

Tuesday, July 19, 2005
9:00 to 11:00 AM
Oregon State Library Room 103
250 Winter Street NE
Salem, Or



Notes/Presentations

- I. Introductions: Attendees; Myde Boles, Roy Gabriel, Lorey Freeman, Scott Shipman, Jennifer Lin, Regan Duffy, Wei Zhou, Pooya Naderi, Judy Mohr Peterson, Dennis Deck, Jane Myers, Kari Greene, Ellen Brown, Alison Little, Jeanene Smith, Tina Edlund, Lisa Krois, Jessica Miller
- II. Brief update of OHREC activities
- III. **“Counting Pediatricians and Considering the Implications”** Presented by, Scott A. Shipman, MD, MPH Oregon Health & Science University
- IV. **“The Impact of Medicaid Program Changes on Low Income Adults, Results from an Ongoing Prospective Cohort Study”** Presented by, Bill J. Wright, Ph.D. Providence Health System Center for Outcomes Research and Education
- V. Wrap Up

Counting Pediatricians and Considering the Implications

Scott A. Shipman, MD, MPH

Oregon Health & Science University

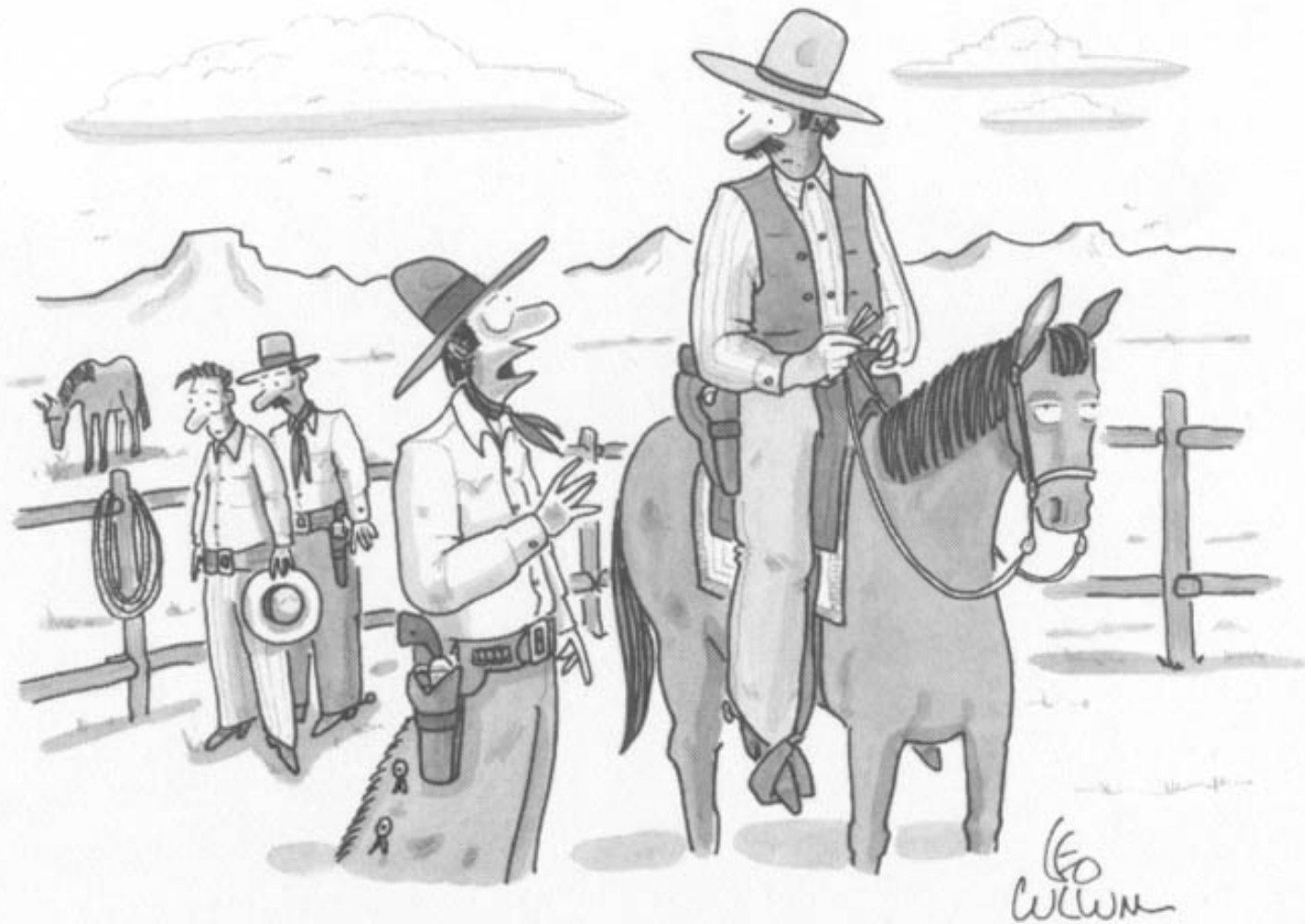
Oregon Health Research and Evaluation Collaborative

July 19, 2005

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Physician Supply

- Too many, too few, or just right?
- Varied ideologies
 - Demand-based
 - Need-based
 - Benchmarking
- Within pediatrics:
 - American Academy of Pediatrics, 1998 Workforce Statement: adequate aggregate supply of pediatricians
 - Future of Pediatric Education II Workforce Workgroup, Final Report: “keep stable levels or ↑ slightly”



"Slim has a dry scaly patch on his neck! Ride to town and bring the dermatologist."

Unified primary care workforce policy: is it appropriate?

- Pediatrics shares much in common with IM, FM:
 - Similar philosophies, traditions, policy challenges
- However, there are significant differences:
 - Subspecialization rates lower for pediatrics than IM
 - Pediatric population quite stable when compared to the growing elderly population
 - The majority of pediatricians are women
 - U.S. student interest:

% of NRMP positions filled by USMGs 2000-2003

Pediatrics 74.3 Internal Med 57.8 Family Med 48.8

Research questions

- Is the future supply of general pediatricians likely to be balanced with the requirements of the population?
- How much influence do assumptions have on the projected adequacy of the supply?
- Are projected workforce trends generalizable across pediatrics, general internal medicine and family medicine?

Methods

- Modeling using Stella® software
- 20 year projection, 2000-2020
- *Baseline workforce:* All general pediatricians practicing > 20 hrs/ week, excludes residents & fellows
- *Annual entry into workforce:*
(pediatrics residency graduates + 0.5med/peds graduates - fellowship entrants - 0.25 of IMG graduates) x (0.94)[†]
[†]*research, administrative, or other non-clinical positions*
- *Annual attrition:* age and gender specific retirement/death rates; all censored at 75 years of age
- *Child population:* all U.S. children < 18 years of age

Methods: Data sources

Current general pediatrician supply	1999 American Medical Association (January 1 1999) and American Osteopathic Assoc. (June 1 1999) Physician Masterfiles
New general pediatricians	1999-2000 AMA Annual Survey of Graduate Medical Education
International Medical Graduates	1999-2000 AMA Annual Survey of Graduate Medical Education
Death and Retirement	Bureau of Health Professions Separation Rates, 1995
FTE adjustment	American Academy of Pediatrics, 2000
Population	US Bureau of Census, 2000
Market share	Nat. Ambulatory Medical Care Survey, 1999

Methods: Sensitivity Analyses

Pediatrician Supply

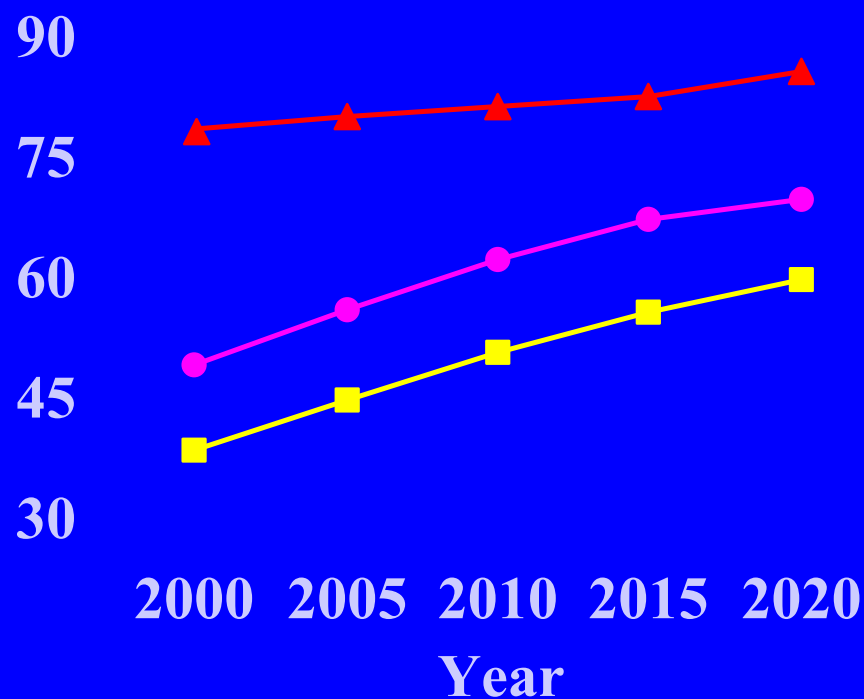
- Number of new entrants*
 - Simulated policy mandates, variable student interest
- Gender of new entrants
- Retirement rate*, age
- Productivity/ work effort*
 - Variable by age group

Requirements for Pediatricians

- High, middle, low Census estimates for child pop.*
- Market share by age group (0-4, 5-9, 10-14, 15+)*
- Shifting ethnicity of child population

*sensitivity analyses included in this presentation

Results: Projected Number of Pediatricians and Children, 2000-2020



Rate of growth*

Children: 9%

Pediatricians: 55%

Per capita supply: 42%

*over 20 years

- ▲ Child population (millions)
- Pediatricians (thousands)
- MD per 100K children

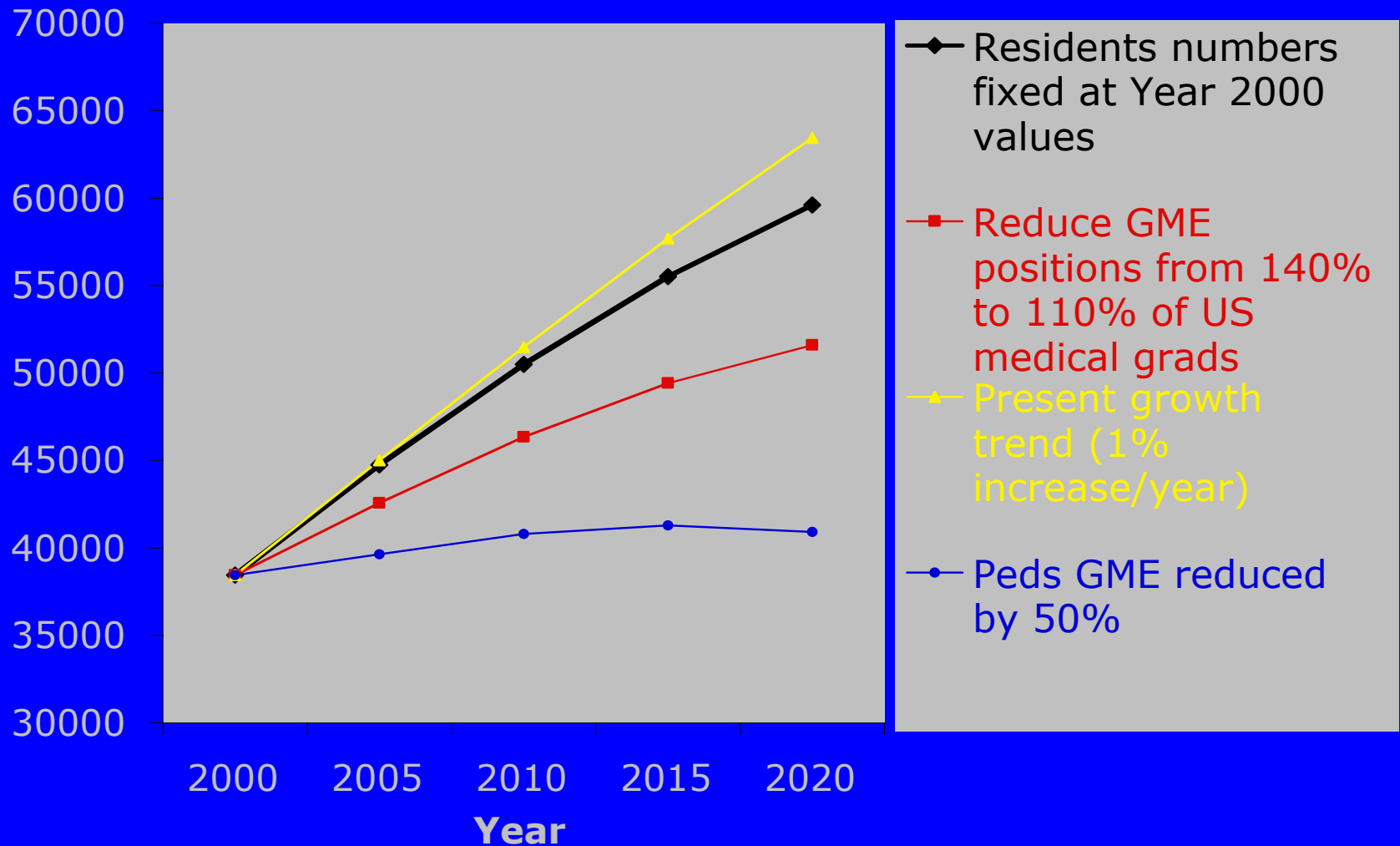
General Pediatrician Supply: Baseline model and sensitivity analyses

	Excess* general pediatricians		
	2000	2010	2020
Baseline	0	10,820	17,685
50% ↓ in new entrants	“	3,510	1,295
↓ productivity mid-late career	“	4,330	9,045
Doubling of retirement rate	“	9,065	14,610

*Beyond the number needed to maintain per capita ratio at 2000 values

All analyses FTE adjusted

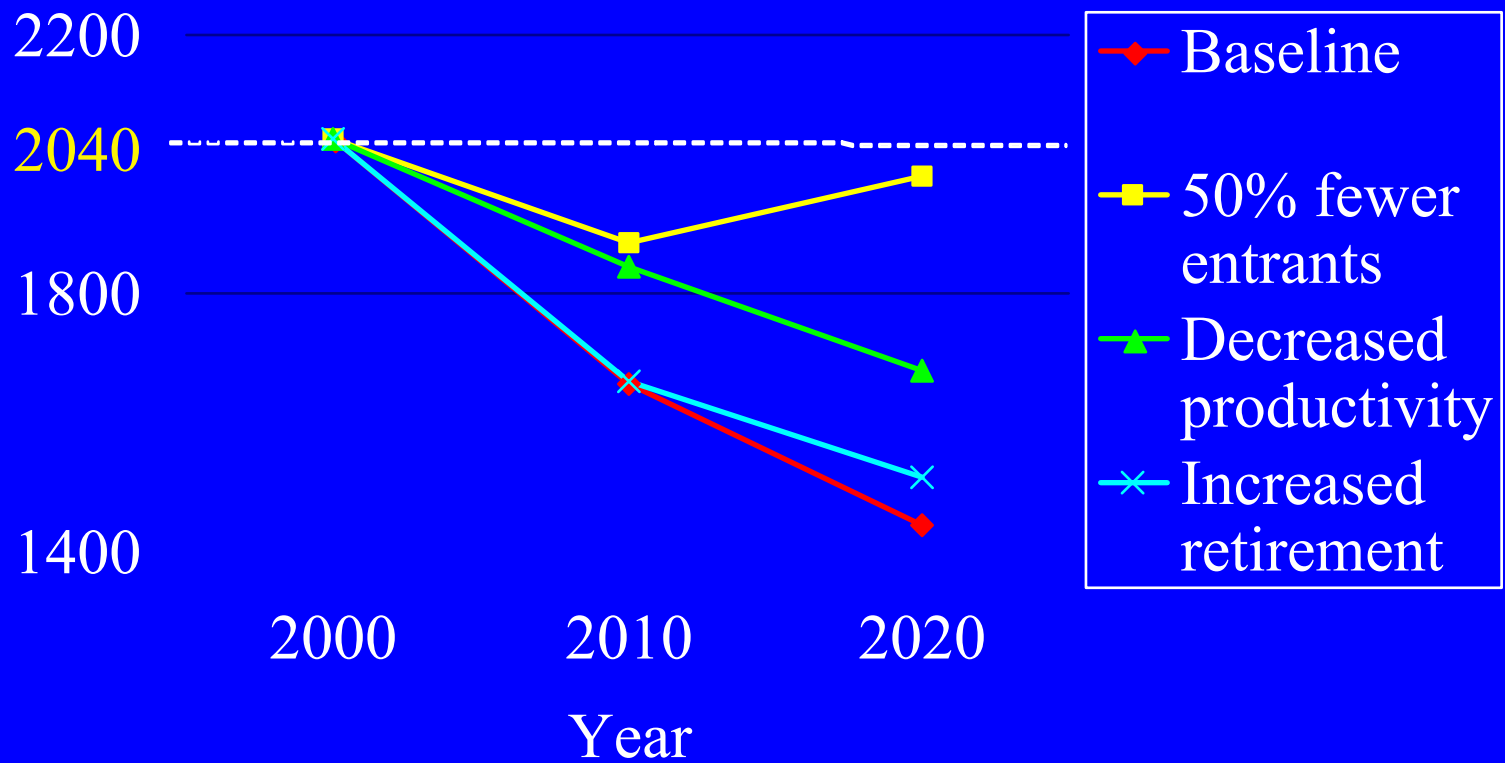
Effect of GME Variation on General Pediatrician Workforce



Impact of Retirement and Productivity on the General Pediatrician Workforce



Supply sensitivity analyses: No. of children per pediatrician



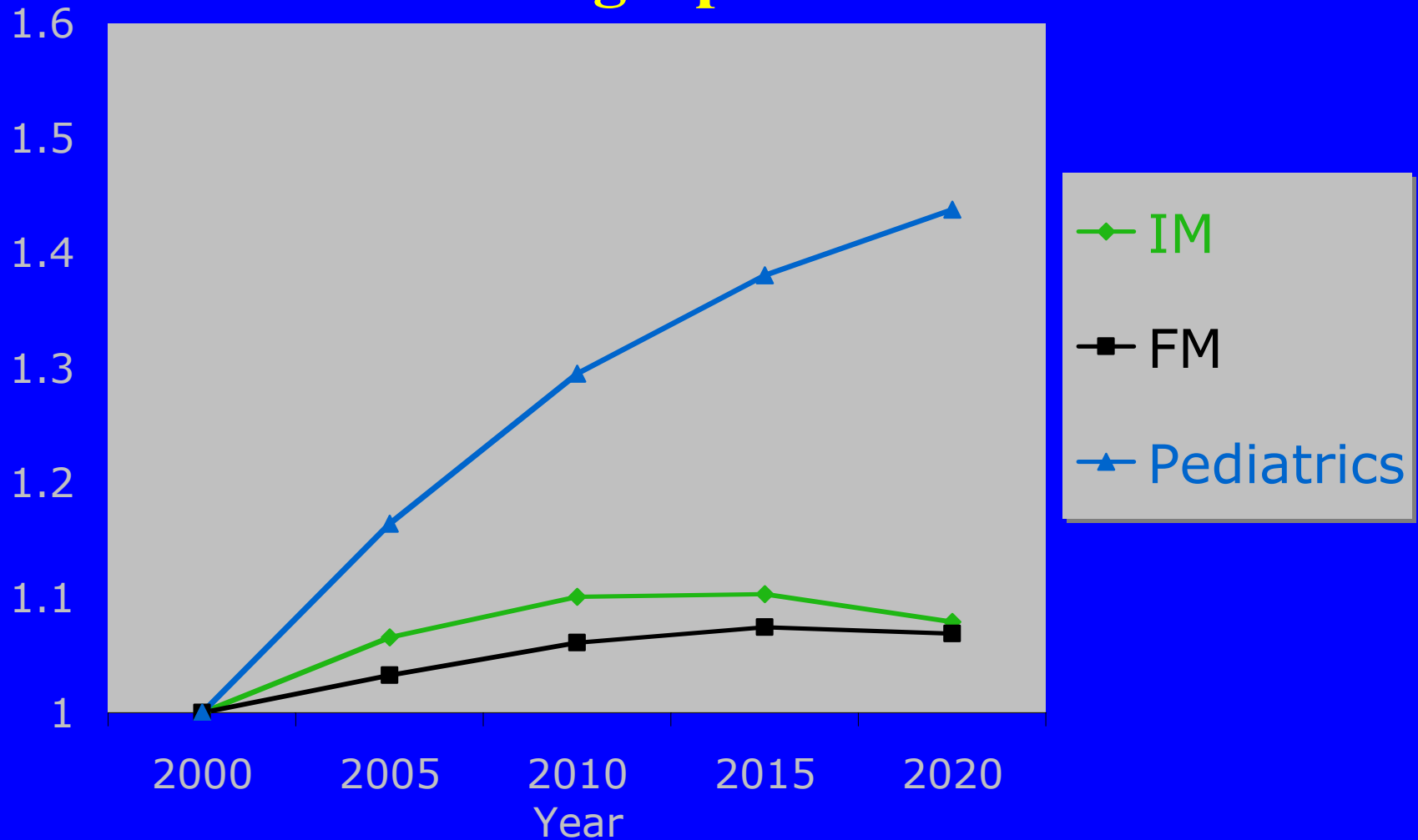
All analyses FTE adjusted

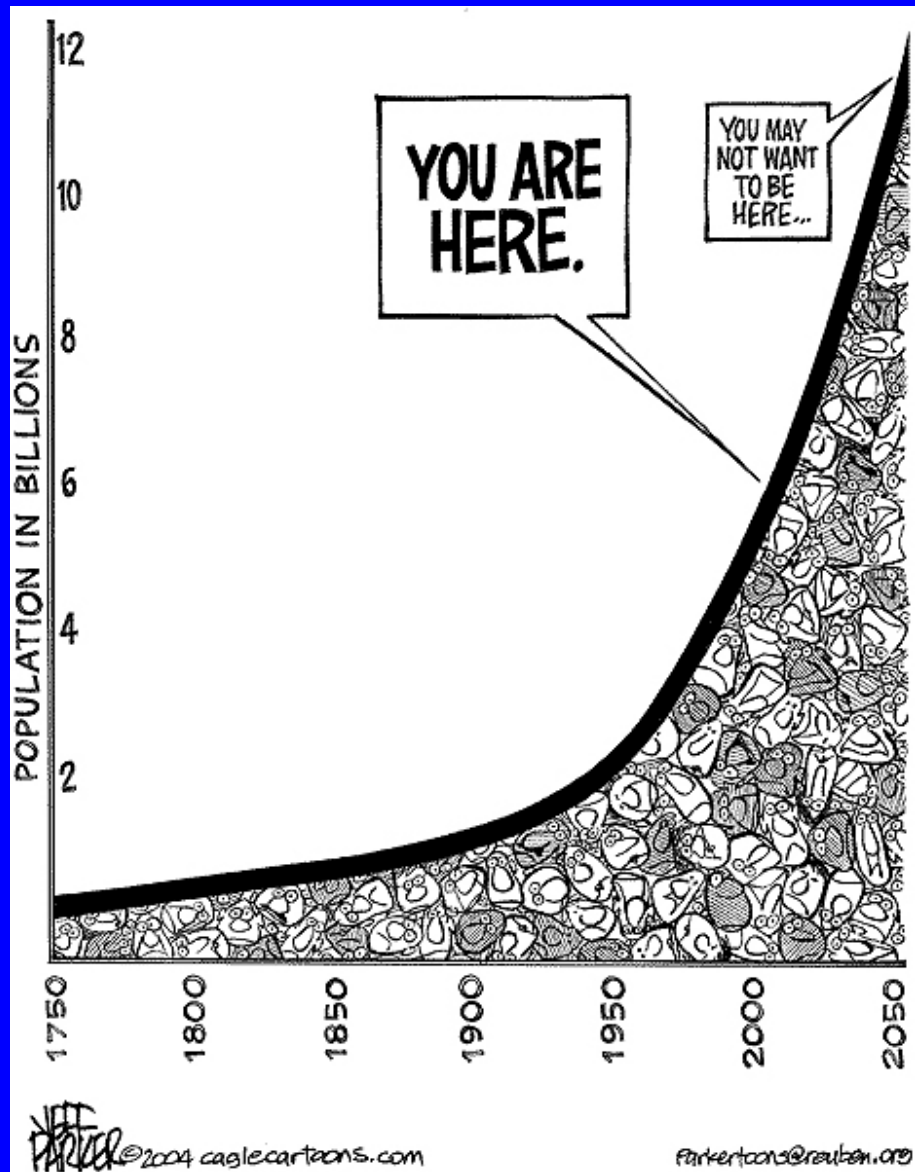
Requirements for Pediatricians: Sensitivity Analyses

	Added Peds FTEs needed		Excess supply beyond need	
	2010	2020	2010	2020
100% market share of visits ages 10-18	5,425	5,735	5,395	11,950
100% market share of all child visits	11,275	11,915	(540)	5,685
High population census estimate	2,170	6,455	8,570	11,140

All analyses are FTE adjusted

Projected Per Capita Supply for Primary care Physicians, Adjusted for Changing Population Demographics





Limitations

- National workforce model
 - Does not account for regional variation in supply
- Model is only as good as data sources
 - Retirement/death data, from 1995, is most recent available
- Workforce projections become more suspect over time
 - Limited to 20 years, robust within this period

Summary

- General pediatrics is experiencing a marked growth in supply, in excess of the growth in the child population
- Numerous scenarios that could decrease the effective supply of pediatricians or expand the requirements for their services are not adequate to overcome the expansion in per capita supply
- The robust expansion in per capita workforce within general pediatrics is unique among the primary care specialties

How might pediatric practice change?

- Less volume, less productivity
- Provide a broader array of services
- Expand care to new age ranges
- More non-clinical roles
- Greater dispersion of pediatricians
- Increased emigration of pediatricians

Workforce policy implications

- Additional factors may accentuate the impact of the growing general pediatrics workforce
 - e.g. expansion of non-physician providers, hospitalists
- For meaningful workforce considerations, may need to consider the primary care specialties independently
- Unless multiple forces act to limit workforce growth, the scope of practice of general pediatrics may need to evolve to maintain viable practices

OREGON Physician Workforce: policy trends

- OHSU wishes to double medical school enrollment to stave off a “physician shortage” in the state
- 2004 OMA/OHPR Physician workforce study found 22% of respondents anticipate retirement in next 5 years

OREGON Physician Workforce

- Generalist workforce ↑ 18% 1990-2000
- Specialist workforce ↑ 23% 1990-2000
- Population ↑ 20% 1990-2000

- Generalist workforce
 - 16th highest overall per capita supply
 - 9th highest rural per capita supply

Child Physician Workforce: OREGON

- 1 Pediatrician per 2,049 children
- 1 Child physician per 1,415 children
- 78 Oregon Primary Care Services Areas
 - 1 Pediatrician per 910 children in Portland
 - 1 Pediatrician per 10,200 children in Woodburn
 - 43 have no pediatrician
 - 12 have no family physician either

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Workforce lessons

- Little evidence to support assumption that a population's health is improved in areas with more physicians
- Consistent evidence showing that costs increase in areas with more physicians
- Cautionary note: growing overall supply may not achieve desired results, and may have unintended consequences

Workforce lessons, cont.

- Physician shortages are primarily a regional phenomenon
- Efforts to overcome shortages require **targeted efforts** to improve distribution to underserved areas
 - e.g. Per capita pediatrician workforce is growing rapidly, yet shortages persist

Questions and Feedback?



"You're doing it wrong."

The Impact of Medicaid Program Changes on Low Income Adults

Results from an Ongoing Prospective Cohort Study

Bill J. Wright, Ph.D.

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Center for Outcomes Research and Education

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Office for Oregon Health Policy and Research

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Office for Oregon Health Policy and Research

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Office of Medical Assistance Programs

Summary of Changes to OHP

Early 2003

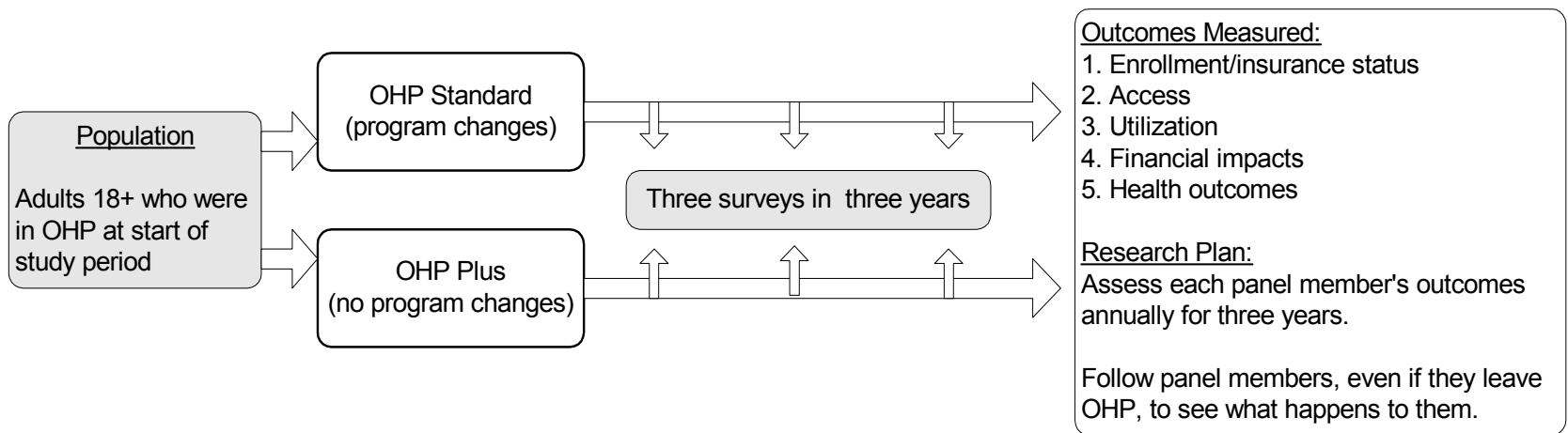
- Premium changes - \$6-\$20 per month based on income.
- Expansion of co-pays - office visits, labs, ED, prescriptions, hospitalization; ranging from \$5 to \$250.
- Non-payment of premium results in 6 month “lock-out” from OHP.
- Eliminated coverage for dental, vision, outpatient mental health, substance abuse, durable medical equipment.

Summer 2004

- In response to a legal ruling, copays dropped for Standard members.
- Outpatient Mental health and chemical dependency benefits restored.

Design of the OHP Cohort Study

Longitudinal cohort study designed to assess impacts of program redesign by following a group of people for three years after the initial changes.

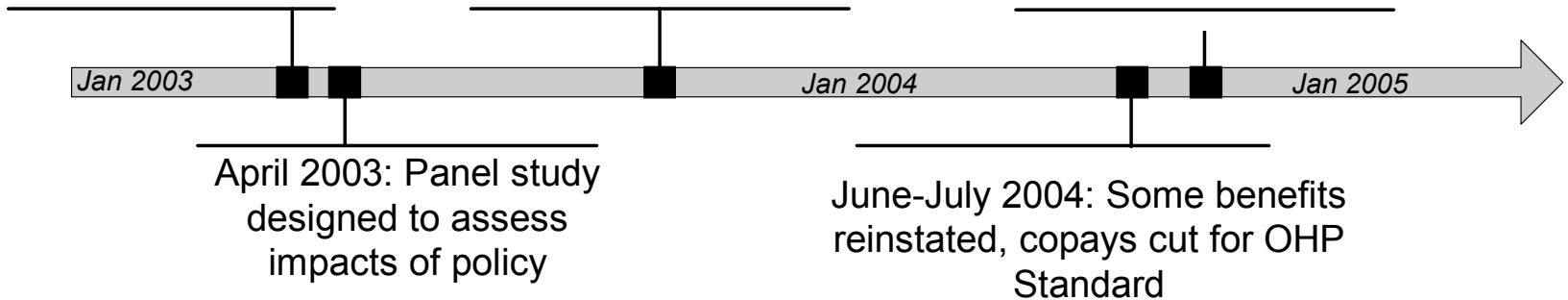


OHP Program Redesign and Cohort Study Milestones

March 2003: Benefits cut,
cost sharing increased for
OHP Standard

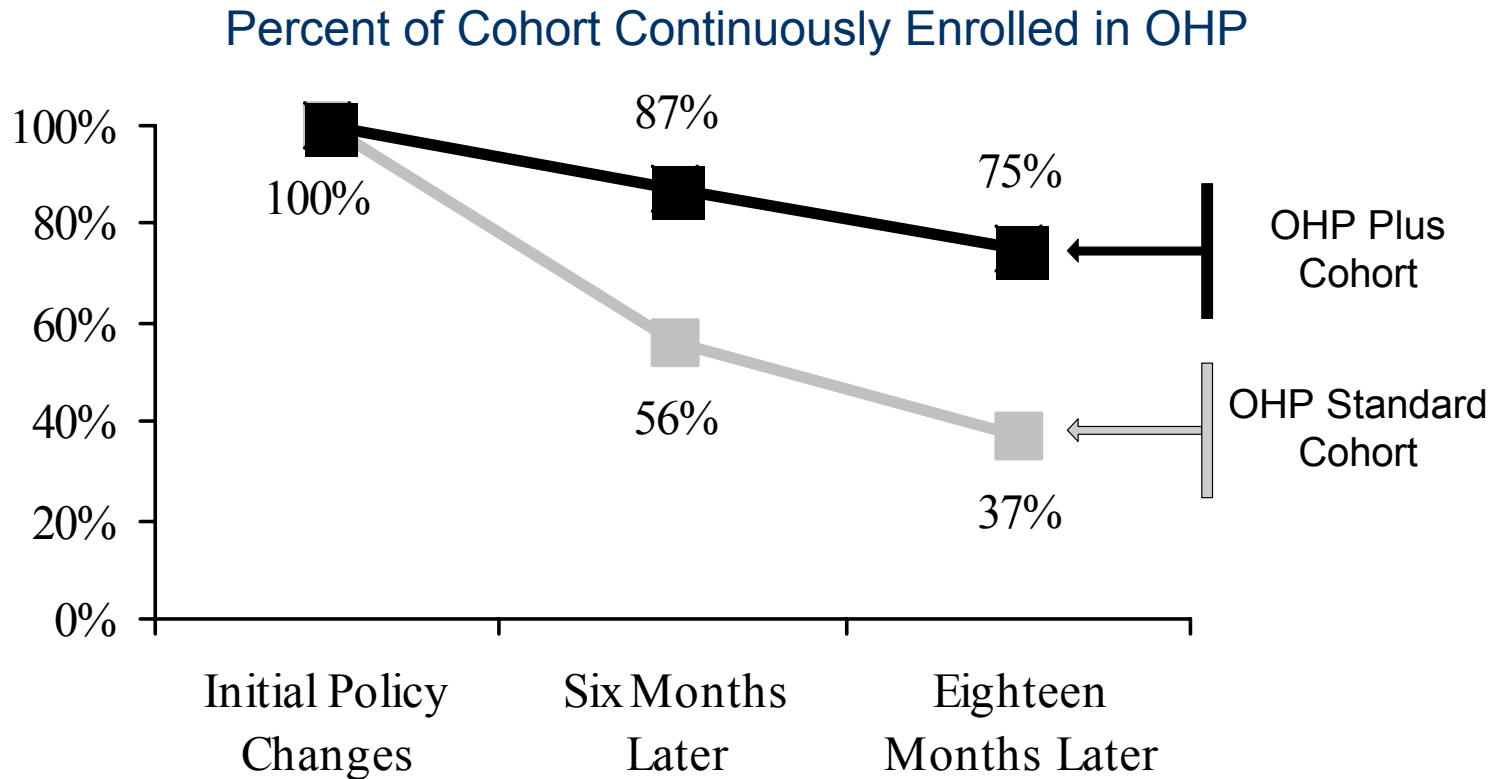
Sep 2003: Panel
recruitment & baseline
(Wave 1) surveys begin

Nov 2004: Wave 2
surveys begin



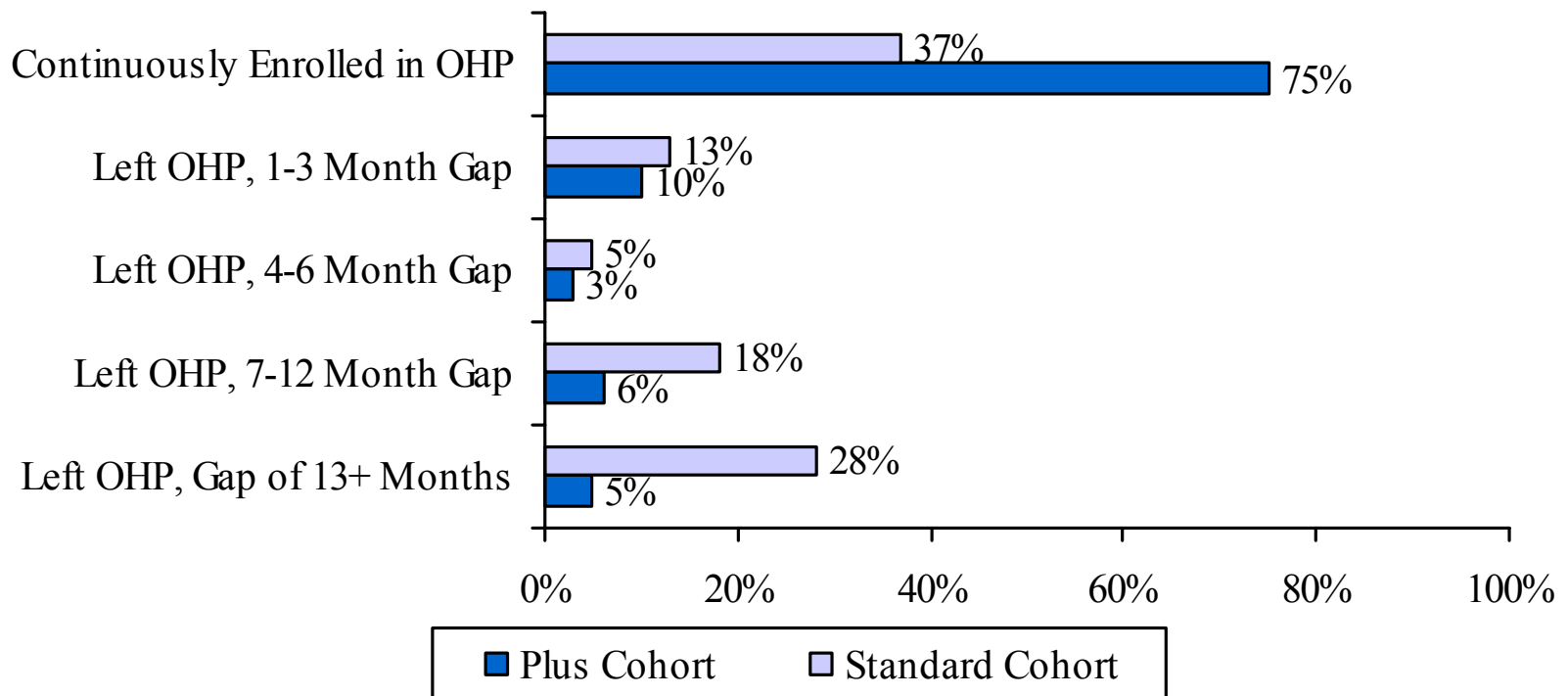
Insurance Status

Nearly 2/3 of the Standard cohort have left OHP since the initial program redesign.



Insurance Coverage

Most Standard cohort members who left experienced gaps in coverage of more than six months.



31% of Standard were uninsured at second survey, compared to 9% of Plus.

Insurance Status

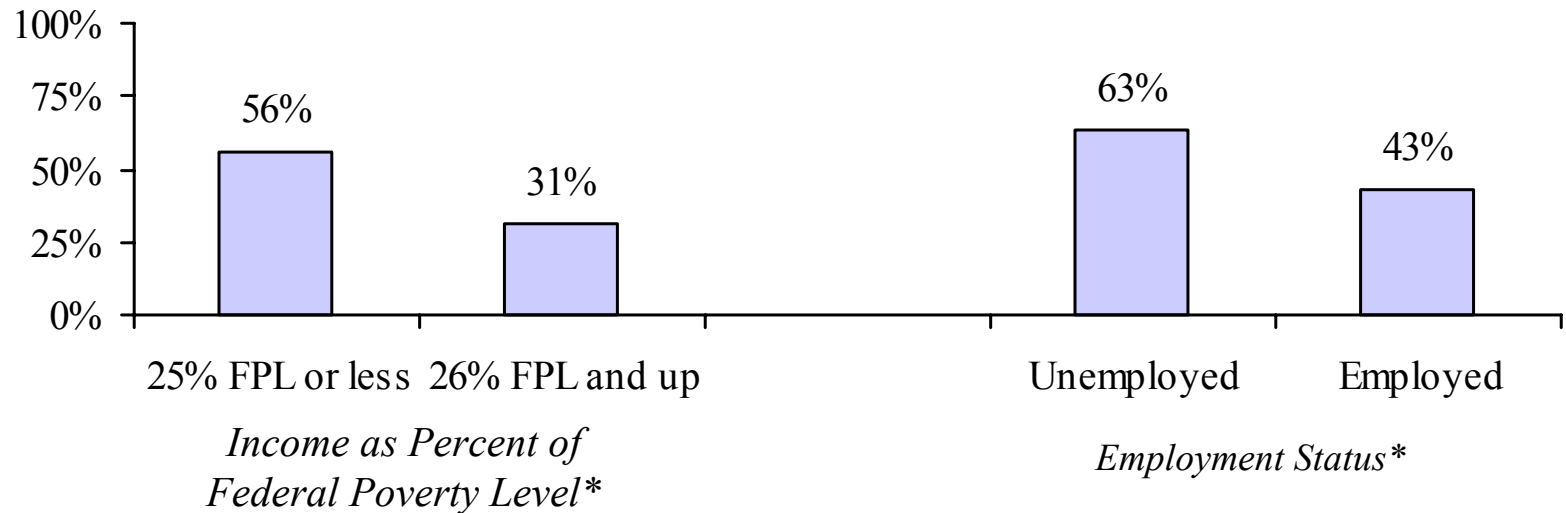
The program redesign was an important reason why many Standard members left OHP during the study.

Policy-Related Reasons for Leaving OHP	Percent Choosing Reason (Multiple Responses Allowed)
Could Not Afford the Premiums <i>New Policy: Increased Premiums, No Premium Exemptions</i>	23%
Owed Back Premiums <i>New Policy: Six Month Lockout for Non-Payment of Premiums</i>	22%
Could Not Afford the Copays <i>New Policy: Co-pays Introduced For Most Services</i>	20%
Loss of a Benefit <i>New Policy: Mental Health, Chemical Dependency, DME, Vision, Dental Cut</i>	7%
Percent Who Chose At Least One of the Above	53%

Insurance Status

Coverage impacts were especially strong among the most economically vulnerable members.

Percent who left for reasons related to the program redesign

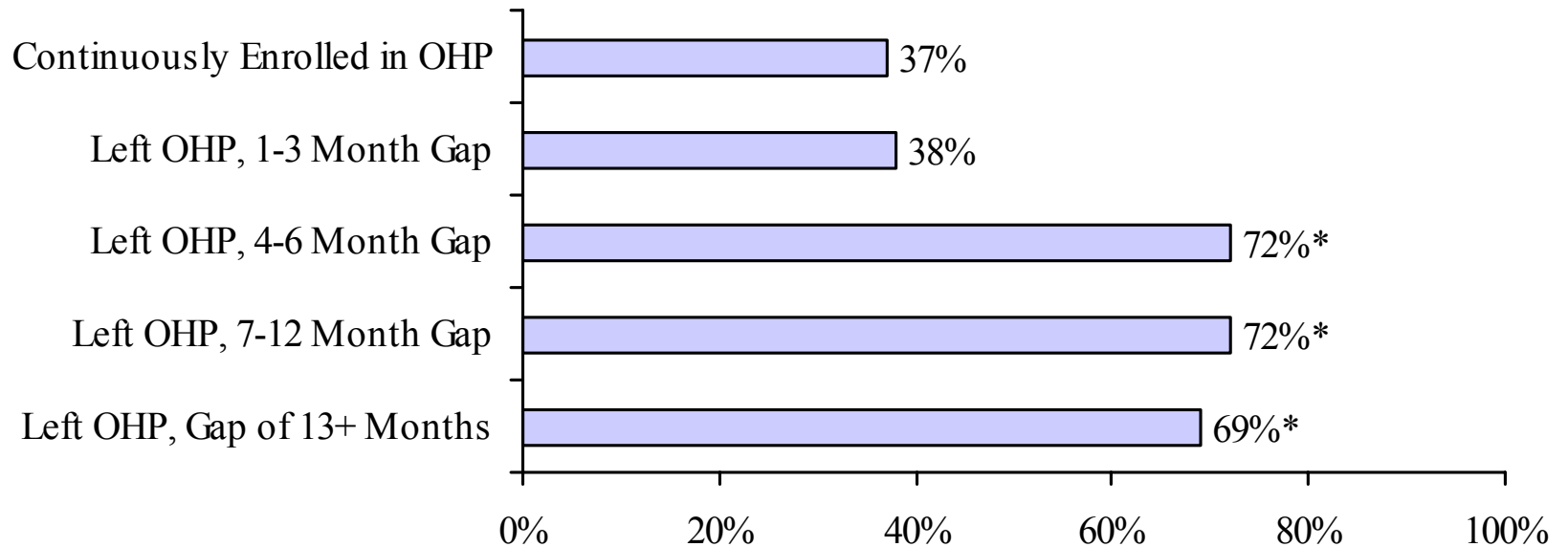


*Statistically significant difference, $p < .01$, two-tailed chi-square test.

Access to Care

Those who left OHP During the study had higher unmet need for care, when coverage gaps were over 3 months.

Percent who experienced unmet need for health care during study

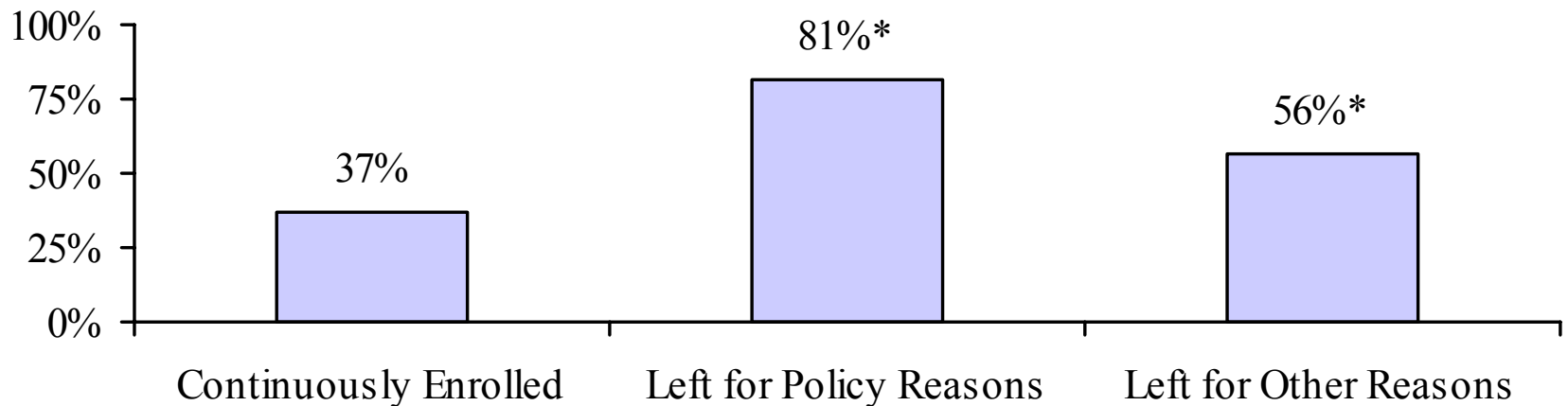


*Statistically different than the score for the continuously enrolled, $p < .001$, two-tailed z-test.

Access to Care

Those who left OHP for policy reasons had the highest levels of unmet need throughout the study.

Percent who experienced unmet need for health care during study



*Statistically significant than the score for the continuously enrolled, $p < .001$, two-tailed z-test.

Access to Care

For those who stayed in OHP, cutting copays & restoring benefits does seem to have helped access.

Changes in Unmet Need Among the Continuously Enrolled

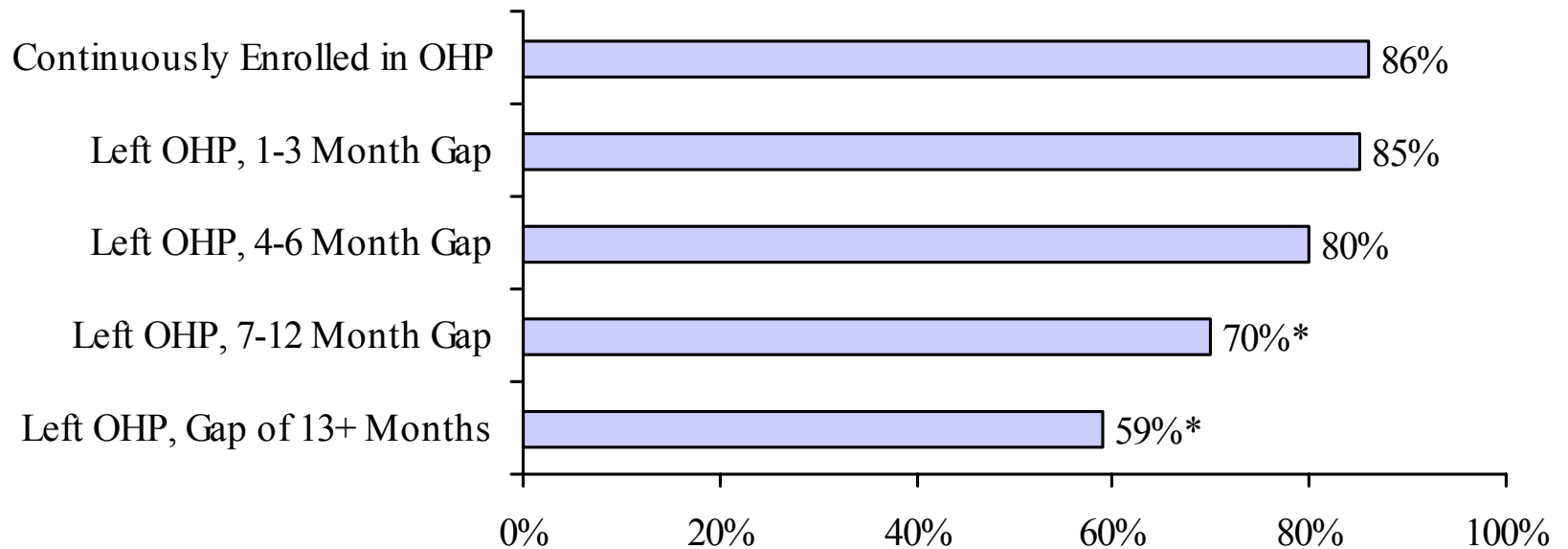
	First Survey (Before Copays Eliminated)	Second Survey (After Copays Eliminated)
Percent Who Experienced Unmet Need	28%	19%*
Of Those with Unmet Need, Percent Identifying Cost as the Reason	55%	32%*

*Statistically significant than the score from the first survey, $p < .001$, two-tailed z-test.

Utilization

Those who left OHP used primary care less, if coverage gaps were more than six months.

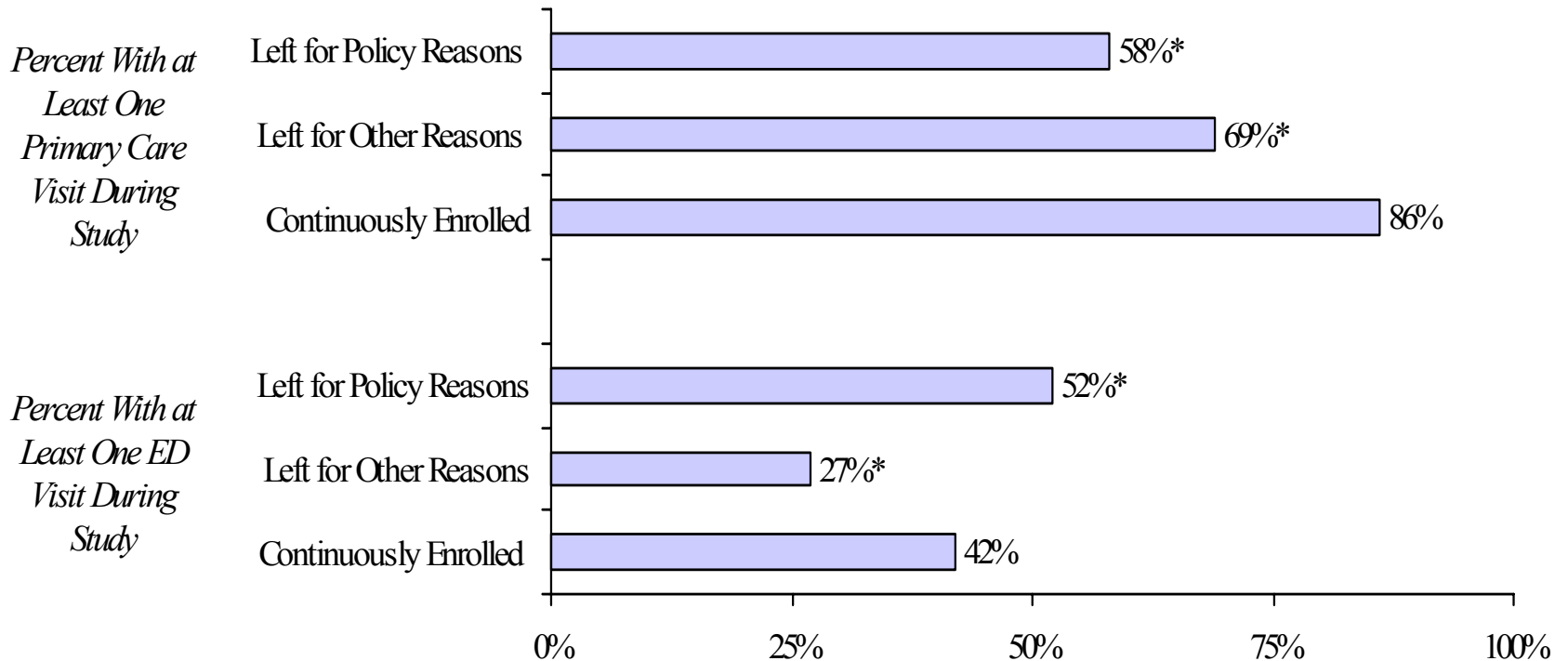
Percent with at least one primary care visit during study



*Statistically different than the score for the continuously enrolled, $p < .001$, two-tailed z-test.

Utilization

Those who left OHP for policy reasons were less likely to use primary care and more likely to use hospital EDs.

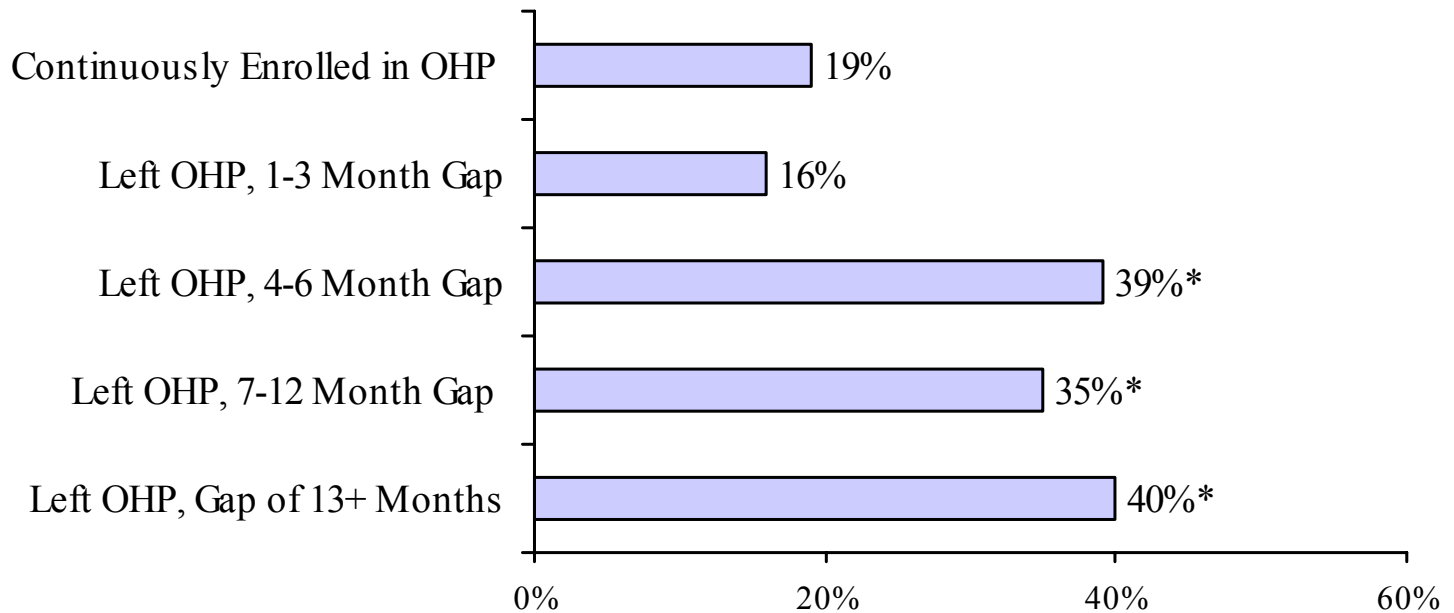


*Statistically different than the score for the continuously enrolled, $p < .001$, two-tailed z-test.

Financial Impacts

Those who left OHP were much more likely to owe \$500 or more in medical debt, even if they later returned.

Percent who owe \$500 or more in medical debt



*Statistically different than the score for the continuously enrolled, $p < .001$, two-tailed z-test.

Financial Impacts

For those who stayed in OHP, cutting copays & restoring benefits helped alleviate financial strains.

	First Survey Period	Second Survey Period
Had to borrow money from family or friends to pay medical costs in last 6 months	30%	23%*
Had to cut back on food to pay for medical costs in last 6 months	35%	26%*
Had to underpay or miss payments on other bills due to medical costs in last 6 months	34%	27%*
Had to pay more than \$100 in out-of-pocket medical expenses in past six months	43%	34%*

*Statistically significant than the score from the first survey, $p < .001$, two-tailed z-test.

Conclusions

Reducing benefits and increasing copays dramatically impacted the health care of OHP Standard members.

- The initial 2003 program redesign contributed to widespread loss of coverage among OHP Standard members over the next 18 months.
- Most of those who lost coverage did not find other insurance.
- The most vulnerable were also most impacted by the program redesign.
- Loss of coverage was associated with reduced access to care, less use of primary care, greater strain on personal finances.
- *Policy-related* loss of coverage was also associated with higher ED use.
- Impacts of coverage loss were mostly mitigated for those who had coverage gaps of 3-6 months or less.
- Eliminating copays and restoring certain benefits improved access to care and reduced financial strains, but only for those who were still in OHP when those changes took place.

Policy Implications

Data suggest re-examination of premium exemptions and the length of the lockout period.

- Even small cost sharing increases may create loss of coverage among the most vulnerable members. Allowing exemptions for very low income might help ensure the most needy are not the ones who leave the system.
- Those who leave because of cost sharing are highly vulnerable; they will have high levels of unmet need, will use primary care less and acute care more, and will accumulate significant medical debt after leaving.
- The impacts of coverage loss begin to occur after gaps of just 3-6 months. Eliminating or reducing the current six month lockout period for non-payment of premiums could alleviate the worst impacts of coverage loss on access, utilization, and finances.

Acknowledgements

- The Robert Wood Johnson State Coverage Initiative, through the Office of Oregon Health Policy and Research, provided support for the planning and first wave of this study.
- The Commonwealth Fund provided financial support for the second wave of the study.
- The Office of Medical Assistance Programs has also provided considerable financial support for this research.
- This study is being conducted through the *Oregon Health Research and Evaluation Collaborative*: Portland State University, Providence Health System, Oregon Health and Science University, Oregon State Office of Medical Assistance Programs, and the Office for Oregon Health Policy and Research.