Health and Human Services created a "Health Data Inventory" containing information on supply, demand, distribution, education, and utilization of practitioner services.
- C New York:** The Center for Health Workforce Studies at the State University of New York collects data annually from the New York Department of Health, Education, and Labor to supplement the state's licensing and physician survey data.
- D North Carolina:** Ongoing coordination of nationally recognized health workforce data uses the analytic capabilities of the North Carolina Health Professions Data System (HPDS) and the expertise from the University of North Carolina's Cecil Sheps Center for Health Services Research.

STRENGTHENING PRIMARY CARE WORKFORCE CAPACITY

- A North Carolina:** Has one of the oldest and largest AHECs in the United States providing an integrated system of support for primary care and community-based education. This initiative began in 1993 to strengthen support and expand capacity for training primary care students in community settings throughout the state.
- B Carolina:** Offers a health careers training programs in underserved areas for individuals from underrepresented populations.
- C New York:** Study conducted by Mount Sinai School of Medicine at New York University showing nontraditional medical students (those who did not follow traditional pre-medicine majors) were more likely to enter residencies in primary care and psychiatry.
- D Mississippi:** Operates a Rural Physician Scholarship Program, which offers 40 scholarships totaling \$1.2 million. Program seeks out medical students looking to return to rural areas.
- E As of 2010, Medicaid programs** in ten states require direct linkage of GME payments to state policy goals intended to (1) redistribute the health care workforce or (2) encourage training physicians in primary care fields experiencing shortages.

PRIMARY CARE WORKFORCE DISTRIBUTION AND REDUCTION OF SERVICE SHORTAGE AREAS

- A New York:** LARP program called "Doctors Across New York" funded through New York's general fund. Allows entities licensed by local and county governments, as well as by the state, which encourages local groups to develop region-specific initiatives to the fullest extent possible. Program made roughly 100 loan repayment awards (which can be up to \$150,000 for 5-year commitment).
- B Pennsylvania:** Department of Health consolidates its primary care provider loan programs to cover non-physician clinicians: physician assistants, nurse practitioners, and certified nurse midwives.
- C Nineteen states allow an MCO patient panel** to expand when a physician assistant (PA) joins a practice, 16 states have no defined patient panel, 3 are self-limiting, and the remaining have MCO patient panels that may not expand when a PA joins the practice.
- D Twenty-eight state Medicaid plans** enroll PAs and ask them to bill their own identifiers (usually a national provider identifier [NPI]) as the rendering provider. A 29th, North Carolina, is in the process of changing its rules to enroll PAs.

PRACTITIONER COMPENSATION FOR HIGH-QUALITY CARE

- A Colorado:** Department of Health Care Policy and Financing implementing a patient-centered medical home (PCMH) program for low-income children enrolled in the state's Medicaid and Children's Health Insurance Program. The integrated system utilizes 97 community-based practices and 310 physicians, as of March 2009.
- B Community Care of North Carolina:** Program began to reduce emergency room visits for individuals with asthma; saved an estimated \$154 million in Medicaid costs through integrated staffing models and streamlined processes.
- C Washington:** Disease management/medical home approach through a partnership with King County Care Partners; connects recipients with clinics that assess, provide, and coordinate health care.

Current Activities and Initiatives in Maryland

Maryland has a demonstrated commitment to primary care workforce enhancement. Critical components of that effort follow.

COMPREHENSIVE PRIMARY WORKFORCE PLANNING AND DATA ANALYSIS

- A State Health Improvement Plan:** Component of plan encompasses devising region-specific strategies for increasing number of primary care providers.
- B Institute of Medicine—Future of Nursing Workgroup:** Based on Future of Nursing Report recommendation #8, charged with creating strategies for data collection and analysis on integrated health care teams (to include all providers under GWIB definition).

STRENGTHEN PRIMARY CARE WORKFORCE CAPACITY

- A The GME carve-out** has improved Maryland's Medicaid (HealthChoice) enrollees' access to teaching hospitals.
- B General Assembly** attempted to pass legislation for alternative financing methods for GME.
- C Three AHECs** (Western Maryland, Eastern Maryland, and Baltimore City) operate programs to engage interest in health professions from elementary through high school—developed “grow your own,” which points to research detailing that a provider is four times more likely to practice family medicine in a rural area if they are trained (or are from) that area. AHEC cite the lack of (1) a formal consortium of partners (kindergarten through college), (2) private funding, (3) support for local students while in Baltimore, (4) scholarships or incentives for students to return to rural community, (5) mandatory rotations in rural or underserved areas, and (6) a rural residency.
- D AHEC's Youth Health Service Corps** (YHSC) encourages diverse high school students to pursue careers in health care through training curriculum, volunteer service, rewards and recognition, and service learning projects.

PRIMARY CARE WORKFORCE DISTRIBUTION AND REDUCTION OF SERVICE SHORTAGE AREAS

- A** MLARP: Loan Assistance and Repayment Program with separate shortage designation by DHMH funded by rate increase from HSCRC. Centers for Medicare & Medicaid Services (CMS) ruled that such a rate increase would not be consistent with Maryland's Medicare waiver. Another potential funding option is physician licensing fees.
- B** Workforce Shortage Student Assistance Grant: Intended for students seeking undergraduate or graduate degree in discipline of need (2010 report cites that nursing comprises 47 percent of awards).
- C** Workforce Shortage Advisory Council convenes every two years to recommend to MHEC on fields no longer facing shortages. Council will meet in the fall to re-assess disciplines in program, though 2008 report notes that new programs/disciplines would only be added if funding was appropriated. FY 2012 appropriation is \$1.25 million.
- D** Health Personnel Shortage Incentive Grant, funded by Board of Physician fees, aims to enhance or expand health occupations experiencing shortages. Nurse practitioners and physician assistants are included.
- E** Community Health Resources Commission (CHRC) releasing grant opportunities for projects that serve a geographically defined service area or other efforts to expand access to network of primary care.

PRACTITIONER COMPENSATION FOR HIGH-QUALITY CARE

- A** The MHCC's PCHM initiative has enrolled 50 practices, encompassing 200 primary care physicians with the capacity to reach 200,000 individuals. All major carriers in Maryland are providing enhanced payments to these pilot practices.
- B** CareFirst Blue Cross Blue Shield's PCHM initiative estimates that reimbursement for primary care physicians would increase by 12 percent if they join their initiative. Sixty-five percent of primary care physicians participating with CareFirst are signed up, most of whom are small two- to three-practice-size organizations.
- C** Western Maryland Health System established a program to reimburse primary care physicians at a higher rate than the Baltimore metropolitan area to incentivize practicing in the region. They noted, however, that it is not sustainable.
- D** Maryland is expected to receive 100% funding support via CMS for increased physician payments equal to the difference between 2013 and 2014 Medicare rate and the state plan rate in effect on July 1m 2009.
- E** Maryland providers (primary care physicians, nurse practitioners, certified nurse midwives, or physician assistants practicing in a Federally Qualified Health Center) and hospitals are eligible for incentive payments for adoption, implementation, upgrading, or meaningful use of certified electronic health records (EHRs). Roughly 1,000 providers have enrolled as of June 2011.
- F** Physician assistant are not able to (1) participate independently in innovative models such as CareFirst or MHCC's PCHM or (2) bill under a unique identifier in Medicaid.

STRATEGIC GOALS AND OBJECTIVES

Building on the work of the HCRCC Workforce Workgroup and the quantitative and qualitative analyses described above, the following goals and objectives are intended to facilitate the expansion of primary care capacity required for the anticipated increase in primary care utilization.

★ GOAL 1: Comprehensive Primary Care Workforce Planning and Analysis

Background: The HCRCC's January 1, 2011, Final Report recommended comprehensive workforce development planning to assure a sufficient number of health care providers to meet the primary care needs of Maryland residents. The Council underscored the importance of its recommendation by calling for improved data collection to enable a more accurate assessment of primary care workforce capacity and coordination of workforce development efforts statewide. The federal government also has acknowledged the importance of data collection, analysis, and reporting to comprehensive primary care workforce planning and supports state efforts in this area through grants issued by the Health Resources and Services Administration (HRSA).

At present, Maryland has no centralized capacity for collecting, analyzing, and reporting health care workforce data. This capability is critical to identifying key workforce issues, assessing the magnitude of those issues, and providing evidenced-based information for the formulation of improved public policies.

OBJECTIVE 1A: By January 2012, designate a new or existing agency or organization with responsibility for primary care workforce data collection, analysis, and reporting.

- Establish an Advisory Board of key stakeholders representing data gatherers and users from the public and private sectors to facilitate collaboration and communication dedicated to comprehensive workforce planning and to assure that primary care workforce data and evaluation needs are addressed through comprehensive workforce planning.
- Identify ways to support the designated agency/organization in these tasks.

OBJECTIVE 1B: By July 2012, develop and implement a statewide program for data collection, analysis, and reporting to inform comprehensive and coordinated primary care workforce planning and development.

- Identify minimum data elements that are both consistent with national guidelines and sufficient to accommodate state-specific needs.
- Identify relevant data sources.
- Integrate data collection from several sources,

including the health professions licensure boards and health care services providers.

- Develop a comprehensive quarterly dashboard for ongoing assessment of Maryland's primary care workforce.

OBJECTIVE 1C: By January 2013, issue an initial annual report on primary care workforce planning and development.

- Report on the numbers, types and diversity of primary care practitioners currently employed, where they are employed, and in what roles and what types of activities they perform.
- Describe the numbers, types and diversity of health professional students in the educational pipeline, including allied health training programs.
- Assess primary care workforce adequacy.
- Evaluate primary care workforce developmental projects and special initiatives funded by state, federal and private sector organizations and agencies.
- Review primary care workforce-related legislation, regulations, policies and practices.

OBJECTIVE 1D: By January 2013, establish a comprehensive primary care workforce website that includes data, maps, training education tools, recruitment and retention incentives and job opportunities.

- Explore coupling new primary care workforce data analysis with existing mapping tools, such as Maryland's StateStat or the geo-mapping initiative through DHMH.

★ GOAL 2: Strengthening Primary care workforce capacity

Background: The HCRCC's January 1, 2011, Final Report emphasized the importance of developing and implementing an expanded and "robust workforce pipeline," coupling new education and training initiatives with the promotion of nontraditional paths to the health care workforce.

Educating and training a primary care workforce is a long-term process, beginning in grade school and continuing through health professions pre-practice training. The skill set required by primary care practitioners is evolving and likely will require venues that offer exposure to interdisciplinary, coordinated, and team-based care.²⁸

Moreover, increases in the racial and ethnic diversity of the primary care workforce, and the cultural competency it requires, are essential to addressing the health care needs of many populations in Maryland. Even greater attention to this longstanding issue will be required to assure improved and accessible health care for the underserved.

OBJECTIVE 2A: By January 2014, develop and implement a program that promotes and sustains opportunities for nontraditional paths to primary care workforce development.

- Explore the feasibility of designing and implementing a “Grow Your Own” Program in Maryland.
- Determine the feasibility of enhancing CHAMP to include pre-practice training opportunities for advanced practice nurses and physician assistants.

OBJECTIVE 2B: By July 2014, devise mechanisms to expand and support Maryland’s health care workforce pipeline.

- Investigate ways to develop and periodically update a comprehensive repository of federal and state education and training program opportunities.
- Consider ways to utilize GME payments for community-based primary care workforce pre-practice training.
- Explore the development of a statewide CHAMP program in Maryland that includes community health centers in urban and rural areas.

★ GOAL 3: Address Primary Care Workforce Distribution and Support Service Shortage Areas

Background: Maryland lacks an adequate number of primary care practitioners to meet the current needs of its population in four of the five regional workforce areas. Maryland has 51 medically underserved areas or populations (MUA/Ps) and 137 health professional shortage areas (HPSAs)—51 in primary care, 42 in mental health care, and 39 in dental care.²⁹ Without significant improvements in the size and distribution of the primary care workforce, shortages will continue to worsen, especially with the full implementation of the Affordable Care Act. Immediate and longer-term solutions are needed that will reduce the number of federally designated shortage areas, as well as those areas that are identified by the state and local jurisdictions.

In developing a planned approach to this issue, a review of practice in other states found that most address these problems through the use of loan assistance scholarship programs (see Matrix of Best Practices from States). The federal government may provide an extensive complement of new and existing resource opportunities. Full funding of federal authorizations for new and existing loan assistance and repayment programs will enhance greatly the state’s ability to improve access to needed health care services (see Matrix of New or Existing Federal Primary Care Workforce Funding Opportunities). A collaborative and coordinated approach to loan assistance and repayment in Maryland will facilitate the effort.

As mentioned in the HCRCC Final Report, comprehensive workforce development also includes alleviating the administrative burdens in both licensing and reciprocity for practitioners, as well as making important improvements to existing workforce liability policies. Scope of practice changes can be instituted in the form of (1) allowing physician assistants to bill independently in Medicaid; and (2) creating a mechanism when one or more professional boards cannot come to an agreement on amending scopes of practice. Currently, few states have established mechanisms to handle “fair, expeditious, expert, and objective appraisals” of scope of practice changes when professional boards are in disagreement.³⁰

OBJECTIVE 3A: By January 2013, conduct a comprehensive assessment of the State’s health professions shortage areas with the goal of determining how best to maximize support for their primary care workforce through loan assistance repayment and other strategies.

- Conduct a comprehensive reassessment of the state’s health professions shortage areas, using both federal and state criteria.
- Complete the first annual assessment of state and federally authorized health professions educational and training opportunities for those who wish to enter the primary care field.
- Coordinate existing LARPs.
- Align the goals, objectives, policies, and procedures of existing LARP with the goals and objectives of this strategic plan whenever possible.

OBJECTIVE 3B: By July 2012, explore feasible mechanisms to ensure full use of innovative state and federal opportunities for primary care workforce development.

- Investigate options for fully funding the Maryland Loan Assistance and Repayment Program (MLARP) as authorized by the Maryland state legislature in 2009.
- Explore the feasibility of expanding MLARP to include all state designated primary care professions.
- Initiate a statewide volunteer program geared toward augmenting the primary care workforce in designated shortage areas and designed to provide medical malpractice coverage for volunteer providers in community settings.
- Work with the legislature to develop a mechanism to address scope of practice expeditiously when two or more professional boards cannot come to an agreement. This mechanism should include input from the relevant boards, expert review and public comment.

- Consider scope of practice legislation that would permit physician assistants to bill Medicaid independently for primary care service delivery.
- Facilitate independent practice among advanced practice nurses in accordance with recent Maryland legislative authorization.
- Consider other creative solutions to increasing the number of health professionals in underserved areas.

OBJECTIVE 3C: By January 2013, launch an initiative to reduce and/or eliminate practice barriers.

- Review health professional licensure processes to identify greater efficiencies, taking care to protect patient safety and standards of quality.
- Explore options for developing reciprocity agreements with other states for all primary care disciplines.
- Review current credentialing practices and identify opportunities to minimize unnecessary administrative burdens.
- Evaluate alternatives to current medical tort litigation.

★ GOAL 4: Practitioner compensation for high-quality care

Background: Both the HCRCC's January 1, 2011, Final Report and the October 31, 2010, White Paper focus special attention on the importance of increasing reimbursement levels of payment for both fee-for-service and managed care systems. Both the income gap between primary care practitioners and specialists and the inequity in payments levels between non-physician clinicians and physicians were cited as challenges that need to be addressed. Solving these problems means finding affordable payment solutions through new approaches and innovations triggered by providers, payers, and the other stakeholder organizations.

The Patient-Centered Medical Home (PCMH) concept is an example of a health care delivery model that focuses on improving patient care through financial rewards to physicians for the quality of care they provide. The framework of the model is based on a team of practitioners, lead by a physician, to oversee the continuous care of a particular individual. This team-based approach lends itself to decreasing costs through the emphasis of preventive, coordinated care.³¹ Primary care providers who demonstrate a reduction in health care costs will receive an additional level of payment. There are two demonstrations in Maryland—MHCC's "Patient Centered Medical Home Pilot" and CareFirst's "Patient-Centered Primary Care Medical Home Program."

MHCC's own PCMH initiative will have initial results in July 2012 as to the effectiveness of reducing health care expenditures and shifting savings (such

as through administrative efficiencies) to providers. The program has enrolled 50 practices, encompassing 200 primary care providers with the capacity to reach 200,000 individuals.³² All major carriers in Maryland (Aetna, CareFirst, CIGNA, Coventry, United HealthCare, Medicaid, and possibly Medicare) are providing enhanced payments to these pilot practices.³³ Supportive efforts are underway, in the form of MHCC's learning collaborative, that provide training and education to primary care practices participating in MHCC's pilot program. This learning collaborative, conducted by the University of Maryland School of Medicine and Department of Family Medicine at Johns Hopkins University, will "identify and systematically address challenges of MHCC's PCMH implementation unique to each primary care practice."³⁴ MHCC's program is open to primary care physician- and nurse practitioner-lead teams.

CareFirst's program, open to only primary care physicians, estimates a 12 percent increase in reimbursement for primary care physicians who join their initiative. In addition, physicians would receive an additional professional service fee for coordination of services. CareFirst has engaged 65 percent of their primary care physicians in the program, compared to their target of 75 percent. Most of these physicians practice in small two—three person organizations.³⁵ These emerging health care systems introduce new levels of collaboration between hospitals, physicians, and other providers.

Accountable care organizations (ACOs) also may serve as a way to increase reimbursement for primary care professionals. The decision to participate in this federally incentivized model rests with providers. Per section 3022 of the ACA, an ACO is a newly devised model which allows gain-sharing in Medicare. That is, if providers choose to form ACOs and accept overall responsibility for the care of their enrollees, Medicare will share savings that result from improvements in service delivery with ACO providers. The more ACOs limit their Medicare costs without affecting quality, the greater the increase in their overall compensation.³⁶ This model will be a nationwide option for physicians, hospitals and other providers in 2012. In addition, section 2706 of the ACA creates a pediatric accountable care organization demonstration project. This project would allow pediatricians who meet certain requirements to be recognized as accountable care organizations for the purposes of incentive payments for federal fiscal years (FFY) 2012 through 2016.³⁷

The ACA affords a third option for increasing reimbursement for primary care professionals. Through ACA, Maryland is expected to receive 100% funding support via CMS for increased Medicaid primary care physician payments equal to the difference between the 2013 and 2014 Medicare rate and the Medicaid state plan rate in effect on July 1, 2009.³⁸ This Medicaid reimbursement

increase for primary care physicians will be for services rendered in FFY 2013 and 2014. In addition, primary care practitioners will receive a 10 percent Medicare payment bonus for specified primary care services from January 1, 2011, through January 1, 2016.³⁹ With the temporary increases in Medicaid and Medicare rates, the state is presented with an opportunity to strengthen primary care payment systems through the use of innovative payment models. The HCRCC's Workforce Report identified the continuation of improved Medicaid reimbursement rates for all providers; emphasizing the need for a plan that is "improving Medicaid reimbursement rates as the economy improves."⁴⁰

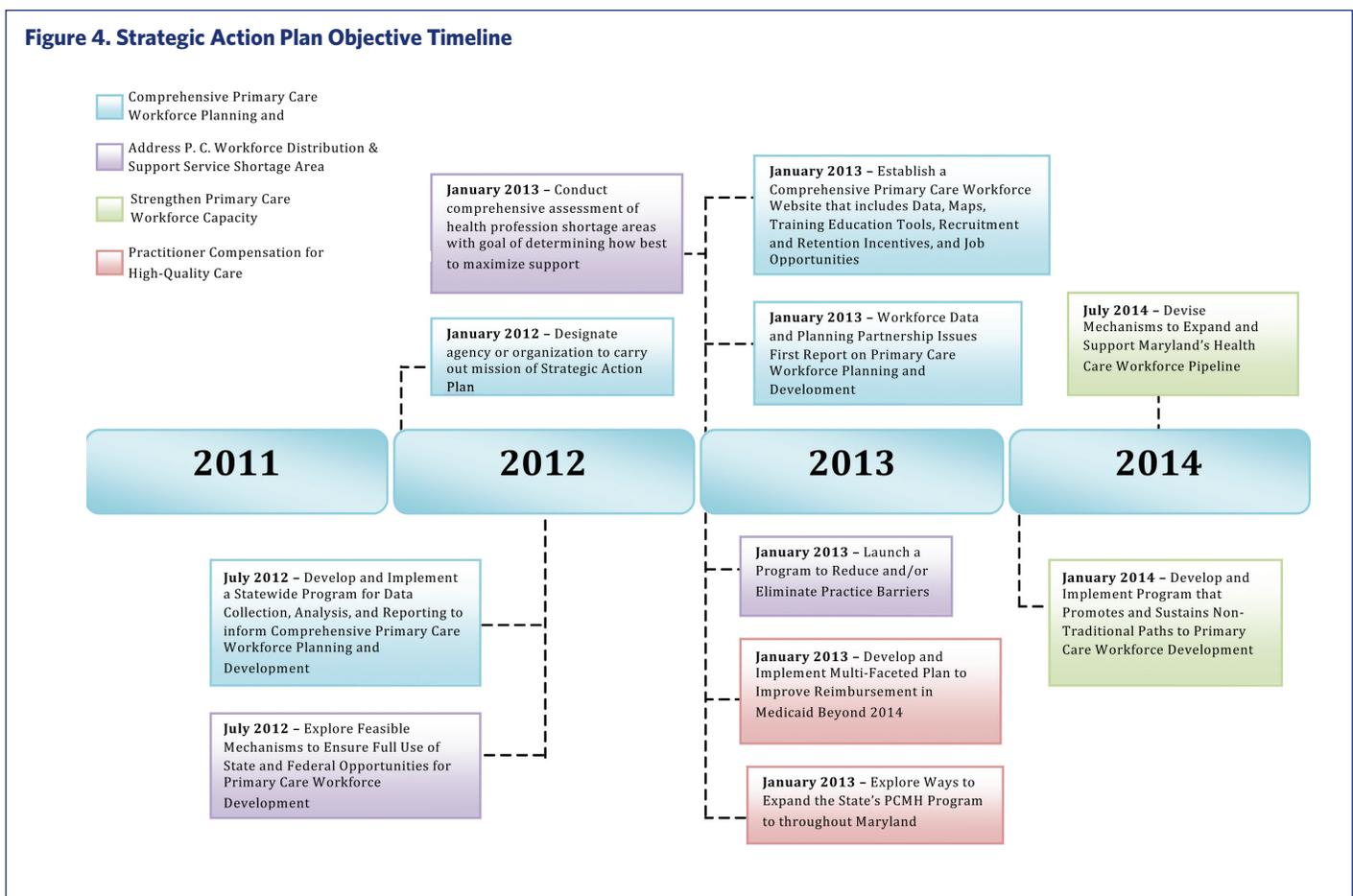
OBJECTIVE 4A: By January 2013, explore ways to expand the state's Patient-Centered Medical Home programs throughout Maryland.

- Review the outcome data from two models in the state: the programs overseen by the Maryland Health Care Commission and CareFirst. Based on this review, consider expansion to all state primary care providers.

OBJECTIVE 4B: By January 2013, develop and implement a multifaceted plan to improve primary care compensation and reimbursement under Medicaid beyond 2014.

- Investigate ways to sustain the anticipated rate increase beyond 2014.
- Explore ways to incorporate the anticipated rate increase into payment models that go beyond fee-for-service.
- Determine the feasibility and appropriateness of permitting physician assistants to bill Medicaid directly.

Figure 4 below outlines the above objectives by calendar year, placing emphasis on workforce data collection and analysis before Exchange operation and Medicaid expansion.



SUMMIT HIGHLIGHTS

On September 19, 2011, the Governor's Workforce Investment Board convened a Summit of statewide stakeholders to present a 10-year Health Care Workforce Expansion Plan. Participants had an opportunity to review and validate industry findings resulting from the regional listening tours, and further deliberate on strategies for increasing the primary care health care workforce. Summit participants will include high-level leaders from the health care industry, workforce development system, and government and education sectors. Dr. Fitzhugh Mullan of George Washington University served as the keynote speaker and provided an overview on the national landscape as it relates to primary care shortages.

Four breakout sessions were also conducted during the Summit aligning with the four main goals of the strategic plan. Subject matter experts served as panelists and engaged participants in further discussion about the goals.

Below is a summary of the break sessions:

PANEL 1: Comprehensive Primary Care Workforce Planning and Data Analysis

Linda Bartnyska, Chief, Cost and Quality Analysis, Maryland Health Care Commission (MHCC)

- There are plans underway to merge practice information from the Maryland Board of Physician's survey data into MHCC's existing Medical Care Data Base (MCDB)—which houses private insured and Medicare covered service-level data. MHCC has been collaborating with organizations since 2008, e.g., Maryland Medical Society (MedChi), Maryland Hospital Association (MHA), Maryland Board of Physicians, and CareFirst BlueCross BlueShield around forming consensus to track (1) number and allocation of work hours and (2) new information accounting for health information technology (HIT), practice size and location, and hospital admitting privileges.
- Concerns have expressed over Maryland's Board of Physicians (MBP) data range because residents are not included, differing interpretations of allocating work hours, and changing data requested on the re-licensure application can require time-consuming buy-in from various agencies organizations. Additionally, the Board's physician survey data is considered a *confidential data set*.
- There are tentative plans to produce commonly used metrics from the MBP survey data and make it available to the public on the MHCC website.
- MHCC is investigating looking beyond a count of full-time providers to tracking the availability of care in the context of changing practice patterns across time, locales, and populations, e.g., linking "visit production"

to information on "practice configuration," in order to refine the impact of workforce levels on visit capacity.

Christopher Hogan, Ph.D., President, Direct Research

- MHCC analysis of various Maryland-specific physician workforce studies, comparing with the HRSA U.S. Benchmark, suggests only Southern Maryland has a slight physician shortage.
- If there is a 50 percent reduction in the uninsured in Maryland by 2020, Maryland would need a 15 percent increase in the supply of primary care physicians (6,434; based on 2011 estimate detailing 5,580 primary care physicians).
- An accurate physician head count is a good start, but data integration is needed to attain a better picture of impact.

Elizabeth Vaidya, Director, Primary Care Office (PCO), Department of Health and Mental Hygiene (DHMH)

- The ongoing process of re-examining the methodology used by the Health Resources and Services Administration (HRSA) to designate health professional shortage areas (HPSA) and medically underserved areas (MUA) could affect the amount of federal funds for those localities, such as changing the MUA designation from a permanent designation to one that's re-evaluated on a consistent basis.

Katie Gaul, Research Associate, Sheps Center for Health Services Research, University of North Carolina

- The North Carolina Health Professions Data System is a partnership consisting of the Sheps Center for Health Services Research, health professional licensing boards, and the North Carolina Area Health Education Center (AHEC). This is a potential model which Maryland can emulate for data collection and analysis, e.g., relicensing opportunities, etc.
- Key challenges when creating a workforce planning and data analysis entity include (1) the licensure body lacks staff to undertake data collection, (2) protecting confidentiality, and (3) maintaining data objectivity (Sheps Center as an academic institution has credibility and is seen as objective).
- Identifying the financing mechanism is critical—whether the licensure body, tax-payer, AHEC, private foundations, or professional associations fund the workforce planning and data analysis entity.
- Of the states that have consulted the Sheps Center for their workforce planning and data analysis needs, there seems to be no clear preference towards (1) building the workforce planning entity through new appropriations or re-allocation of existing resources, and (2) forming collaborations among existing agencies/organizations.

PANEL 2: Strengthen Primary Care Workforce Capacity

David Stewart, M.D. M.P.H, Chair, Department of Family Medicine, University of Maryland School of Medicine

- Most medical schools have federally funded “pipeline” programs, for example, the AHEC program, bringing science teachers into the school, holding summer “med school” and “mini-med school” for students.
- In medical school, students are mentored by the faculty, they perform community service, and they have an opportunity to learn about the Public Health Service. First-year students are sent out to AHECs and other locations, they have (at UMSOM) required rotations in Family Medicine, and they have service projects in the community.
- UMSOM has many primary care residents who go on to the Public Health Service School.
- Currently, the school is expanding so that it can take more residents.
- The average debt for medical school is \$135,000, and that doesn’t include the debt from undergraduate school. Many residents go to the Public Health Service in order to get help with the debt. The faculty spends a lot of time looking for funding for students.
- The primary care workforce in this country is demoralized. As the government downsizes and formerly available services are gone, much of the load falls on the primary care providers.
- Dr. Stewart described his day as an example of a primary care provider and educator. He saw 12 patients in the a.m., and six patients in the evening, most with chronic issues as well as whatever reason brought them in that day. We should assume that primary care providers are burned out.

Miguel McInnis, M.D., CEO, Mid-Atlantic Association of Community Health Centers

- It was explained that FQHCs are located in medically underserved areas, and that they are required to serve anyone who needs care regardless of his ability to pay.
- Partnerships that are now popular between community clinics and hospitals have been going on for years in Baltimore. These partnerships create a continuity of care and specialty care for patients. Over the last few years, partnerships have been formed in order to give ER patients an alternative, and to also give them follow-up care when they are discharged. The other important result is that residents are trained in these clinics.
- Baltimore Medical System (BMS) has two FQHCs. The first is with Johns Hopkins Bayview Hospital. This

partnership is 27 years old and the two partners are now tightly integrated. The second is with St. Agnes Hospital, where BMS has a clinic on the St. Agnes campus. This gives access to patients and keeps them from going to the ER. It also gives patients a medical home after their hospitalizations. Medical residents get the experience of caring for those who need care the most, and BMS gets to influence the residents to perhaps stay and work in the clinic after receiving their degrees.

- The facilities that partner must have synergy and trust in order to give the patients the care they need. The hospitals see these clinics as investments, since they keep the cost of ER visits down. Hospitals are willing to give community grants to the clinics, and everyone benefits. Board representation for both sides is a necessity so that everyone understands the needs, the fiscal portion and for strategic planning.

Janet Allan, PHD, RN, Dean & Professor, University of Maryland School of Nursing

- The University of Maryland School of Nursing is the primary educator of nurse practitioners in the state, with approximately 200 graduating each year.
- Maryland nurses are working together to implement the four main precepts of the Institute of Medicine and the Robert Wood Johnson Foundation’s report on the future of nursing. The four are: (1) Practicing to the full extent of education and training; (2) Achieving higher level of education and training through seamless academic progression; (3) Participating fully with all providers in redesigning health care; and (4) Developing policy and planning for better data collection and information infrastructure.
- Nurse practitioners can alleviate the shortage of primary care providers, but they must be able to work independently, and have barriers (such as credentialing, lack of faculty, and reimbursement) removed.

Terri Socha, Program Director, Western Maryland Area Health Education Center (WMAHEC)

- The WMAHEC is part of the national AHEC system, and they receive federal and state grants. The AHEC’s mission is to improve access to and promote quality in health care through educational partnerships. Their initiatives include:
- AHEC K-12 initiatives include STEM partnering, the Youth Health Service Corps, job shadowing, CPR training, and volunteer opportunities. The AHEC also provides opportunities for Exploring Careers in Health Occupations; Clinical education for medical students; and Retention of health professionals.

- West Virginia's long-running program results in 40 percent of rural providers living where they went to high school, 63 percent affirming that familiarity with the rural community influenced their decision, and 65 percent wanting to practice close to their families. Eight Health Personnel Shortage Areas in West Virginia were eliminated between 1997 and 2006.

PANEL 3: Primary Care Workforce Distribution and Reduction in Service Shortage Areas

Monica Wheatley, Acting Associate Director, Office of Student Financial Aid, Maryland High Education Commission (MHEC)

- The Nurse Support Program (NSP) II saw a 60 percent increase in applicants from fiscal year (FY) 2010 to FY 2011—coupled with a 26 percent increase in awards during that span.
- The Workforce Shortage Student Assistance Program (WSSAG) saw the number of applicants for nursing decline from 420 students in FY 2010 to 104 in FY 2012.
- Maryland Loan Assistance and Repayment (M-LARP) expenditures decreased from \$600,000 in FY 2010 to a projected \$490,000 in FY 2012. The suspected reason for the decline is that the program competes with, but is not as generous as, similar federal programs.

Paula Hollinger, Associate Director for Health Care Workforce, Department of Health and Mental Hygiene

- Notes her office's participation in Maryland's State-wide Commission on Shortage in the Health Care Workforce, the Maryland Mental Health Workforce Steering Committee, and Base Realignment and Closure (BRAC) Workgroups.
- Though a shortage in nursing in Maryland doesn't exist, attention needs to be given to employing more nurses as federal health reform implementation takes place.

James Cawley, President, Maryland Academy of Physician Assistants

- There are three physician assistant programs in Maryland (Towson University, Anne Arundel Community College, and the University of Maryland, Eastern Shore), with an estimated 110 new physician assistants graduating per year in Maryland.
- Physician assistant supply projections show by 2015 there will be an estimated 95,000 physician assistants in active clinical practice.
- Workforce policymakers can "reasonably count on physician assistants to augment physician supply in the medical workforce"

Mark Luckner, Executive Director, Community Health Resources Commission (CHRC)

- In the past five years, the CHRC has awarded 78 grants totaling \$21.6 million. In FY 2012, the CHRC received 103 letters of intent requesting \$34 million—but will only be able to award \$1.2 million.
- The CHRC has a particular interest in supporting local health implementation plans built around the State Health Improvement Process (SHIP), as well as developing an approach to provide technical assistance to safety net providers.
- Identifying workable models of medical liability coverage for professionals who volunteer at federally qualified health centers (FQHCs) and free clinics—Maryland Volunteer Peace Corps, Montgomery County Medical Volunteers Program, and Florida's Access to Health Care Act are models the CHRC will examine for potential replication

PANEL 4: Practitioner Compensation for High-Quality Care

Susan Tucker, Executive Director, Division of Program Support Services, DHMH

- The Division of Program Support Services is identifying source of funds to achieve and sustain fees for primary care providers in Medicaid at 100 percent of Medicare rates.
- Effort are being made to enable the information technology (IT) system to accommodate Evaluation and Management fee differentials between primary care and specialty providers.

Ben Steffen, Interim Director, Maryland Health Care Commission (MHCC)

- The Patient-Centered Medical Home (PCMH) initiative engages public and private; rural and urban; suburban and urban; small and large; academic and non-academic participants. Johns Hopkins Hospital and the University of Maryland are on board, while the U.S. Military's TriCare Program is still pending.
- Data sharing is limited by current law regarding patient consent (2009 Maryland Law).
- There is a need to determine how to economize incentives to enable up-front costs of practice transformation, including structural and functional changes required for care coordination.

**Chet Burrell, President and CEO,
CareFirst Blue Cross/Blue Shield**

- Incentive structure for voluntary participation in Primary Care Medical Home initiative include:
 - ★ **Baseline reimbursement structure for primary care services that exceeds Medicare fees**
 - ★ **Potential for primary care providers to increase compensation by 30 percent through gain-sharing.**
- Though no cost savings are expected in the first year, anticipate bending the cost curve for adult care by at least 2 percent year after year thereafter. Savings from pediatric care are expected sooner than 5-10 years out and are anticipated to be much less than adult care. Savings accrue from more efficient management of chronic conditions which are more prevalent in adults than in children.

**Allan Field, Executive Director, TriState
Health Partners/Meritus Medical Center**

- The Physician Hospital Organization (PHO) is positioned to become an Accountable Care Organization (ACO) servicing self-insured market.

John Fleig, Chief Operating Officer, United HealthCare

- There is a shift toward collaboration, with outcome-based payments and new benefit design.
- Value based contracting will include accountability; integration among providers; innovations in medical technology; and based on provider feedback, experience and best practices.

- ACO currently is exploring three pilots including physician performance based contracting. 33 groups and over 9000 physicians will be a part of this effort.
- In the future, there will be the same focus on quality and efficiency, but with smaller groups.
- Currently, there are nine pilot Patient Centered Medical Homes, with 127 practices.
 - ★ **Most have chosen to become National Committee for Quality Assurance (NCQA) PCMH certified.**
 - ★ **Typical reimbursement: FFS + Care Management PMPM + Performance bonus.**
 - ★ **In the future, there will be a move toward a more efficient chronic care model.**
- Currently, there are 143 Medicare Advantage PCP Incentive Program groups that receive rewards for quality, cost effective care.
 - ★ **Quality thresholds must be met before surplus opportunity begins.**

NOTE:

The following recommendation was submitted by DHMH's Office of Minority Health Disparities: **Strategies should be identified to increase and sustain diversity in the primary care workforce, that options for state coordination with existing health workforce development and STEM pipeline programs aimed at increasing diverse representation in the health workforce, and that opportunities to enhance diversity in existing workforce pipeline incentive programs (i.e., LARP and other financial assistance programs) be explored.**

ACKNOWLEDGEMENTS

The Governor's Workforce Investment Board wishes to thank the following individuals and organizations to their time, expertise and willingness to collaborate in support of developing this strategic plan. Their assistance was essential to the successful completion of this grant.

Health Care Workforce Planning Grant Steering Committee:

Mr. William Robertson, President, Adventist Health Care, Inc.; Chair, GWIB

Mr. Ronald Robertson, President, Johns Hopkins Health Systems; Co-Chair, GWIB

Mr. Alexander M. Sanchez, Secretary, Department of Labor, Licensing and Regulation

Mr. John Reid, Executive Vice President, 1199 SEIU United Healthcare Workers

Ms. Patrice Cromwell, Associate Director, Annie E. Casey Foundation

Ms. Peggy Daw, NSPII Coordinator, Maryland Higher Education Commission

Mr. Fred Mason, Jr., President, Maryland & D.C. AFL-CIO

Dr. Charlotte Exner, Dean, College of Health Professions, Towson University

Ms. Linda Gilligan, Vice President, Johns Hopkins Health Systems

Mr. Ben Stutz, Policy Director, Office of the Lieutenant Governor

Dr. Claire Smith, Dean, School of Health Professions, Anne Arundel Community College

Ms. Kathy Bolton, Director, Sponsored Programs, Anne Arundel Community College

Ms. Wendy Kronmiller, Assistant Secretary, Department of Health and Mental Hygiene

Ms. Monica McCann, Workforce Diversity Director, Office of Minority Health and Health Disparities, Department of Health and Mental Hygiene

We also wish to extend a special thank you to the following. Without their assistance and subject matter expertise, this work would not have been possible.

Joshua Sharfstein, MD Secretary, Maryland Department of Health and Mental Hygiene

Ms. Carolyn Quattrocki, Executive Director, Maryland Health Care Reform Office

Finally, thank you to our colleagues at The Hilltop Institute, University of Maryland Baltimore County, who served as true partners throughout this effort:

Cynthia Boddie-Willis, M.D., Director, Health Services Policy and Research

Mr. Carl Mueller, Policy Analyst

Ms. Donna Folkemer, Director, Long-Term Services

Mr. Ron Carlson, Consultant

Ms. Alycia Steinberg, Senior Policy Analyst

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- 36** ACA §3022
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- 37** ACA §2706
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- 38** ACA §1202(a)(1)(C). Defined as physician with primary specialty designation of family medicine, general internal medicine, or pediatric medicine.
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- 39** ACA §5501(2)(A). Defined as (1) physician (*with primary specialty designation of family medicine, general internal medicine, or pediatric medicine*) or (2) nurse practitioner, clinical nurse specialist, or physician assistant, or (3) practitioner where specified primary care services account for at least 60 percent of overall services.
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