Fact Sheet

Health Reform and the Workforce: Will There Be Enough Providers?

Health care reform legislation recently signed into law will greatly increase the availability of health insurance and broadly impact the delivery of health care in America. This fact sheet looks specifically at how the legislation will affect the number of physicians, nurses, and other health professionals—especially those providing primary care services—available to treat the expanding ranks of insured Americans.

One of the most important achievements of health care reform is the expansion of health insurance coverage. The Congressional Budget Office estimates that 32 million more Americans will have health insurance by 2019 than would have had it without health care reform.[1]

Significant expansion in the number of insured individuals raises concern about whether there will be enough providers to care for all those who will gain coverage under the new law. Will there be a shortage of primary care providers, who are especially important in providing the preventive services, early treatment, and chronic care management critical to keeping health care costs down? Will there be enough providers in rural areas and inner cities, which often have fewer providers per capita?

This fact sheet describes the provisions in the new law designed to increase the number of providers available to care for patients and the willingness of providers to provide critical primary care services. It also describes several ongoing initiatives separate from health care reform that should help increase the provider workforce.

Payment Provisions Will Reward Providers for Providing Critical Primary Care Services

Two provisions in the law will increase the amount that primary care providers are paid for providing these critical services:

- One provision will pay all primary care providers a 10 percent bonus for the primary care services they provide to Medicare beneficiaries for five years, 2011 through 2015. These providers include physicians, nurse practitioners, clinical nurse specialists, and physician assistants practicing in family medicine, internal medicine, geriatrics, or pediatrics. The bonus applies to a range of primary care services delivered in a variety of settings. Also under this provision, general surgeons working in health profession shortage areas will be paid a 10 percent bonus for major surgical procedures during the same five-year period.
- A second provision guarantees that primary care physicians treating Medicaid patients will be paid no less than what Medicare currently pays for services. For two years, 2013 and 2014, states must pay

primary care physicians (those with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine) at least 100 percent of the Medicare payment rate. If the Medicare payment rate goes down before 2013, the providers are to be paid the Medicare rate at the end of 2009 for primary care services. The federal government will pay any difference between what state Medicaid programs currently pay for those services and the full Medicare rate.

Workforce Provisions to Increase the Number of Providers

The new law includes a set of provisions designed to strengthen and expand the primary care workforce through changes to rules for medical residency training and grants to states and providers that will allow them to expand services to underserved populations. The specific provisions include these:

- **Distribution of unused medical residency positions.** Teaching hospitals that want to train more residents using Medicare's graduate medical education (GME) funding will be able to request additional slots from a pool of unused residency slots. To qualify for the additional slots, teaching hospitals will have to commit at least 75 percent of the new positions to primary care or general surgery. Preference will be given to programs in rural areas and health professional shortage areas. A related provision will allow for the transfer of residency positions from any teaching hospital that closes.

- **Easing rules on residency time and training.** Two provisions relax the rules that govern how teaching hospitals count residents' time for purposes of Medicare GME funding. Residents will be able to spend more time training in nonhospital settings such as physician offices, clinics, and other outpatient settings. The result will be more providers available to treat patients in outpatient settings and newly trained physicians who are better prepared to provide care in offices and clinics.

- **Creation of a Medicare graduate nursing education demonstration program.** This four-year demonstration program will provide Medicare funding (mandatory spending) for graduate nursing education. The goal of the program is to increase the number of advanced practice registered nurses (nurse practitioners, clinical nurse specialists) who can provide primary care and chronic care management, along with nurse midwives and nurse anesthetists to provide women's health care and pain management, respectively.

- **Rural physician training grants.** These appropriated grants are intended to increase the number of medical school graduates who practice in underserved rural communities by helping medical schools recruit students most likely to practice medicine in such communities and by providing rural-focused training to all medical students.

- **National Health Service Corps for Community Health Centers.** The law establishes a scholarship and loan program for students who are committed to providing care in Community Health Centers for two to four years and a student loan repayment program for current primary care providers in these locations for two years. Ten percent of this funding is directed toward nurses. This funding is mandatory and is above the annually appropriated funding for the National Health Service Corps.

- **New demonstration grants for family nurse practitioner training programs.** These grants provide for a one-year residency program for nurse practitioners in federally qualified health centers and nurse-managed health clinics. Congress must appropriate money for the grants annually.
- **Improved Title VIII funding for nursing education.** The annually appropriated funding for nursing education under Title VIII of the Public Health Service Act has been updated to help increase nursing education capacity. The updated Title VIII provisions include the Loan and Scholarship program and the Advanced Education in Nursing (AEN) grants. The former reimburses nurses up to 85 percent of their student loans in exchange for three years of service in a designated area. The new law adds nursing faculty as eligible recipients. The latter program, the AEN traineeships, provides funding for masters' and doctoral-level nursing students that can be used for tuition, fees, books, and limited stipends. The new law removes the 10 percent cap that applied to doctoral-level nursing students. By funding more doctoral-level nurses through traineeships with the AEN and by supporting more faculty with loan repayments, the law will allow more nurses to be prepared as nursing faculty, which in turn will enable nursing schools to accept more students.

Other Initiatives to Help Increase the Provider Workforce

The new health care reform law is not the only means to address concerns about provider shortages. Separate efforts to increase the provider workforce are already under way.

One such effort aims to increase the number of medical school graduates. In 2006, the Association of American Medical Colleges called for increased enrollment in medical schools by 30 percent over 10 years, and in 2005 the Council on Graduate Medical Education recommended a 13 percent increase in the number of residents who enter training each year.[2] In 2009, 18,390 students matriculated at U.S. allopathic medical schools, a more than 10 percent increase over five years.[3] In recent years, three new allopathic and five new osteopathic medical schools have been accredited, and at least eight other schools are in the process of gaining accreditation. This expansion is a huge change from previous decades; before 2008, only one allopathic medical school had opened in the past 20 years and only 10 osteopathic schools in the past 25 years.[4]

In addition to physicians, advanced practice registered nurses—particularly nurse practitioners—provide high-quality primary care and chronic care management. However, barriers at the federal and state levels often prevent consumers from receiving health care from these providers. For example, federal rules specify that if a nurse practitioner prescribes home health or nursing home services, a physician must provide a final signature. These laws delay patients' access to services, despite research that continuously demonstrates that advanced practice registered nurses provide primary care of a quality as high as that provided by physicians.[5]

Most states have laws that mandate physician supervision of advanced practice registered nurses in order for the latter to provide the health care in which he or she is well educated and prepared to deliver independent of physician oversight. In several states, advanced practice registered nurses are regulated by both a board of nursing and a board of medicine. Both of these barriers to

practice can delay consumer access to necessary items such as prescription medication. These laws need to be reconsidered and modernized.

Will These Efforts Be Enough?

For several reasons, it is a challenge to assess whether the various provisions of the new law, together with initiatives independent of health reform, will be sufficient to ensure a large enough workforce, with the right kinds of providers distributed across the nation proportionate to need. First, little consensus exists on exactly how many providers is the "right" number to provide care,[6] or the right mix of primary care physicians, nurse practitioners, nurses, physician assistants, and specialist physicians to meet changing care needs.[7] Second, the law includes many provisions intended to change the way care is delivered; these provisions will likely alter the existing models of demand for services. Innovations such as the medical home, transitional care benefit, and incentives to reduce readmissions may change the mix of providers needed, while efforts to make care more efficient may reduce the number of providers required to deliver care. Finally, changes in overall population health make the future demand for health care uncertain.

Given these uncertainties, it is impossible to say that the workforce provisions in the health care law will be sufficient to meet the needs of insured Americans. However, the Massachusetts experience with reform and a rapid expansion in the insured population offers some insight.

Following enactment of health care reform in 2006, Massachusetts added some 400,000 residents to the health insurance rolls.[8] This large increase in the number of insured persons exacerbated existing physician shortages in the state. Primary care providers were in particularly short supply. A 2009 survey by the Massachusetts Medical Society found that only 60 percent of family medicine/general practitioner physicians and only 44 percent of internal medicine physicians were accepting new patients in 2009, with an average wait time of 44 days for those who were taking new patients.[9] At the same time, surveys report better access to care for those who now have insurance, suggesting that the provider community has been able to accommodate the newly insured.[10]

The efforts described in this fact sheet recognize the need to strengthen primary care and aim to accomplish that in two ways: (1) by increasing the capacity of our medical and nursing education system to educate and produce health professionals who are ready to provide care, and (2) by creating incentives for providers to work where they are most needed: in primary care settings treating underserved populations. Initiatives to expand the physician workforce can succeed only if the capacity of our residency system expands along with the increasing number of medical school graduates. Increasing the number of nurses prepared to serve patients will also be challenging until there is a permanent mandatory source of federal funding for graduate-level nursing education. Without concurrent changes in their scope of practice at the state level and without reforms in how we deliver primary care, nurses will be constrained in their ability to help meet care demands.

Getting more providers to work in primary care and underserved areas is another tough challenge. Existing efforts, such as the National Health Service Corps loan repayment program for physicians who agree to work in underserved areas and higher payment rates for primary care residency slots in Medicare, have had only modest success.[11] More fundamental changes,

such as payment reform that recognizes the value of primary care or allows patients in rural areas to access care remotely, may be necessary to match supply with demand.

Even if the efforts described here are successful, it will take many years for them to produce significantly greater provider numbers. The largest demand for access to care will come in 2014, when the full coverage provisions of the law go into effect. Many of the newly insured may be in need of care to address health issues that began while they were uninsured. We should expect to see strains on health care workforce capacity in 2014 and for several years thereafter, regardless of efforts to expand the workforce.

The provisions in the health care reform law that are intended to increase the capacity of the workforce to treat growing numbers of insured Americans are not likely to succeed by themselves, but they are an important start. Future efforts should build on the initiatives that show positive results.

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[1] Congressional Budget Office, March 20, 2010, letter to the Honorable Nancy Pelosi.

[2] COGME, *Sixteenth Report: Physician Workforce Policy Guidelines for the United States, 2000–2020* (Washington, DC: COGME, 2005).

[3] AAMC Applicant and Matriculant data, http://www.aamc.org/data/facts/applicantmatriculant/table4-fact2009slrmat-web.pdf (accessed January 27, 2010).

[4] Myrle Croasdale, "Flood of New Medical Schools Filling Accreditation Pipeline," *American Medical News* (January 21 2008).

[5] M. O. Mundinger and others, "Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial," *JAMA* 283, no. 1:59–68; B. J. Kirkwood, D. J. Coster, and R. W. Essex, "Ophthalmic Nurse Practitioner-Led Diabetic Retinopathy Screening. Results of a 3-Month Trial," www.ncbi.nlm.nih.gov/pubmed/16254596?dopt=citation (accessed April 1, 2010); U.S. Congress, Office of Technology Assessment, "Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives: A Policy Analysis," www.princeton.edu/~ota/disk/1986/8615/8615.pdf (accessed April 1, 2010).

[6] David C. Goodman and Elliott S. Fisher, "Physician Workforce Crisis? Wrong Diagnosis, Wrong Prescription," *New England Journal of Medicine* 358, no. 16 (2008): 1658–61.

[7] Lynn Nonnemaker, *Graduate Medical Education and Medicare: Understanding the Issues* (Washington, DC: AARP Public Policy Institute, 2010).

[8] Massachusetts Insurance Connector, "Health Reform Facts and Figures" (April 2010), www.mahealthconnector.org/portal/site/connector/menuitem.d7b34e88a23468a2dbef6f47d7468a0c?fiShown=default (accessed May 17, 2010).

[9] Massachusetts Medical Society, "Physician Workforce Study" (September 2009), www.massmed.org (accessed May 17, 2010).

[10] Jennifer Wilson, "Massachusetts Health Care Reform Is a Pioneer Effort, But Complications Remain," *Annals of Internal Medicine* 148, no. 6:489–92.

[11] George M Holmes, "Does the National Health Service Corps Improve Physician Supply in Underserved Locations?" *Eastern Economic Journal* 30, no. 4:563–81; Donald E. Pathman, Thomas R. Konrad, and Thomas C. Ricketts, "The Comparative Retention of National Health Service Corps and Other Rural Physicians," *JAMA* 268, no 12:1552–8.

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