

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

Report to the Joint Commission On Health Care

The Advisability of Establishing a MidLevel
Provider License

7/1/2015

Executive Summary

In response to House Joint Resolution 689,¹ the Joint Commission on Health Care (JCHC) approved a number of policy options to address projected workforce shortages, including a request to the Department of Health Professions (DHP) to convene a workgroup to consider the advisability of establishing a mid-level provider license.² The letter further requested that if the workgroup determined that the establishment of a mid-level provider license is advisable, it will include in its report to the JCHC in 2015, additional education or training requirements and next steps:

- (i) To establish a mid-level provider license and thereby define the requirements for individuals, who are licensed to practice medicine in another country, to be licensed to practice under the supervision of a physician licensed in Virginia; and,
- (ii) To establish a mid-level provider license and thereby define the requirements to allow medical school graduates, who have not completed a residency, to be licensed to practice under the supervision of a physician licensed in Virginia.

In response to the JCHC request, DHP established a workgroup consisting of representatives from the various stakeholders. Specifically, the workgroup members included:

David E. Brown, DC, Virginia Department of Health Professions
Charles (Chuck) E. Carr, Virginia Rural Health Association
Myra L. Clark, Virginia Rural Health Association
Lori D. Conklin, MD, Virginia Board of Medicine
Diane Farineau, University of Virginia Health System
Elaine Ferrary, MS, RN, FNP-BC, Virginia Council of Nurse Practitioners
Robert Glasgow, PA-C, MPAS, MPH, DFAAPA, Virginia Academy of Physician Assistants
Scott Hickey, MD, FACEP, Virginia College of Emergency Physicians
Jaime H. Hoyle, Virginia Department of Health Professions
Parham Jaber, MD, Virginia Department of Health
Mike Jurgensen, Medical Society of Virginia
Donald Kees, MD, Virginia Tech Carilion School of Medicine
John Lucas, DO, Edward Via College of Osteopathic Medicine
Mary Alice O'Donnell, Ph.D., VCU School of Medicine
Susan C. Ward, Virginia Hospital and Healthcare Association
Linda D. Wilkinson, Virginia Association of Free and Charitable Clinics

The workgroup held a meeting in September 2014 to discuss the establishment of a midlevel provider license. DHP staff facilitated the discussion and presented background information from an extensive literature review. After hearing the presentation and engaging in discussion, the workgroup determined that establishment of a midlevel provider license is not advisable at this time. However, the workgroup recommended the subject be revisited after enough time has passed for data to be gathered on Missouri's experience with a mid-level provider license. In the meantime, Virginia should explore other approaches to address any physician workforce shortage, such as:

¹ House Joint Resolution 689 (Delegate Purkey – 2013). Available at <http://lis.virginia.gov/cgi-bin/legp604.exe?ses=131&typ=bil&val=hj689>.

² Joint Commission on Health Care. "2013 Annual Report of the Joint Commission on Health Care." *Virginia Report Document #164*. (2014).

1. Increasing the number of Graduate Medical Education (GME) residency slots.
2. Ensuring state methods and organizational structures target GME positions toward state health workforce needs.
3. Leveraging emerging technology and telemedicine to reach the underserved and address geographic mal-distribution of physicians.
4. Utilizing a team-based approach to health care delivery with integration of nurse practitioners and physician assistants.
5. Ensuring Virginia effectively utilizes currently regulated professions, such as nurse practitioners and physician assistants, to address access to care issues before establishing a new level of provider.
6. Considering an increase in the licensure fee to fund rural physicians.
7. Ensuring the sustainability of any solution to address physician shortages.
8. Ensuring any solution to address workforce issues does not compromise patient care and safety.

Background

The Health Resources and Services Association (HRSA) projects a shortage of primary care physicians of 20,500 by 2020,³ and the Association of American Medical Colleges (AAMC) warns the United States faces a shortage of more than 130,600 physicians by 2025.⁴ Health economists and analysts base these forecasts on numerous factors. First, the passage of the Affordable Care Act (ACA) gives millions of people health insurance for the first time, and research indicates that health insurance leads to increase use of health care services, especially in primary care. The AAMC projects the increase in coverage through the ACA will increase use of all physicians by 4%.⁵ Second, at the same time the Affordable Care Act leads to millions entering the health care system, 10,000 baby boomers qualify for Medicare every day. This aging population drives the demand for services. According to HRSA, aging and population growth will account for 81% of the change in demand between 2010 and 2020. The estimated expansion of health insurance coverage under full implementation of the ACA, including an assumption that all states expand Medicaid, constitutes the remainder of the projected change in demand.

Long term solutions to address physician shortages mainly focus on increasing the supply of physicians. As such, states have been adding medical schools, and consequently, medical school enrollment has increased 30% between 2002 and 2012. Virginia medical school enrollment has increased 15% since 2008. Additionally, Colleges of Osteopathy will increase the number of graduates by over one thousand by 2018.

GME Funding

Even as America's medical schools increase their enrollments to address the physician shortage, new medical school graduates must still complete a residency training program before they can become licensed physicians and begin seeing patients. Medical school graduates receive this training as

³ U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *Projecting the Supply and Demand for Primary Care Practitioners Through 2020*. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.

⁴ "The Complexities of Physician Supply and Demand: Projections Through 2025," Center for Workforce Studies, AAMC. 2008.

⁵ Dill MJ, Salsberg ES. *The Complexities of Physician Supply and Demand: Projections Through 2025*. Association of American Medical Colleges; 2008.

residents in over 1,000 of the country's teaching hospitals. The federal government, through Medicare, is the single largest financial supporter of GME funding, with an investment in physician training amounting to roughly half a million dollars per physician. In an effort to constrain federal spending, the federal government capped GME funding in 1997. Many argue that this stagnant GME funding conflicts with efforts to expand the nation's physician supply. GME funding has not increased to keep up with the current pace of increased medical school enrollment and remains capped at 1997 levels.

Currently enough residency slots exist to match the number of graduates with a residency program, but projected data indicates this limited number of residency slots leads to many more unmatched graduates in the future. According to Health Affairs, with the annual influx of 6,000 International Medical School Graduates (IMGs), many of whom are United States citizens, there may be too few training positions to accommodate all of these new doctors who have invested considerable time and money into their medical education.⁶ Further pointing to the fact that increased medical school enrollment does not necessarily address the physician shortage, many of the residency slots are designated for specialty choices, not primary care.⁷ Because many medical school graduates choose a specialty program, and often the same specialty program, many residency slots already go unmatched. Addressing these issues would require a variety of GME funding reforms, incentives tying residency slots to physician workforce needs, as well as better education on specialty choice.

Geographic Mal-distribution

Merely increasing the number of physicians fails to fully address the lack of access to physicians. Equally important to the discussion of physician shortages are the demographics of the physician workforce. Geographic mal-distribution plays a major role in persons not accessing healthcare. GME payments to teaching hospitals located in urban areas worsen the problem because physicians tend to practice in the location of their residency program.⁸ Suggested approaches to addressing geographic mal-distribution include investing in training and education focused on rural healthcare; leveraging technology and telemedicine; and utilizing non-physician healthcare providers through team-based medicine as well as easing scope of practice laws and regulations.

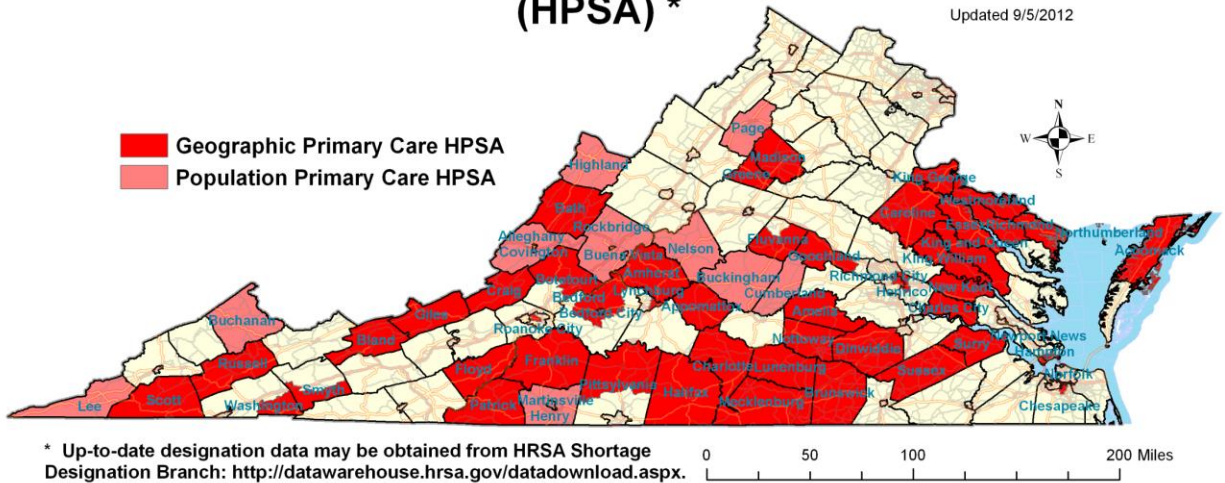
⁶ "Health Policy Brief: Graduate Medical Education," Health Affairs, August 16, 2012.

⁷ Stephen M. Petterson, Winston R. Liaw, Carol Tran, and Andrew W. Bazemore. "Estimating the Residency Expansion Required to Avoid Projected Primary Care Physician Shortages by 2035." *Ann Fam Med* March/April 2015 13:107-114.

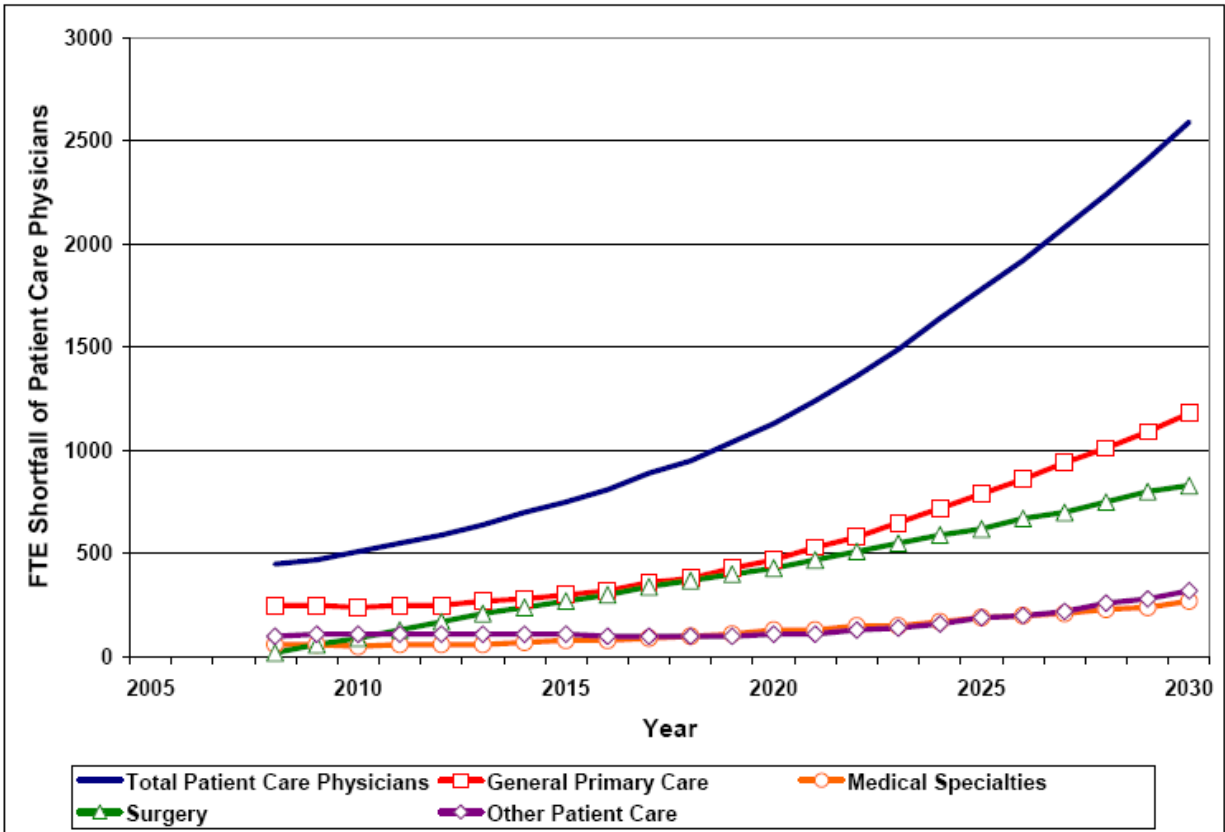
⁸ Seifer SD, Vranizan K, Grumbach K. Graduate medical education and physician practice location. *JAMA*. 1995; 274 (9):685-91.

Virginia Primary Care Health Professional Shortage Areas (HPSA) *

Updated 9/5/2012



2010 DHP Report: Projected Future Shortages Would be Most Prevalent in Primary Care and Surgery Specialties



Midlevel Providers

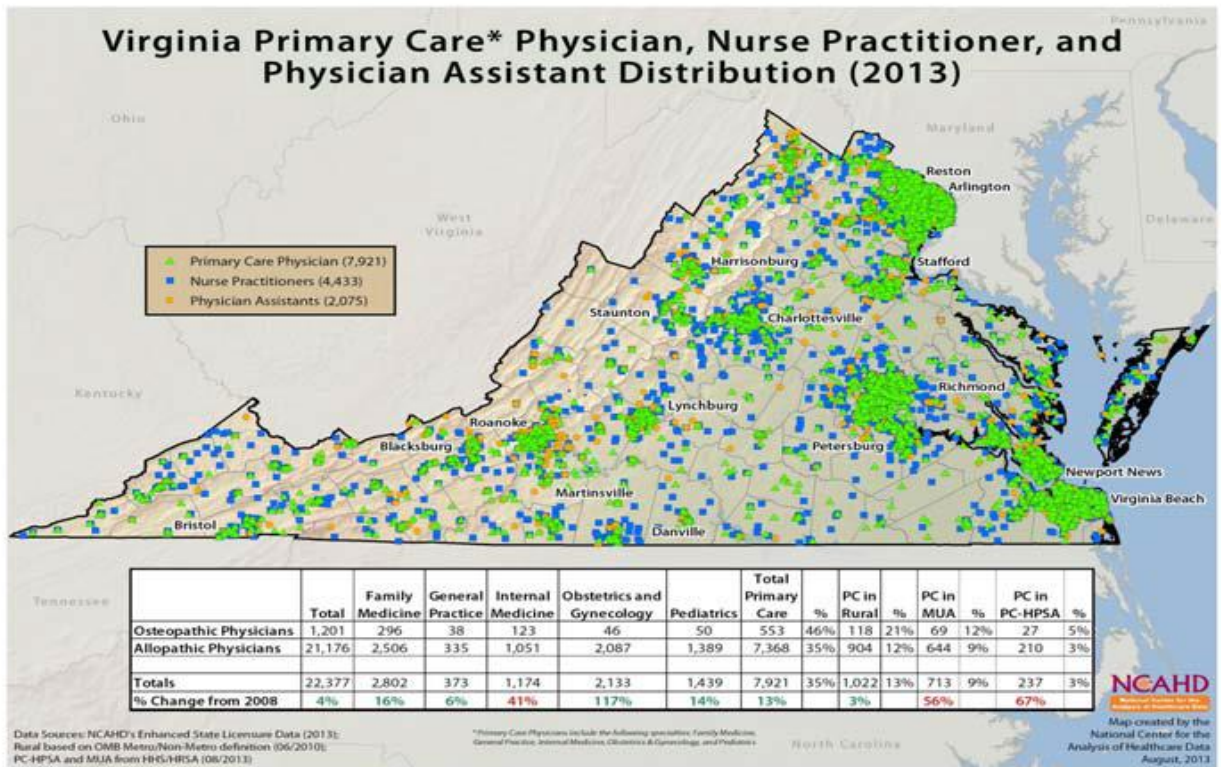
Midlevel providers are licensed non-physician health care providers who have received less extensive training and have a more restricted scope of practice than physicians. The majority of jurisdictions in the United States distinguish two separate categories of midlevel provider: nurse practitioners (NPs) and physician assistants (PAs).

More people look to midlevel providers to address the primary care physician workforce shortage. From 1996 to 2008, the number of primary care physicians grew by 29%, while NPs and PAs increased by 123% and 153%, respectively.⁹ HRSA projects the supply of primary care NPs to increase by 30%, from 55,400 in 2010 to 72,100 in 2020.¹⁰ HRSA also projects the supply of primary care PAs to increase by 58%, from 27,700 to 43,900 over the same period.¹¹

⁹ U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *Projecting the Supply and Demand for Primary Care Practitioners Through 2020*. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.

¹⁰ *Ibid.*

¹¹ Available at https://www.aamc.org/download/158076/data/updated_projections_through_2025.pdf



If the health care system effectively integrates and leverages NPs and PAs, it could reduce the projected physician shortage of 20,400 by 2020 to 6,400.¹² If fully utilized, the percent of primary care services that NPs and PAs provide will grow from 23% in 2010 to 28% in 2020.¹³ Physicians would remain the dominant providers of primary care, only decreasing from 77% of the primary care services in 2010 to 72% in 2020.¹⁴

The ACA incentivizes the growth and use of NPs and PAs by increasing funding for midlevel providers in underserved areas and encouraging interdisciplinary practices with team-based approaches to coordinated care. Full utilization of midlevel providers, however, could require changes to scope of practice laws and payment reform to allow midlevel providers to perform expanding roles.

Missouri Mid-level Provider Law

Missouri is the only state to pass legislation establishing a mid-level provider license for an assistant physician, which would comprise medical students who were unable to secure a residency slot.¹⁵ Missouri's law requires passage of steps one and two of the United States Medical Licensing

¹² U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *Projecting the Supply and Demand for Primary Care Practitioners Through 2020*. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.

¹³ Ibid.

¹⁴ U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *Projecting the Supply and Demand for Primary Care Practitioners Through 2020*. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.

¹⁵ Available at <https://legiscan.com/MO/bill/SB716/2014>

Examination (USMLE). The law permits applicants who have graduated from medical school within at least three years prior to apply for licensure. This license would allow the assistant physician to enter into an “assistant physician collaborative practice arrangement” with a physician. Collaborative practice arrangements limit the assistant physician to providing only primary care services and only in medically underserved rural or urban areas. However, the assistant physician would practice somewhat autonomously and have the authority to prescribe Schedule III, IV and V drugs.

Workgroup Recommendation

The workgroup determined that establishment of a midlevel provider license is not advisable at this time. However, the workgroup recommended the subject be revisited after enough time has passed for data to be gathered on Missouri’s experience with a mid-level provider license. In the meantime, Virginia needs to explore additional approaches to address any physician workforce shortage, such as:

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