

Oregon Healthcare Workforce Committee

AGENDA – August 16, 2016 10:00 am– 12:00 pm

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Meeting Objective:

- Develop Final Recommendations to Oregon Health Policy Board on HB 3396

#	Time	Agenda Item	Presenter(s)	Action Item
1	10:00 – 10:05	Convene HCWF Committee, Welcome	David Pollack	
2	10:05 – 10:15	Public Comment on HB 3396	Any	
3	10:15- 10:20	Update from July 15 OHPB Meeting	Carla McKelvey Robyn Dreibelbis	
4	10:20 – 10:30	Walk-Through of Meeting Materials: <ul style="list-style-type: none">• Lewin Group Reports• Listening Session Summary• Discussion Document• Summary of Recommendations	Marc Overbeck	
5	10:30 – 11:50	Committee Discussion/Action: <ul style="list-style-type: none">• Recommendations Document• Other Recommendations?• Longer-Term Options for system restructuring	All	X
6	11:50 – 12:00	Next Steps/Good of the Order	All	
7	12:00	Adjourn: Confirm Next Meeting September 7	David Pollack	

Meeting Materials

1. Agenda
2. Lewin Cover Memo and Executive Summary
3. Lewin Full Report
4. Listening Session Summary
5. Discussion Document
6. Summary of Recommendations
7. Map of potential “new” framework for system of supports for health care workforce

August 12th, 2016

To: Oregon Health Authority

Subject: HB 3396 Lewin Report

One of the requirements of House Bill 3396 passed by the Oregon Legislature in 2015 is to study and evaluate Oregon's health care workforce incentive programs, in light of current and projected health care workforce shortages. The Lewin Group was tasked to conduct an analysis of existing strategies to address these shortages and evaluate provider incentive programs to inform future funding decisions by the Oregon Legislative that ensure incentive programs are based on demonstrated effectiveness and are as cost effective as possible. The current study and recommendations will provide the Oregon Health Policy Board and the Legislature with information to help ensure Oregon is supporting programs that are both effective and cost-efficient in terms of recruiting and retaining qualified health care providers, particularly in rural and areas in high need of medical services.

We consider the incentive programs to be effective if the number of provider FTE-years in targeted areas increases as a direct result of the program. Based on this metric, we find empirical evidence that all programs increase the number of provider FTE-years above what would have been available in rural areas over the period between 2010 and 2014 without the programs. Some programs have a recruiting effect – they attract new providers into the area, some have a retention effect – they keep providers in the area longer, while some have both a recruiting effect and retention effect. More specifically, we find that:

- NHSC LRP has an important recruiting effect on primary care physicians, and an even larger effect on NPs and PAs, which makes this program an effective recruiting tool
- NHSC LRP also has a relatively minor retention effect
- The other loan repayment programs (SLRP, BHLRP and MPCLRP) are likely to have similar effects, given that they are similar in terms of award amounts and eligibility criteria
- RPTC and RMPIS have negligible recruiting effect on primary care physicians, but do have a small recruiting effect on NPs and PAs
- Instead, RPTC and RMPIS have a sizeable retention effect on all providers, which makes them efficient retention tools in rural areas
- Costs of attracting an additional FTE-year through any of the programs are lower in the case of NPs and PAs, relative to primary care physicians
- Costs of an additional primary care physician FTE-year are similar across programs, and the same is true for NPs and PAs.

We also formulate a number of recommendations that have the potential to improve the analysis and evaluation of the provider incentive programs in the future. These recommendations are aimed at increasing the programs' recruiting effect, retention effect, or both, as well as improving their cost-effectiveness. Our analysis of the key features of the current programs yields a number of insights into the features that tend to be associated with incentives that offer greater cost-effectiveness. They are centered on issues such as the:

- targeting of benefits
- budget control
- cash vs in-kind benefits
- current vs deferred benefits
- costs incurred today vs costs incurred later

We then assess the current programs through the prism of these features and provide observations on how the programs may be made more efficient and cost-effective. Also, as future efforts to enhance the effectiveness of these programs should focus on increasing the number of providers who would not serve in rural areas without incentive programs, we formulate a number of recommendations on how to achieve this objective. These include:

- Creation of a bidding mechanism allowing providers to offer more years of service in rural areas
- Increasing the value of the program “package” (for instance, by allowing for a stipend to cover moving expenses for providers who are not in rural areas)
- Relaxing job requirement as a condition for a loan repayment application
- Increasing awareness of the availability of programs, by providing a consolidated single source of information and applications across programs
- Encouraging multiple program participation
- Increasing the amount of awards
- Increasing the number of loan repayment awards
- Allowing for different award amounts by provider type

Moreover, once participating providers locate to rural areas, we propose a set of measures to increase the retention of participating providers in those areas. These recommendations include:

- Encouraging the combination of benefits
- Introducing obligation periods
- Retaining former obligors in the state
- Increasing the number of limited-funded awards

Although they are outside the scope of the incentive programs, changing clinical practices in rural centers, and boosting community support for providers may also have the beneficial effect of increasing retention of providers in rural areas.

The main conclusion of this report is that all incentive programs analyzed are successful in increasing the number of providers in rural areas in Oregon. Some programs are better recruiting tools, while other programs are better retention tools. Our program and policy recommendations are aimed at further increasing the efficacy and cost-effectiveness of programs in the future. Also, our data collection recommendations ensure that future program evaluations will have a deeper and wider scope, hence more effectively informing funding decisions by the Oregon Legislative.



HEALTHCARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.

Data Analysis, Evaluation, and Recommendations Concerning Health Care Workforce Incentives in Oregon

Summary Final Report

Prepared for: Oregon Health Authority

Submitted by: The Lewin Group, Inc.

August 10, 2016

Table of Contents

I. INTRODUCTION.....	3
II. THE OREGON HEALTH MARKET	5
III. PROVIDER INCENTIVE PROGRAMS IN OREGON.....	7
A. Participation in Incentive Programs.....	7
B. Retention Analysis of Incentive Program s.....	8
C. Recruitment Analysis of Incentive Programs.....	8
IV. PROGRAM RECOMMENDATIONS.....	11
Features Associated with Efficient, Cost-Effective Incentive Programs	11
D. Observations on Oregon Provider Incentive Programs	11
V. POLICY RECOMMENDATIONS	13
Improving Recruiting.....	13
1. <i>A Bidding Mechanism</i>	13
2. <i>An Incentive “Package”</i>	13
3. <i>Relax Job Requirement as Condition for a Loan Repayment Award.....</i>	13
4. <i>Increase Awareness on the Availability of Programs.....</i>	13
5. <i>Multiple Program Participation – NHSC, RPTC and RPMIS</i>	14
6. <i>Increase Award Amounts</i>	14
7. <i>Increase Number of Loan Repayment Awards.....</i>	14
8. <i>Different Award Amounts by Provider Type</i>	14
E. Improving Retention.....	15
1. <i>Support for Clinical Practices of Team-Based Care</i>	15
2. <i>Increase Community Support.....</i>	15
3. <i>Combine Benefits.....</i>	15
4. <i>Include Obligation for Some Programs.....</i>	15
5. <i>Retain Former Obligors in the State.....</i>	15
6. <i>Increase the Number of Limited-Funded Awards</i>	16
VI. RECOMMENDATIONS ON DATA COLLECTION.....	17
A. <i>Collect Information on All Program Applicants.....</i>	17
B. <i>Collect Additional Provider-level Information.....</i>	17
C. <i>Field a Provider Survey.....</i>	17

D. <i>Collect Data on Tele-Medicine</i>	18
E. <i>Identify Providers in APAC Data</i>	18
F. <i>Create a Unique Provider Identifier</i>	18
G. <i>Create a Comprehensive Provider Dataset</i>	18
VII. CONCLUSIONS	19

I. Introduction

To meet the requirement of House Bill 3396 passed by Oregon legislature and to assess Oregon's current and projected health care workforce shortages, the Lewin Group was tasked to conduct an analysis of strategies to address these shortages, evaluate provider incentive programs to inform future funding decisions by the Oregon Legislative to ensure incentive programs are based on demonstrated effectiveness. The comprehensive study and recommendations will provide the Oregon Health Policy Board and the Legislature with information to ensure Oregon is supporting programs that are effective and cost-efficient in terms of recruiting and retaining qualified health care providers, particularly in rural and areas in high need of medical services.

Our analysis of the various incentive programs offered to Oregon providers began with an examination of the main characteristics of the health care market in Oregon. The Lewin Group analyzed the current size, distribution and composition of the health care workforce in Oregon, along with the size and mix of the patient population throughout the state and in rural and medically underserved areas that are served by providers participating in relevant incentive programs. The Lewin Group first set out to assess the demand for key health care providers across the geographic areas in Oregon, evaluate the shortages of these providers in rural and medical provider shortage areas currently and in the near future, and examine the current incentive programs for health care providers who serve in those rural and underserve areas.

These analyses encompassed three major focus areas: (1) the Oregon health care market; (2) the Oregon incentive programs (state and federally funded); and (3) an assessment of the available incentive programs. Based on previous rates of growth in the population of providers and on observed utilization patterns in the Oregon patient population, The Lewin Group constructed forecasts of the demand for and supply of providers over the period between 2016 and 2020. Next, in order to assess the provider incentive programs and to gain a thorough understanding of their breadth and outreach within the state, we provide an overview of the current programs and program participation rates. We also present historical trends and changes in the composition of providers who participate and providers who do not participate in federally and state funded incentive programs.

Using various proprietary and administrative data sets covering the 2011-2015 period, we find that all provider incentive programs we analyzed increase the number of FTE-years in rural areas. This work was performed under Task 2 of this project (Lewin, 2016(2)). We measured the impact of the incentive programs in two related ways. First, we considered a program "recruiting" effect, defined as the program's ability to attract providers into targeted areas who would not be there without the program. Second, we considered a "retention" effect, defined as the program's ability to induce providers to stay in targeted areas longer than they would in the absence of the program. We find empirical evidence that some programs have both a recruiting and retention effect, some have only a recruiting effect, while others are largely limited to a retention effect. Overall though, all programs are effective in increasing the number of FTE-years relative to the level without programs. This is consistent with findings from other studies (e.g., Holmes, 2005). Also, combining estimated program effects with the program costs, we calculate the cost of attracting an additional FTE-year in a rural area. This cost, also called the marginal cost, while it varies among programs, it is of the same order of magnitude across programs.

We currently estimate that about a third of the NHSC participating primary care physicians and about two thirds of the NHSC participating NP/PAs are providers who would not have served in rural areas in Oregon in the absence of that program. The estimates are robust to a number of alternative regression specifications and they reflect a substantial recruiting effect of the NHSC loan repayment program. Combining this estimate with conditional retention rates in HPSAs after program completion, we construct estimates of the additional cost of inducing a new FTE into a rural area of \$31,756. As we discuss in Lewin (2016(2)), the actual additional cost per one new FTE is undoubtedly even lower. Even so, our additional cost estimate points to a solid return to investment for the NHSC program in Oregon, which is mainly driven by the probability of providers to serve in HPSAs even after completion of their obligation, and by the fact that many of the NHSC participants serve in HPSAs only as a result of the program. Although this estimate applies only to NHSC, it is likely that the effect of the Oregon loan repayment programs is similar in magnitude to the effect of NHSC.

Despite a number of inherent (and insurmountable for the time being) limitations, the empirical results we obtained allow us to formulate a number of policy and program recommendations. The data limitations we faced in this project provided us with a unique opportunity to formulate a number of detailed recommendations on how these limitations may be successfully overcome in the future, with the ultimate goal of being able to inform solid program evaluation and policy-making.

II. The Oregon Health Market

The Lewin Group examined the Oregon population and its characteristics that are potential drivers of the demand for health care services and providers. Using Provider360 data, in Table II-1 we show the total number of health care providers that we observed in the state of Oregon during the 2014-2015 timeframe. In total, there are 72,766 health care providers, of which 11,567 are physicians. Approximately 60 percent of these physicians offer primary care services.¹ The estimated number of behavioral health providers is 5,434, while the number of dentists is 2,914. Physician assistants (PAs), nurse practitioners (NPs) and registered nurses (RNs) represent three of the largest categories of non-physician providers.

Table II-1: Number of Health Care Providers per Population, by Provider Type

Provider type	Oregon Providers	Providers per 1,000 Population	
		Oregon	United States
All Health Care Providers	72,766	18.33	14.79
Physicians	11,567	2.91	2.83
Primary Care Physicians (PCP)	6,981	1.76	1.71
Non-Primary Care Physicians	4,586	1.16	1.12
Behavioral Health Providers (BHP)	5,434	1.37	1.08
Dentists	2,914	0.73	0.63
Physician Assistants (PA)	1,466	0.37	0.32
Nurse Practitioners (NP)	2,305	0.58	0.56
Clinical Nurse Specialists (CNS)	64	0.02	0.02
Advanced Practice Midwives (APN)	219	0.06	0.02
Registered Nurses (RN)	38,832	9.78	9.66
Licensed Practical Nurses (LPN)	3,737	0.94	2.58
Nurse Anesthetists (NA)	343	0.09	0.15
Population (2014)	3,970,239	--	--

Note: The main source of data for this table is the 2015 Provider360 Data (owned by Optum Services Incorporation). The number of RNs in 2014 comes from the OHA Report "Oregon Health Professions: Occupational and County Profiles". The national-level numbers of RNs and LPNs that are used to construct the ratios in the last column are for the year of 2016 and come from the Kaiser Family Foundation.

After reviewing the current state of the health workforce in Oregon, we analyzed the patterns in the utilization of medical services by various segments of the population, using claims data from Oregon's 'All Payer All Claims' (APAC) data. With these elements, we constructed forecasts of the future demand for medical service of the Oregon population, as well as forecasts of the supply of providers over the period between 2016 and 2020.

¹ Primary care includes the following categories: family practice, general practice, internal medicine, OB-GYN, Pediatrics and selected categories of Psychiatry and Neurology. Behavioral health providers include psychologists, social workers, and marriage and family therapists.

Table II-2: Projected Demand and Supply for Oregon Providers by Provider Type

Provider Type	2015	2016	2017	2018	2019	2020
	Demand					
Primary Care Physicians	7,094	7,146	7,250	7,358	7,469	7,580
Specialty Care Physicians	4,689	4,736	4,823	4,906	4,995	5,088
Behavioral Health	5,487	5,484	5,521	5,549	5,587	5,618
Dentists	2,963	2,985	3,028	3,068	3,115	3,156
Physician Assistants	1,495	1,512	1,535	1,557	1,582	1,608
Nurse Practitioners	2,337	2,348	2,376	2,407	2,435	2,465
	Supply					
Primary Care Physicians	6,883	6,917	6,952	6,987	7,022	7,057
Specialty Care Physicians	4,505	4,631	4,761	4,894	5,031	5,172
Behavioral Health	5,291	5,317	5,344	5,371	5,398	5,425
Dentists	2,856	2,857	2,858	2,859	2,859	2,860
Physician Assistants	1,455	1,497	1,541	1,585	1,631	1,679
Nurse Practitioners	2,261	2,381	2,507	2,640	2,780	2,927

Comparing the projected demand and supply under various policy-relevant scenarios should provide insights into whether “gaps” are expected to emerge in given geographical areas, or for various provider types. Comparing the forecasts from Table II-2, we estimate that the state-level gap between demand and supply for primary care physicians will grow to about 500 providers by 2020. Similar gaps may be emerging for other categories, but note that in the cases of nurse practitioners and physicians assistants our forecasts indicate that the supply may be higher than the demand. However, it may be that the growth rates in the number of NPs and PAs are too large. The current growth rates may be capturing trends that are specific only for the last few years, dominated by the Affordable Care Act and other initiatives. In the future, the growth rates for these two categories may be smaller.

III. Provider Incentive Programs in Oregon

A. Participation in Incentive Programs

In this section we examine the extent of participation in the various provider incentive programs. Table III-1 shows the number of participants in each of the financial programs available over the period between 2010 and 2015. Overall, the total number of participants increased from 3,119 providers in 2010 to 3,338 providers in 2012 and then gradually declined to 3,224 participants by 2014. Much of the increase in 2012 is due to the increase in the number of participants in NHSC LRP. On the other hand, the number of participants in state funded programs such as RPTC and EMS-TC remained relatively stable. There has been a steady decline in the number of participants in the malpractice insurance subsidy program (RMPIS) during this period.

Table III-1: Participants in Provider Incentive Programs, by Year and Program

Programs	2010	2011	2012	2013	2014	2015
RPTC	2,137	2,164	2,203	2,214	2,216	104*
RMPIS	861	822	769	702	687	639
EMS-TC	557	565	572	562	520	269*
J1-VW	66	64	59	74	75	84
MPC-LRP	-	-	-	-	17	42
BH-LRP	-	-	-	-	-	14
SLRP	-	6	11	27	40	50
NHSC	127	185	321	257	262	346
NHSC LRP	122	179	222	240	237	316
NHSC SP	5	6	13	17	25	27
NHSC others	0	0	86	0	0	3
Total Participants	3,119	3,186	3,341	3,272	3,224	1,520*

Note: * indicates that the data on these programs for 2015 is incomplete.

In terms of the number of participants, RPTC is the largest program and the number of participants remained relatively stable at around 2,200 providers over our timeframe. This is consistent with our assessment that there have not been any substantial changes in the funding, scope or eligibility of this program. On the other hand, there has been a substantial increase in NHSC participation over recent years, most likely as a result of the injection of additional funding under the American Recovery and Reinvestment Act (ARRA) in 2009 and the Affordable Care Act (ACA) in 2011.² Although a few changes in terms of eligibility rules for RMPIS have been made in the recent past, it is unlikely that such changes may explain the gradual decline in the number of program participants. Further study is required to understand the specific cause of the decline in participation in this program, but it is possible that as

² Source: <https://aspe.hhs.gov/report/provider-retention-high-need-areas/american-recovery-and-reinvestment-act-arr-and-patient-protection-and-affordable-care-act-aca-funding-expansion>.

providers get employed with hospitals they drop from RMPIS since hospitals cover their insurance premium.

B. Retention Analysis of Incentive Programs

To be able to measure the benefits of the incentive programs considered in this study, we need to determine by how much the number of providers in targeted areas increases as a direct result of the program, as well as the extent to which time served in those areas increases due to the program. We call the first effect the *recruiting effect* of the program, and it measures the number of providers who would not have located in those areas without the program. The second effect is called the *retention effect*, and it reflects the amount of time a typical participating provider spends in a targeted area above what he or she would have in the absence of the program. In this section we focus on the retention analysis. While typically recruiting is viewed as preceding retention, in this report we examine the retention effects first, because that analysis yields a number of relevant program-specific descriptive statistics that are then used in the econometric analysis of the recruiting effects. We return to recruiting effects in the next chapter.

C. Recruitment Analysis of Incentive Programs

We conducted an analysis to evaluate the effectiveness of the various Oregon incentive programs in terms of their ability to attract providers to locate and practice in certain targeted underserved or rural areas. In return for receiving the incentive, the eligible provider must be located in or move to a geographical area designated by the program. These targeted areas are usually rural areas, or other areas where it is believed that the population is “underserved” because of too few providers of certain types in the vicinity.

To be effective, the program must induce some providers to locate in targeted areas that would not have otherwise chosen. Many providers do, of course, choose to practice in these areas and do not require an incentive to induce them to do so. However, those who would have located in the targeted areas without the incentive may, of course, apply for and receive the incentive, if they are otherwise qualified. Hence, the incentive payments to such a type of program participants are unnecessary payments (or “economic rent”, as it is typically referred to in the economics literature) in the sense that these participants would have been practicing in the targeted areas even without the incentive, and the payment of the incentive to these providers does not increase the supply of providers to the targeted area. Some providers, however, who would not have chosen to practice in the targeted areas may be induced to do so by the incentive. If so, they increase the supply of providers in the area. This is a major purpose of the programs, and this is what we call the *recruiting effect* of the incentive programs. From a policy perspective, the best outcome is to determine the optimal range of energy and resources that are needed to bring into rural areas those providers who are unlikely (or less likely) to go to those areas.

In Table VI.2 we present the estimates of the total effects of all the programs considered for both primary care physicians and NPs and PAs. We find that some programs have only a retention effect (RPTC, RMPIS in the case of primary care physicians), while the other programs have both a recruiting effect and a retention effect. In the cases of programs that generate both effects, the recruiting effect tends to be substantially larger than the retention effect. Most importantly, as shown by the rightmost column in Table III-2, in the case of all programs and for each provider

type, the programs have a positive impact on the number of FTE-years in rural areas. These are FTE-years that would not be supplied in those areas without the programs.

Table III-2: Recruiting, Retention and Total Program Effects by Provider Type

	Providers	Recruiting Effect (FTE-years)	Retention Effect (FTE-years)	Total Effect (FTE-years)
Primary Care Physicians				
RPTC	827	0	736	736
RMPIS	459	0	459	459
SLRP	26	39	13	52
BHLRP	--	--	--	--
MCPLRP	8	15	4	19
NHSC	64	99	32	131
NHSC & RPTC	30	58	18	76
NPs and PAs				
RPTC	632	90	510	600
RMPIS	78	54	57	111
SLRP	20	56	7	63
BHLRP	14	39	5	44
MCPLRP	15	43	5	48
NHSC	108	301	40	341
NHSC & RPTC	74	250	28	278

As mentioned above, due to the fact that participation into the state-funded loan repayment programs is limited, and in some cases the number of providers ending their obligation is very low, we could not identify any statistically significant effect of these programs. However, it does not mean that those effects are truly zero. In fact, given that those programs are similar in structure, administration, target population and generosity, it is likely that they have a similar effect as the NHSC LRP program. Therefore, the magnitude of the NHSC effect we estimate may serve as a benchmark or a range over which the true effect of the Oregon loan repayment programs may be.

Using the estimates from the previous section we can now estimate the cost of attracting an additional FTE in a rural area. In Table III-3 we also include the average cost, which is simply the amount of the award for an individual in a given year, as well the cumulative cost paid to one provider during the period that provider participates in one or more programs.

Table III-3 Additional Cost per New FTE by Program and Provider Type

	PC Physicians	NP/PAs
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	Average cost (\$)	Cumulative Cost (\$)	Marginal cost (\$)	Average cost (\$)	Cumulative cost (\$)	Marginal cost (\$)
RPTC	5,000	18,350	20,787	5,000	17,800	18,960
RMPIS	3,890	14,626	14,820	3,890	14,081	9,866
SLRP	23,386	60,804	30,402	23,386	65,000	19,303
BH LRP	20,000	52,000	31,756	20,000	52,000	16,471
MCP LRP	27,321	71,035	29,909	27,321	65,000	22,198
NHSC (No RPTC)	25,000	65,000	31,756	25,000	65,000	20,587
NHSC & RPTC	30,000	94,000	36,908	30,000	91,000	24,233

Note: The average costs for SLRP and MPC LRP are equal to the average awards observed in the data for a year of commitment. In the absence of data on the time in service, the cumulative costs of those programs were calculated by assuming a service period that is equal to the typical service period in NHSC LRP. Also, due to lack of data BH LRP average costs is equal to the maximum award under that program, and we approximate the marginal cost of BH LRP for PC physicians with the marginal cost of NHSC LRP for PC physicians.

The estimated additional cost per one new FTE is smaller for NHSC PA/NP participants than for NHSC primary care physicians. Also, the difference between the additional cost of providers who participated in both NHSC and RPTC and the NHSC participants who do not participate in RPTC is smaller for NHSC NP/PAs than for NHSC physicians. These are primarily due to the larger recruiting effect. In either case, the increase in the estimated additional costs due to participation in RPTC among additional providers is lower than the actual cumulative RPTC award per participant during the entire period they serve in the rural areas.

Comparing the RPTC and RMPIS programs, it appears that the RMPIS program is relatively more cost effective in increasing the provider years in rural areas. This difference is largely due to the higher recruiting effect of the RMPIS program, and it is particularly visible in the case of NP/PAs. Finally, all incentive programs appear to have lower additional costs for NP/PAs than for physicians. Nonetheless, the additional cost estimates are of the same order of magnitude for each program and for each program type.

IV. Program Recommendations

In our report for Task 2, we evaluated Oregon provider incentive programs based on two major, and related criteria: the ability to attract qualified providers into select, targeted areas that are considered underserved and the ability to retain qualified providers in these areas. In that report, we provided quantitative estimates of both a recruiting effect (attracting qualified providers into targeted areas in which they would not otherwise serve) and a retention effect.

Features Associated with Efficient, Cost-Effective Incentive Programs

The following are general propositions regarding characteristics or features associated with efficient, cost-effective incentive programs.

- A. **Targeted programs:** incentives that are “across-the-board” are likely to be less efficient than programs that attempt to target those outside of the underserved areas to provide services in select, targeted areas.
- B. **Budget control:** A program, for which explicit awards are allocated to qualified applicants based on the merit of the applicant, and for which one can terminate new awards when the budget for that time period is exhausted, offers greater budget control
- C. **Cash or Cash-like versus in-kind incentives:** incentives that represent general purchasing power to the recipient or awardee tend, for a given cost of providing the incentive, to have a greater value and greater incentive effect than incentives that are provided in-kind. Cash incentives, unless explicitly provided an exception in both state and federal legislation, would be treated as ordinary income and subject to state and federal income taxes, paid by the recipient. Even if the state were to exempt them from taxation, it is likely that they still would be subject to federal tax
- D. **Current (up front) versus deferred benefit incentives:** incentives that provide an immediate benefit will be more highly valued, in general, than otherwise equal incentives that are available only later in time. For example, providing an incentive that repays a loan that is due currently would, other things being equal, be more highly valued than, for example, a retirement benefit that is received only years in the future.
- E. **Costs incurred today versus incurred later:** program incentives for which costs are incurred at time periods substantially before any program benefits accrue, such as program incentives that fund medical school tuition, tend to be more costly than an equivalent incentive that is provided in the form of a loan repayment while the provider is practicing in the rural or underserved area and providing health care services.

D. Observations on Oregon Provider Incentive Programs

In this section, we briefly review and provide observations regarding the major Oregon provider incentive programs.

Rural Practitioner Tax Credit (RPTC): It is not likely to target, especially, those practitioners who would not have otherwise practiced in rural areas. In fact, a provision of the program allows the provider to apply for and receive up to three years of tax credits retroactively. Hence, for these providers, it would be difficult to argue that they would not have been practicing in the rural area without the RPTC. In addition, the RPTC does not target, within rural areas, those areas that are in greater need than others. Finally, because the program is open, passively, to all

who meet the eligibility requirements, the cost of the program may be difficult to control, at least in the short run, because it depends from year to year on how many eligible providers apply

Rural Medical Practitioners Insurance Subsidy Program (RMPIS): the incentive clearly has no impact on practitioners who are working within organizational relationships in which they do not, themselves, directly pay for medical liability insurance. This feature suggests that, perhaps, a pure cash stipend, independent of whom pays for medical liability insurance, may be more efficient.

Scholars for a Health Oregon Initiative (SHOI): The program is limited in that only OHSU students are eligible. Moreover, preference is given to applicants who are from rural areas. This “targeting” of the program may limit its effectiveness in that it may tend to select out a high proportion of students who would have served in rural and underserved areas anyway. The program is more costly than, for example, a loan repayment program in which costs are incurred as the provider is practicing in rural or underserved areas. Moreover, it may limit flexibility in that, if priorities change over a period of two or three years, resources are already committed to the students in the program.

Oregon State Partnership Loan Repayment Program (SLRP): the program allows one to select, to an extent, based on additional criteria such as where the provider will actually practice and which type of provider is added to the area. Because the number of awardees is selected from among qualified applications, the budget can be directly controlled by selecting fewer, or more, awardees, depending on the budget (B).

Medicaid Primary Care Loan Repayment Program (MPCLRP): This program targets specific providers and, in particular, ensures that they serve Medicaid patients (A). In other respects, it is similar to other loan repayment programs.

V. Policy Recommendations

In this section we articulate several policy recommendations that are aimed at increasing the effectiveness of the current incentive programs. More specifically, the focus is on increasing the number of providers that current programs attract and retain in rural and underserved areas.

Improving Recruiting

It is recommendable to increase the number of providers that are induced by the program and to the extent possible, reduce the program awards to providers who would serve in rural areas without the program. In what follows, we provide details on the potential ways in which the Oregon can achieve a greater return, in recruiting, retention, or both.

1. *A Bidding Mechanism*

One way to increase the effectiveness of such programs is to allow all qualified applicants to “bid” for awards, where the “bid” is a dimension which increases the FTE to the rural areas. This may be done by allowing applicants to offer additional years of obligated service. The number of years served in rural areas will increase relative to the current state. From a cost perspective, this increase will have a cost of zero if the bidding is set up in such a way that those who offer to serve additional years agree to receive no payments or additional loan payments for those additional years

2. *An Incentive “Package”*

It may be important to add program features that would be most valued by providers who are not currently serving in a targeted area, to induce them to move to such an area. For example, if program participation would result in a move from a non-qualified area to a target area, a moving expense stipend of a non-trivial amount could be offered. Other non-financial features that would be most valued by providers who are not currently serving in a targeted area may include support with spousal employment.

3. *Relax Job Requirement as Condition for a Loan Repayment Award*

In the case of some loan repayment programs, there is a requirement for providers to first obtain a job in an underserved area in order to be eligible for the program. It is advisable to relax the job requirement as a pre-condition for program application. In this way, the program will be more likely to act in a desired way, that is, induce providers to serve in rural areas.

4. *Increase Awareness on the Availability of Programs and Ease of Use*

Increasing awareness in general may be done through appropriate dissemination of information through relevant medical, dental, nursing, physician assistant and behavioral health undergraduate and graduate programs, through the use of social media, and other sources. Easy access to program information may help attract providers who would not have gone to rural areas in the absence of the program. Develop a truly “one-stop” website source with available information for all programs, eligibility requirements, application

procedures, and further contact points. It is advisable to make the application process as easy, understandable and low cost as possible.

5. *Multiple Program Participation - NHSC, RPTC and RPMIS*

Being able to participate in multiple programs has the effect of increasing the value of the “package” for providers. In this sense, if providers with negative preferences for rural areas are induced to serve there by being compensated for these negative preferences, having a combined total of benefits that is larger than the award of only one program may potentially increase the number of providers with negative preferences to serve in rural areas. Since these are the providers who would not serve in rural areas without incentives, allowing for multiple program participation can conceivably have the effect of increasing the recruiting effect.

6. *Increase Award Amounts*

Allowing for the award amounts to increase in value may have the result of suggesting to a larger number of providers with negative preferences that they consider the possibility of serving in those areas. A more generous award would increase the number of providers with negative preferences who are at the “margin”. Also, as above, if the number of providers at the margin (i.e., those who would not serve without incentives) dominates the number of providers who are ready to serve without incentives, then this recommendation may increase the recruiting effect.

7. *Increase Number of Loan Repayment Awards*

If feasible from a budgetary perspective, it may be efficacious to increase the number of loan repayment program slots. However, this initiative builds on the assumption that the “margin” is “dense” enough. In other words, there exists a sufficiently large pool of eligible applicants who can be induced to serve in rural areas by the availability of the award.³

8. *Different Award Amounts by Provider Type*

Loan repayment programs tend to have higher recruiting effects among NP/PAs than among primary care physicians. If there is a large number of NP/PAs who are at the margin (i.e., the density of the preferences distribution around the value of the award amount is high), then it may be worth increasing the award amount for those providers. That way the recruiting effect may be further increased.

³ If the density of the distribution of preferences is high around the value that is equal to the (negative of the) award amount, then an increase in the number of program slots would increase the “margin”. Conversely, if the density of the preferences distribution is low around the value of the award amount, then an increase in the number of program slots would not increase the number of applicants who would not have served without the award. It would instead increase the applications from providers who would serve in rural areas without incentives. If the latter effect is dominated by the former, then the recruiting effect would increase. This depends on how many providers are at the margin given the current distribution of preferences and the current value of the awards.

E. Improving Retention

The recruiting effect tends to dominate the retention effect for many programs. In this section we focus on recommendations that have the goal of increasing retention, or at least maintaining retention at the same level as before when recruiting is increased.

1. Support for Clinical Practices of Team-Based Care

Providers cannot form accurate ex-ante expectations on neither how their rural experience will unfold, nor how they will perceive that experience. In other words, serving in a rural area is an “experience” good for many providers. A change in perception may be caused by factors that pertain to the individual and may include: a high level of community support, well-trained supporting staff, or a positive working environment. To the extent that these characteristics can be changed by policy makers in substantial and systematic ways, the retention of providers in rural areas will increase relative to the programs’ current retention effects.

While we recognize that changing or adoption of team-based practices is not within the scope of the incentive programs, a beneficial by-product of team-based settings in rural areas may be to increase the effectiveness of incentive programs.

2. Increase Community Support

Other ways in which perceptions of participants may change in positive ways include the availability of amenities like good schools for their children, support in finding job opportunities for spouses or partners, or access to cultural events and opportunities. As before, these elements are not directly actionable within the scope of the incentive programs; nonetheless, if they are achieved as a result of other state- or local-level programs or initiatives, they can contribute to the increasing of provider retention in rural areas.

3. Combine Benefits

The expected years in rural years is larger for NHSC participants who participate in the RPTC program, than it is for those who only participate in NHSC. To the extent that this option is feasible from a budgetary perspective, it may be useful to recommend combining those benefits once a NHSC participant is approaching the end of their service obligation.

4. Include Obligation for Some Programs

To the extent possible, it may be useful to consider including an obligation to serve for a year or more in the case of programs like RPTC and RMPIS. The introduction of an obligation period for the programs that do not have one can increase the retention effect across all categories of program participants.

5. Retain Former Obligor in the State

Negrusa, Ghosh and Warner (2014) found that once NHSC participants complete their obligation, many of them move away from the location where they served, but many tend to move to other similar areas. To further increase the retention effect, it may therefore be important to try to retain within the state these former obligors (from NHSC as well as from

the state loan repayment programs). Preventing them to move to other states will have the effect of increasing the amount of services supplied to rural locations in Oregon.

6. Increase the Number of Limited-Funded Awards

This measure would increase the number of loan repayment participants and to the extent that the new participants are similar to those who would have received the awards without this proposed expansion in the number of awards, the number of FTE-years in rural areas would increase. This is merely the result of having more program participants who generate a higher volume of FTE-years. This assumes that the new participating providers who are similar to the ones already participating are sufficiently numerous.

VI. Recommendations on Data Collection

The work we performed with the administrative data received from OHA for this project helped us have a detailed understanding of the advantages and limitations of these data. While the APAC data, as well as the individual-level data on provider participation in the various programs offer unique opportunities for analysis and evaluation, there are a number of shortcomings which, if addressed in the future, may provide much more comprehensive insights into the drivers of program participation, provider retention and program effectiveness that would be valuable for improving programs in the future.

A. Collect Information on All Program Applicants

To better inform decision-makers on the efficiency and cost-effectiveness of these programs, it is paramount to collect longitudinal data on all program applicants, including those not offered awards.

B. Collect Additional Provider-level Information

Some of the characteristics that are correlated with the providers' decision to locate to a rural area, such as rural upbringing, race/ethnicity, marital status, spousal employment status, family size, compensation package, or level of community support, may potentially be obtained through more systematic data collection efforts.

C. Field a Provider Survey

Even with more focused administrative efforts to collect additional individual-level provider information, a number of relevant characteristics would remain undocumented. A potential solution would be to field a comprehensive survey on program applicants, including those not offered awards in order to determine:

- i. key factors that drive their decision to locate and stay in rural/underserve areas;
- ii. the importance of program's financial incentives versus other factors in their decision to apply for programs and remain in target areas
- iii. level of difficulty associated with the application process
- iv. experience with clinical practices in target areas
- v. level of community support and its role in the location decision
- vi. experience with service in target areas
- vii. other socio-demographic characteristics that are difficult to obtain through administrative efforts (e.g., spousal employment status, or family size).

Another survey of potential use would be a survey of providers who serve in target areas, but did not apply for the incentive programs. This data would allow for the identification of the:

- i. availability and accessibility of information related to programs
- ii. perception about the level of financial incentives

- iii. perception of whether additional benefits, such as relocation bonuses, or better community support, would make them more likely to apply for incentive programs.

D. Collect Data on Tele-Medicine

Currently there is no systematic way to collect data on the amount of services that providers supply in the form of tele-medicine throughout the state. Such information would be valuable in order to accurately determine the volume of services provided in rural areas, and the degree to which telemedicine can substitute for providers who practice in a specific area.

E. Identify Providers in APAC Data

As APAC data includes the universe of medical claims in the state, identifying providers in APAC data would allow for a clear tracking of the volume, nature of services supplied and populations served in target areas by providers in general, and by participating providers in particular. As of now, it is difficult to identify individual providers in APAC data, as in most cases only identifiers of practices or health care facilities are being reported.

F. Create a Unique Provider Identifier

Additional research and evaluation of incentive programs would be greatly enhanced if it were possible to construct a common provider unique identifier that would allow researcher to determine multiple program participation over time in a consistent fashion. Currently there is no standardized ID used across programs to track multiple program participation.

G. Create a Comprehensive Provider Dataset

With the help of a unique provider identifier, it would be possible to track all providers in the state longitudinally in a centralized fashion and record the year of entry in the program(s), location of the place of service in every year, main services provided, along with the provider's age, gender, marital status, provider type, discipline, specialty, size of practice and so on.

This comprehensive database, linked to APAC data, may be then used for workforce policy, and it would help with the tracking and monitoring of migration patterns over time and could open the door to evaluations of how public health improved as a result of the providers induced by programs, in the form of: number of lives saved, decrease in preventable hospitalizations and emergency department visits, or decrease in incidence/prevalence of various diseases.

VII. Conclusions

We find evidence that is consistent with the assertion that the state programs appear to contribute to an increase in the retention of providers in rural areas, as reflected by the differences in retention in rural areas between program participants and non-participating providers. At this point we cannot rule out the possibility that those differences are in part due to the selection of some providers in the RPTC program.

We find evidence of a pronounced imbalance in the distribution of providers across rural versus urban areas within the state. Less than one fifth of physicians serve in rural areas, while the fraction of PAs and NPs serving in rural areas is lower than one third. Also, there is a notable heterogeneity across counties in terms of provider-to-population ratios for physicians, behavioral health providers, dentists and non-physicians, with the more rural counties having lower provider-to-population ratios. This pronounced imbalance in the distribution of medical providers across rural and urban areas in Oregon emphasizes the important role provider incentive programs may have in attracting providers in rural and underserved areas.

In addition to the current maldistribution of providers, Oregon may face an even more acute lack of medical services in the future, as the fraction of the population that is more likely to be insured through Medicaid and less likely to have employer-provided insurance is projected to increase. Also, these categories of the population are much more likely to be under the federal poverty line (FPL) or in the lower FPL categories, and although declining as a result of the ACA, their un-insurance rates may still be relatively large. Our analyses of the APAC data indicate that if current population trends continue over the next years, the number of visits demanded will continue to increase. Comparing these projections of the demand for providers with our provider supply forecasts indicate that some gaps between demand and supply are likely to emerge in the future. Under certain scenarios, these gaps may prove to be substantial.



August 12th, 2016

MEMO

To: Interested Parties
Subject: HB 3396 RURAL LISTENING SESSIONS

Introduction

In July 2015, the Oregon Health Policy Board adopted a [charter](#) directing the Health Care Workforce Committee (HCWF) to deliver to the Health Policy Board a study and report on the efficacy of Oregon's provider incentives and recommendations on improvements to the current incentives—a direction born out of [HB 3396](#), passed by the 2015 Legislative Assembly.

Oregon's Health Care Workforce Committee has served as the primary forum for stakeholder engagement for HB 3396. In relation to HB 3396, the committee's roles were to:

- Support selection of The Lewin Group and assist with stakeholder engagement;
- Provide key input in determining criteria for evaluating the effectiveness of incentive programs;
- Review progress over time and provide direction to the Lewin Group and OHA staff; and,
- Review incentive provider study and companion report to Health Policy Board.

Based on direction from the Health Care Workforce Committee in spring of 2016, in conjunction with guidance from the 3396 Steering Group, the Oregon Health Authority in collaboration with the Oregon Association of Health and Hospital Systems (OAHHS), Oregon Medical Association (OMA), and the Oregon Office of Rural Health (ORH) facilitated a series of [listening sessions](#) around the state. The five sessions were held as follows:

- St. Charles – Prineville, Monday, June 20, 6-8pm
- St. Anthony Hospital – Pendleton, Tuesday, June 21, 6-8pm
- Mercy Medical Center- Roseburg, Monday, June 27, 6-8pm
- Good Samaritan Hospital – Lebanon, Tuesday, June 28, 6-8pm
- Columbia Memorial Hospital – Astoria, Wednesday, June 29, 6-8pm

Background

The purpose of the listening sessions was to hear from providers, community leaders, clinic administrators, public health officials and other stakeholders about the following:

- How do Oregon's current provider incentive programs impact rural communities with respect to recruiting health care professionals?
- What types of provider incentive programs help address workforce shortages in rural communities?
- How is the ability to recruit and retain providers by specialty (primary care, behavioral, and oral health providers) affected by different incentive programs in rural communities?
- What types of new incentives could Oregon develop to recruit providers to rural

- communities or to retain providers who are already working rural communities?
- Receive feedback on what are the unmet needs among rural communities and what else should be explored in terms of ensuring an adequate primary care work force.

In June, more than 100 Oregonians participated either in-person or remotely through webinars that were hosted at each site location (See appendix A for list of organizations). OHA staff, members of the Health Care Workforce, and members of the 3396 Steering Group attended all five listening sessions. Summarized below is a breakdown of attendees by various categories, which ranged from 12 to more than 60 attendees per listening session:

- 24 out of Oregon's 36 counties were represented;
- 13 of the state's 16 coordinated care organizations (CCOs) participated;
- Organizations: local area school districts, rural health centers, federally qualified health centers, private clinics, local hospitals and health systems, county health departments, area universities, health care professionals, and a migrant health center; and
- Health care professionals: physicians, hospital executives, nurse practitioners, residents, behavioral health professionals, and other interested health allied professionals.

Key Findings from Rural Listening Sessions

Each listening session was scheduled for two hours in the evening at local, community hospitals and were open to area providers. Common themes were compiled, written up and are summarized below. Although the various communities varied in size, composition, available local resources, and needs, a number of thematic areas were identified as key to informing recommendations.

Interestingly, participants across the listening sessions identified the need for both short and long-term solutions to address workforce issues in rural communities. Participants recognized that developing and ensuring an adequate primary care workforce requires a multi-prong strategy that should include investing state resources in "grow your own" pipeline solutions, compared to a number of existing programs that target recruitment, retention, or both. Furthermore, it was apparent that communities would likely benefit from incentive programs, state or local, if combined with federally funded programs that could offer a "comprehensive" package. The underlying issue is rural communities being able to offer a competitive package that simultaneously addresses both recruitment and retention needs, together, rather than separately, on an *ad hoc* basis.

Recommendations from the sessions included:

- A. Continue to fund and support existing incentive programs in Oregon for the immediate future, *and do not reduce the existing state funding level* for such support. Federal funding available through provider incentives is inadequate to address the existing needs among rural communities in terms of recruitment and retention, particularly with an aging primary care provider workforce in the state.
- B. Consider modifying aspects of various current programs, such as service obligations for Oregon funded loan repayment programs (from 2-3 years to 5 years) and how providers and clinics are able to learn about programs and their availability.
- C. Identify and fund programs that train local residents to increase the supply of health care professionals from rural areas. (Put an emphasis on a "grow your own"

strategy in Oregon.)

- D. Support development of new programs including tax credits for preceptors¹ to help incentivize and offset costs incurred by health care providers willing to train new health care professionals (e.g. teaching health centers).
- E. Address the reality that funding for existing programs does not necessarily reflect current economic realities for either providers in rural Oregon or rural communities in which they practice. Available funding for certain programs is limited and potentially does not provide sufficient amount (e.g. incentive) for rural communities to recruit and be competitive with their urban counterparts.
- F. Support communities to move beyond competition for the same pool of local area providers (e.g. hospital vs. independent practice) and expand the opportunity for collaboration.
- G. Simplify and streamline the application, administration and renewal processes for state and federal incentive programs. Consider moving to a single point-of-entry for provider incentives.

Key Themes from Individual Listening Sessions

As described above, a number of themes emerged across the listening sessions. Summarized below are key issues raised at the individual listening sessions.

Prineville

- We need to do a better job of “grow your own.”
- Need more primary care residency programs and slots for residents in rural Oregon
- Retirement options needed, particularly for health providers not affiliated with or employed by a hospital or health system.
- Benefit from larger packages/solutions beyond “loan repayment.”
- Compensation important; however, fit in the community important as well.
- Need to distinguish between short-term and long-term solutions; need both in rural Oregon.

“If loan repayment is it, you will simply have a revolving door—no retention...and it’s more than compensation. It’s family, quality of life and having a rewarding career...”

Rural Provider

“There is a very aging workforce among primary care docs, which is only going to exacerbate the shortage we’re already facing...”

Hospital Executive

Pendleton

- Pharmacists are missing from eligibility for many programs yet there’s a need.
 - Loan repayment amounts are too low; tax credits too low. Better than nothing but need larger amounts to provide a larger enticement for providers.
 - Need for more training, rural rotations, and residency slots.
- Workforce is aging; there’s a crisis that is almost here in rural Oregon.
 - J-1 Visa Program is working; tax credit helpful (although low); need to expand Oregon’s student loan repayment program (SLRP).

¹ Preceptors refer to experienced nurses, physicians or other health care professional who guides and teaches others, often students or recent graduates of health professional programs.

Roseburg

- Resources available through federally funded incentive programs are not enough. We need an “Oregon solution to an Oregon problem; can’t rely on the federal government.”
- Preceptors and mentoring is costly for both providers and health care organizations that host placements.
- Too much uncertainty with whether the incentive programs will continue to provide awards over multiple year periods.
- Offer a new kind of scholarship program for people willing to go rural.
- Lots of burn-out in rural practices, particularly since working in rural communities often requires on call, treating a more extensive range of health conditions, and inadequate access to specialty services.
- Recruitment and retention a full-time job for employers.

“If we didn’t have J-1 we wouldn’t be in business...J-1 is a lifesaver!”
Rural Practitioner and Clinic Owner

Lebanon

- Not enough residency slots—need to invest significantly more in Graduate Medical Education (GME) in Oregon.
- Rural tax credit very important to rural providers.
- Compensation a larger challenge in rural Oregon.
- Incentive programs should be available to all, regardless of institution (i.e. public vs. private).
- Within local communities, bidding wars for local health care providers is a real problem.
- Retirement an issue.

“The real question is what’s the impact if we don’t invest in these incentive programs...”
Rural Provider, 30+ Years in Medicine

“Administrative simplification of the programs would be a huge value-add.”
Rural Hospital Executive

Astoria

- Inadequate housing in the community for training or locating doctors.
- Significant lack of behavioral health providers.
- Federal HPSA (Health Professional Shortage Areas) scores are too volatile.
- Allow individuals to request longer-term service commitments than the usual 2-3 year period.
- Provide paid continuing education for those in the incentive programs to deal with burnout and help inspire providers.

Summary of Listening Sessions

Based on the level of interest expressed by participants and the amount of feedback provided across the five listening sessions there continues to be an unmet need in rural communities across Oregon in terms of ensuring an adequate primary care workforce. Participants frequently mentioned the need for an “Oregon solution.” Such a solution requires both short and long-term changes to the state’s existing provider incentive programs. Each community was clear in the importance of being able to recruit and retain providers, both from the standpoint of ensuring quality access to health care, but also as an economic investment in their community. Concurrently, there is the growing need for primary care services in rural communities as a result of an aging population and existing providers’ entering retirement in the coming years.

The overwhelming sentiment expressed by participants was that Oregon’s existing programs have and continue to serve as vital and needed tools for rural communities to recruit and retain a vital primary care workforce.

Appendix A: List of Organizations represented by Attendees

Asante Health Sytem
Asher Community Health
Astoria School District
University of Oregon Community Education Program (CEP)
CHI Mercy Health, Mercy Medical Center
College of Osteopathic Medicine of Pacific Northwest
Coastal Family Health Care
Community Health Centers of Benton and Linn Counties
Columbia Memorial Hospital
Community Services NW
Deschutes Rim Clinic
Eastern Oregon IPA
Evergreen Family Medicine
Family Tree Medical Clinic
Grants Pacific Clinic
Good Shepherd Health System
Harney District Hospital
Jackson County
Lane County Board of Commissioners
Lifeways
Mosaic Medical
Murray Drug Inc
Northeast Oregon Network (NEON)
Northwest Regional Primary Care Association, North Bend Medical Center
Oregon Association of Hospital and Health Systems (OAHHS)
Osteopathic Association of Oregon
Oregon Health and Science University (OHSU)
Oregon Medical Association
Osteopathic Physicians and Surgeons of Oregon (OPSO)
Oregon Western University
Pacific University
Prime Med Medical Clinic
Providence Health Systems
Rinehart Clinic
Salem Health
Samaritan Health Services
Sky Lakes Medical Center
South River Community Health Center
St Alphonsus Medical Center
St. Anthony Hospital
St Charles Hospital
Trillium Community Health Plan
True Health Medicine
Umpqua Community Health
Western University - COMP Northwest
Weston Eye Center
Woodburn Pediatric Clinic

DISCUSSION DOCUMENT FOR HB 3396

Introduction

Oregon House Bill 3396 (2015) directs the Oregon Health Policy Board to study and evaluate the effectiveness of the financial incentives offered by the state to recruit and retain providers in “rural and medically underserved areas” and make recommendations to the Legislature by September 2016. Specifically, the Oregon Legislature tasked the Health Policy Board with addressing the following (see section 3 of 3396):

1. Continuation, restructuring, consolidation or repeal of existing incentives;
2. Priority for directing the incentives offered by Health Care Provider Incentive Fund; and
3. Establishment of new financial incentive programs.

Key Resources and Evidence: Discussion Tool

In response to HB 3396, the Oregon Health Authority contracted with the Lewin Group, LLC to assess Oregon’s existing provider incentive programs including program effectiveness among both federal and state funded programs, and to develop policy recommendations. As the request of the Oregon Health Workforce Committee, and supported by the HB 3396 Steering Group, the OHA convened five regional meetings across Oregon to solicit input on the state’s current provider incentive programs and request feedback on Lewin’s preliminary analyses.

In response to feedback and guidance from the HB 3396 Steering Group, and to help ensure the Health Care Workforce Committee and the Health Policy Board are able to address the requirements listed above, OHA staff compiled a discussion tool. The tool is designed to compare findings from the Lewin study with input shared during the rural listening session. The tool also outlines a number of key considerations as well as identifies notable data limitations. Lastly, in response to direction from the Health Policy Board (July 15th meeting), the tool identifies potential strategies, both short and long-term, for consideration.

Based on Lewin’s analysis and recommendations, feedback received during the rural listening sessions in June, expertise provided by the 3396 Steering Group and direction from the Health Care Workforce Committee—a substantial amount of information have been compiled to help inform the decision-making process led by the Health Policy Board in addressing section 3 of 3396.

Discussion Tool

The discussion tool or framework can help inform policy makers regarding how to leverage state resources in more effective ways to “attract and retain qualified health care professionals in areas of greatest need.”¹ The tool may also help to answer several critical questions:

- Under what circumstances should providers receive more than one incentive simultaneously?

¹ Senator Steiner Hayward (July 15, 2016): [Comments](#) to the Oregon Health Policy Board regarding HB 3396, Provider Incentives and SB 440, Standardized Metrics.

DISCUSSION DOCUMENT FOR HB 3396

- As a state, how can Oregon accurately measure the efficacy of the programs and continue to track their effects?
- Could/should existing programs be restructured to increase their efficacy and the return on investment of funds allocated to them?

DRAFT

Table 1: Potential Changes to Existing Programs

		Lewin Analysis and Results	Listening Session Feedback	Key Considerations	Short vs. Long Term Strategies (e.g. ≤1 year vs. >18 months)	Potential Recommendations (from Lewin and Listening Sessions)
Oregon Funded Provider Incentive Programs	Continuation	<ul style="list-style-type: none"> Programs appear to have similar, positive impact on recruitment and retention of health care providers. 	<ul style="list-style-type: none"> Additional financial support needed; particularly GME/residency slots Tax credit a valuable retention tool 	<ul style="list-style-type: none"> What are the implications if existing state funded programs are working, but insufficient in recruiting providers in areas with most unmet need? How long is a reasonable period for an area to be without a primary care provider (effectiveness)? 	<p><u>Short Term:</u></p> <ul style="list-style-type: none"> Several incremental changes to the programs could be incorporated based on Lewin findings Prioritize state funding to target more “grow your own” programs <p><u>Long Term:</u></p> <ul style="list-style-type: none"> Develop systematic data collection, monitoring and evaluation program at the state level 	<ul style="list-style-type: none"> Invest more in programs—either individually or overall. Allow Multiple Program Participation --RPTC and RMPIS Build in systematic data collection, monitoring and evaluation efforts for each program offered.
	Consolidation	<ul style="list-style-type: none"> Analysis indicates additional impact when RPTC and RMPIS are combined. 	<ul style="list-style-type: none"> Interest in “bundling” funding across different programs to create a more lucrative compensation package 	<ul style="list-style-type: none"> HB 3396 repeals and replaces (i.e. “consolidates” state funded programs except SHOI). HCWF may recommend keeping existing programs with targeted populations/areas; alternatively, advise that existing funding go into single fund. Target programs in packages relative to “growing the supply,” “attracting,” and “retaining.” 	<p><u>Long Term:</u></p> <ul style="list-style-type: none"> Develop a single, online, integrated application and renewal process for all state funded programs. Develop systematic data collection, monitoring and evaluation program at the state level 	<ul style="list-style-type: none"> Develop a single, online, integrated application and renewal process for all state funded programs. Build in systematic data collection, monitoring and evaluation efforts for each program offered.
	Restructuring	<ul style="list-style-type: none"> Administrative simplification; create a user-friendly system for clinicians and employers learn, apply, and renewal eligibility for programs. Redesign tax credit a program to look more like others—provide credits to those who apply (commit) in advance for the certificate. 	<ul style="list-style-type: none"> Consider larger tax credits for physicians to improve retention effect Redesign programs to be user friendly Increase stability of programs; assurance of award over multiple years per awardee; do not subject to changes in HPSA scores 	<ul style="list-style-type: none"> See cell above. Single online recruitment and retention “hub;” common application for sites and one for clinicians. Modify the amount of awards, i.e. reduce or increase in size 	<p><u>Short Term:</u></p> <ul style="list-style-type: none"> Changes to tax credit program could be immediate; would need to assess impact from changes, long-terms in terms of recruitment. Stability of programs could be addressed potentially in the short-term; would require ongoing evaluation <p><u>Long Term:</u></p> <ul style="list-style-type: none"> Develop a single, online, integrated application and renewal process for all state funded programs. 	<ul style="list-style-type: none"> Increase Award Amounts Increase Number of Loan Repayment Awards Different Award Amounts by Provider Type A Bidding Mechanism An Incentive “Package” Relax Job Requirement as Condition for a Loan Repayment Award Include Obligation for Some Programs Increase the Number of Limited-Funded Awards Support for Clinical Practices of Team-Based Care

DISCUSSION DOCUMENT FOR HB 3396

						<ul style="list-style-type: none"> • Increase Community Support • Combine Benefits • <i>Increase Awareness on the Availability of Programs</i> and User-Friendliness—One-Stop Hub • Retain Former Obligor in the State by including this in service obligation.
Repeal	<ul style="list-style-type: none"> • No indication any incentive program “should be” repealed. Results indicate several programs more effective with retention; other more cost effective for recruitment by provider. 	<ul style="list-style-type: none"> • Potentially, modify rural tax credit and allocate any new state revenue to fund Oregon incentive programs. 	<ul style="list-style-type: none"> • Are there any existing Oregon programs that should be repealed in favor of others (e.g. program effectiveness)? • Note that all Oregon funded programs are slated to be repealed in 2017 under HB 3396—legislature could introduce changes in 2017 session to undo this or not. 	<p><u>Long term:</u></p> <ul style="list-style-type: none"> • Assess any efficiencies from consolidation or restructuring Oregon programs. 	<ul style="list-style-type: none"> • Allow HB 3396 to be fully implemented, repealing all programs and providing the opportunity to make adjustments within a “new” system. 	

Table 2: Priority for Distributing Funds for Oregon Incentive Programs

	Lewin Analysis and Results	Listening Session Feedback	Key Considerations	Short vs. Long Term Strategies (e.g. 18 months vs. 3+ years)	Potential Recommendations (from Lewin and Listening Sessions)
Priority for distributing funds	<ul style="list-style-type: none"> • Lewin’s analysis provides cost per awardee by individual program • Lewin’s analysis provides general data about the costs per FTE for recruiting and retention oriented programs. • Lewin’s analysis provides limited data beyond county level in terms of available workforce 	<ul style="list-style-type: none"> • Students at for-profit and state-supported schools should have equal access to program funds 	<p>Consider “set-asides” in categories that could include:</p> <ul style="list-style-type: none"> • Rural and Non-Rural • Physical, Mental, Dental 	<p><u>Short or Long Term:</u></p> <ul style="list-style-type: none"> • Develop priority for distributing funding by provider type, community need, and program effectiveness • Develop monitoring plan to assess any changes implemented around priority for distributing funds in 2017-19 biennium. • Bidding system • Larger awards to those willing to serve additional years (e.g. > 3+ years) • Tie award to size of student debt 	<ul style="list-style-type: none"> • Develop priority for distributing funding by provider type, community need, and program effectiveness • Consider a bidding system, with larger awards to those willing to serve additional years (e.g. > 3+ years) • Tie award to size of student debt

DISCUSSION DOCUMENT FOR HB 3396

Table 3: Potential New Programs

HB 3396 requirements	Lewin Analysis and Results	Listening Sessions	Key Considerations	Short vs. Long Term Action Items (18 months vs. 3+ years)	Potential Recommendations (from Lewin and Listening Sessions)
Financial Assistance Programs for students in state-run and private educational programs	N/A	<ul style="list-style-type: none"> Do not discriminate by type of school. 	<ul style="list-style-type: none"> Both OHSU and COMP-NW students are eligible for PCLF; issue concerns the legislature’s \$1.5 million for OHSU to create the SHOI program. Does HCWF wish to comment? Is it a matter of making the same investment for a similar program at another school? Does this apply to the NCNM also? 		<ul style="list-style-type: none"> Offer SHOI for COMP-NW students or expand and revise the program so it is available from Admissions Offices at both schools.
Loans, grants to hospitals and teaching health centers for residency programs	N/A	<ul style="list-style-type: none"> Extensive feedback about residency programs at each listening session. 	<ul style="list-style-type: none"> Teaching health centers (THC) not specifically addressed during the listening sessions. Virginia Garcia does work with a THC in Pennsylvania for students and it seems successful. 		<ul style="list-style-type: none"> Support additional funding/current funding for GME Consortium to be directed at THCs
Loans or grants for hospitals at risk of closure	N/A	<ul style="list-style-type: none"> Hospital representatives participated in every listening session; notion of a grant or a loan was not a key point of discussion. 	<ul style="list-style-type: none"> Issue not addressed during the listening sessions. 		
Direct subsidies or bonus payments to providers	<ul style="list-style-type: none"> Discussion of marginal cost per FTE/Year is relevant for overall compensation package. 	<ul style="list-style-type: none"> Feedback during sessions about spending additional award dollars for providers serving in areas that cannot otherwise find a provider. 	<ul style="list-style-type: none"> Issue of how much to spend on which providers is a key concept; not a matter of “whether,” but “which” providers need or will get more resource to practice in a targeted area. Potentially tie bonus payment to continued service. 		
Retirement plans	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Issue was raised in two of the five listening sessions 	<ul style="list-style-type: none"> In several communities, the lack of retirement plans described as a considerable issue. Opportunity to change laws on Special Districts or for State to directly fund. 		
Changes to tax credit	<ul style="list-style-type: none"> Several recommendations, including making the credit a program like others that require an up-front commitment to serve for a period before qualifying. 	<ul style="list-style-type: none"> One session heard participants say that perhaps it was time to eliminate the credit, while others said keep and increase. 	<ul style="list-style-type: none"> 1) Recommend keeping credit, 2) Change credit amounts by profession, 3) Adjust amounts based on loan amounts, or 4) Increase or change for those further from urban areas? 		<ul style="list-style-type: none"> Offer tax credit for preceptors—up to X number of students or prospective for X number of years. (Either replace some existing credit amount or offer new credit.)
Opportunities to secure non-state matching funds	<ul style="list-style-type: none"> Lewin acknowledges Oregon in its use of leveraging federal financial incentives. 	<ul style="list-style-type: none"> No specific program or mechanism identified as a way to secure non-state matching funds. 	<ul style="list-style-type: none"> Future ability to draw down federal financial supports likely tied to HPSA scores; an out-of-the-box approach 		<ul style="list-style-type: none"> Pursue proposal to HRSA to take federal money now going to Oregon clinicians in the federal program to be directed by Oregon.

DISCUSSION DOCUMENT FOR HB 3396

HB 3396 requirements	Lewin Analysis and Results	Listening Sessions	Key Considerations	Short vs. Long Term Action Items (18 months vs. 3+ years)	Potential Recommendations (from Lewin and Listening Sessions)
			might be for Oregon to seek a separate waiver with HRSA <ul style="list-style-type: none"> • Consider seeking a federal waiver from HRSA to waiver program requirements and allocate federal money to target federal funds based on Oregon’s priorities and need. • Pending federal changes to measurement of shortage designation starting in 2018 could result in less overall federal funding for Oregon. 		

Table 4: Other Considerations

	Lewin Analysis and Results	Listening Session Feedback	Key Considerations	Short vs. Long Term Strategies (e.g. 18 months vs. 3+ years)	Potential Recommendations (from Lewin and Listening Sessions)
Data Issues					<ul style="list-style-type: none"> • Collect Information on All Program Applicants • Collect Additional Provider-level Information • Field a Provider Survey • Collect Data on Tele-Medicine • Identify Providers in APAC Data • Create a Unique Provider Identifier • Create a Comprehensive Provider Dataset

SUMMARY OF RECOMMENDATIONS ON INCENTIVE PROGRAMS

1) Enhance data collection for all incentive programs

- Collect common information on all program applicants and participants
- Collect additional provider-level information
- Collect data on tele-medicine
- Identify providers in All-Payer All-Claims data
- Create a unique provider identifier
- Create a comprehensive provider dataset (underway within OHA)

2) Expand program awareness and ease of use among clinicians and employing sites

- Create a common application tool for all clinicians seeking incentive funds
- Create a common tool for all clinical sites seeking to make use of Oregon's provider incentives
- Expand outreach through various networks—training programs, CCOs, statewide associations

3) Consolidate and restructure programs for greater effectiveness and efficacy

- Increase award amounts for locations where recruitment is a bigger challenge.
- Increase number of loan repayment awards
- Offer different award amounts by provider type
- Offer a bidding mechanism
- Offer incentive “package” that is more than just the repayment
- Relax existing job requirement as condition for a Loan Repayment award
- Require future obligations for programs like tax credit and RMPIS
- Develop service agreements that require some years of practice in Oregon after the incentives are paid.

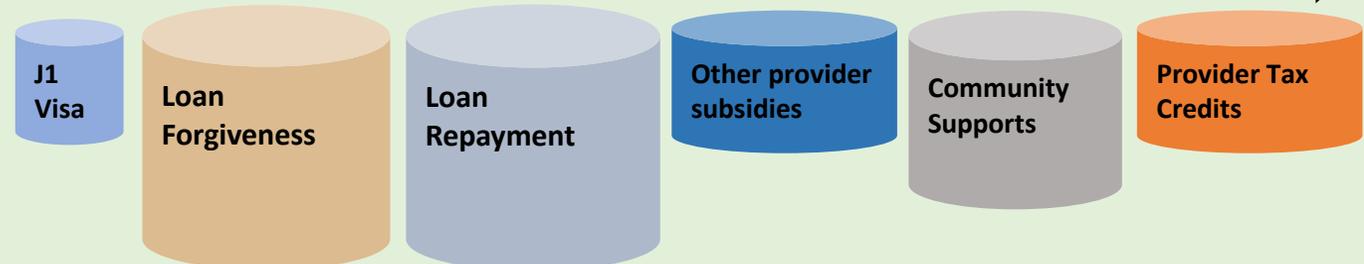
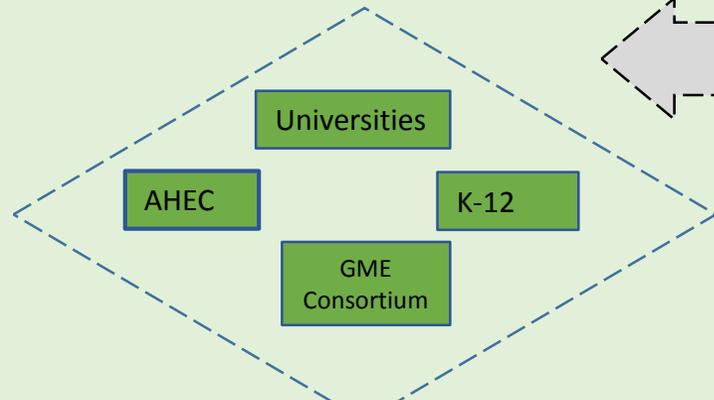
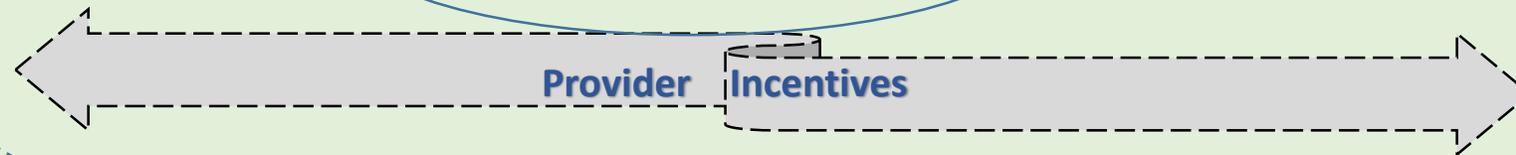
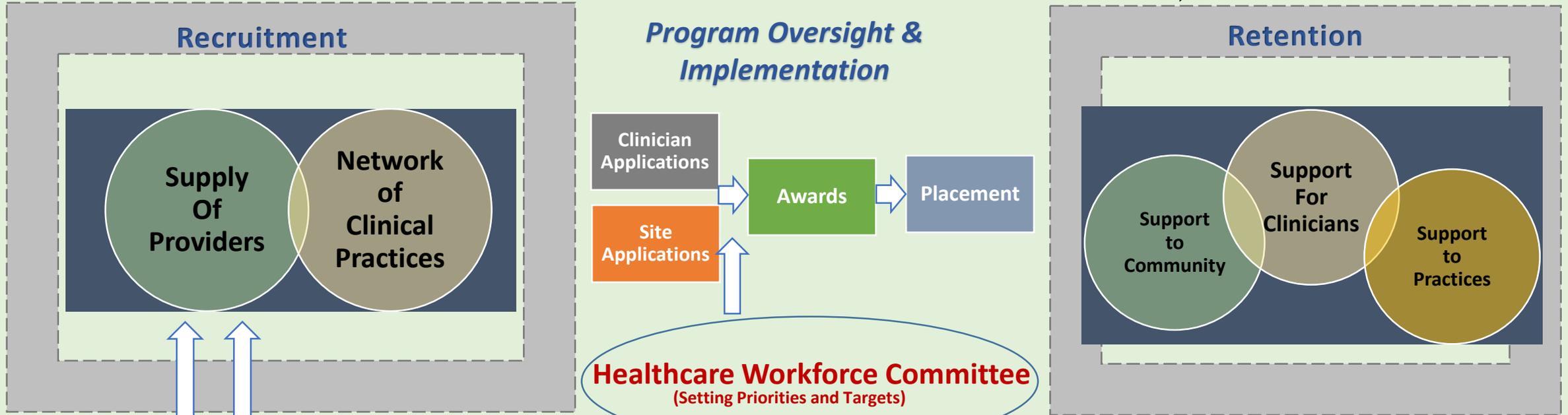
4) Include community support as part of statewide system of supports for providers to practice in rural and non-rural underserved areas

- Consider a “Recruitment and Retention Collaborative” or Institute to train sites and communities
- Use grant dollars to leverage and support communities expanding their recruitment and retention capacity.

Two further considerations:

- A. HB 3396 effectively sunsets all existing programs and allows the tax credit to expire at the beginning of 2018. Does the Committee support allowing this to take effect and in essence, replace the existing programs with a “system” of loan repayment, loan forgiveness, other incentives and tax credits all funded from the new “Health Care Provider Incentives Fund?” (Schematic for oversight, administration and evaluation of the system attached.) OHA could either administer directly or contract out for all or parts as it does currently for several programs.
- B. One additional option is for Oregon to seek a waiver or Memorandum of Agreement with HRSA to allow federal money currently coming to Oregon clinicians (i.e., NHSC, NurseCorps) to come to OHA to support the Oregon approach to recruitment and retention envisioned above. Does the Committee support pursuit of this approach to leverage federal resources in an Oregon-specific way for greater return on investment?

A potential “transformed view”-- Oregon Healthcare Service Corps Recruitment & Retention (OSCRR)



Recruitment

Supply	<ul style="list-style-type: none"> • OHA-J1 • ORH (3RNet) • OHA-PCO (NHSC Job Center)
Network of Clinical Practices	<ul style="list-style-type: none"> • OHA PCO • OHA PCPCH • OHA/HST/FQHC/RH C/ Tribal • ORH

Retention

Support to Communities	<ul style="list-style-type: none"> • OHA CSI/Quality • ORH
Support to Practices	<ul style="list-style-type: none"> • ORH • OPCA (?) • OHA PCPCH • OHA PCO • AHEC?
Support to Clinicians	<ul style="list-style-type: none"> • OHA PCO

Analytics

Identification of need	<ul style="list-style-type: none"> • OHA Health Analytics • ORH
Assessment of program performance and impact	<ul style="list-style-type: none"> • OHA Health Policy • OHA Health Analytics

Growing the Supply of Healthcare Providers

K-12	<ul style="list-style-type: none"> • AHEC
University	<ul style="list-style-type: none"> • AHEC • GME Consortium • Universities
Graduate	<ul style="list-style-type: none"> • GME Consortium • Educational Progs • Preceptors