AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Statement of

American Academy of Family Physicians

Submitted for the Record

U.S. Senate Committee on Finance

The Children's Health Insurance Program: The Path Forward

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On behalf of the American Academy of Family Physicians (AAFP), which represents over 129,000 family physicians and medical students across the country, thank you for the opportunity to submit testimony for the record to the Committee on Finance regarding the continuation of the Children's Health Insurance Program (CHIP).

Congress Should Swiftly Approve a Long-Term Extension of CHIP Funding.

The AAFP urges the Committee to swiftly approve a bipartisan long-term extension of CHIP, in order to promote stability and health security for 8.9 million low-income children[1] and their families. Time is of the essence in completing this work in order to ensure continuous access to primary and preventive services for this vulnerable population, protect progress in public health, and allow States to adequately plan.

The AAFP has supported CHIP since its inception in 1997, and during each subsequent reauthorization and extension of funding (2007, 2009, and 2015), as a way to extend health coverage to uninsured children whose families do not meet eligibility requirements for Medicaid. Since the enactment of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), in April 2015, the AAFP has reiterated support for CHIP funding beyond the current end-date of September 30, 2017—through letters to this Committee and to Congressional Leadership. As a medical specialty, family medicine is committed to the success of all of health insurance programs financed with public dollars, including CHIP. AAFP member data indicates that over two thirds of AAFP members accept new Medicaid patients.[2] Although the AAFP does not collect member survey data on CHIP participation, we know (due to the close connection between Medicaid and CHIP—including the fact that some states operate combined Medicaid / CHIP programs—and the fact that family physicians perform so many pediatric services) that family physicians are helping to carry out Congress's intent behind CHIP: treating low-income children, many of whom would be uninsured without the program.

Family physicians play an important role in addressing American children's health needs. According to the AAFP's latest member census, published December 31, 2016, over 80 percent of AAFP members care for adolescents, and 73 percent care for infants and children.[3] Other AAFP member survey data reflect that about 20 percent of AAFP's members deliver babies as part of their practice, with roughly 6 percent delivering more than 30 babies in a recent calendar year.[4] Of AAFP active members with full hospital

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[1] Centers for Medicare and Medicaid Services, 2016 Enrollment Report, available at https://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf.

[2] AAFP, 2015 Practice Profile Survey (excerpt), *available at* http://www.aafp.org/about/the-aafp/family-medicine-facts/table-12.html.

[3] AAFP Member Census (Dec. 31, 2016), available at http://www.aafp.org/about/the-aafp/family-medicine-facts/table-13.html.

[4] AAFP, 2015 Practice Profile Survey (July 15, 2016).

privileges, 70 percent provide newborn care in the hospital, and 64 percent provide pediatric care in the hospital.[5] This is consistent with family medicine's traditional role of practicing in the entire scope of the physician license, in order to meet the needs of the community in which the family physician practices. A family physician who serves a small rural community without a pediatrician, for example, will often perform most or all pediatric care for that community.

The AAFP also supports health care for all, consistent with the public-health mission of the specialty of family medicine. The AAFP promotes universal access to care in the form of "a primary care benefit design featuring the patient-centered medical home, and a payment system to support it," for everyone in the United States.[6] AAFP believes that all Americans should have access to primary-care services (e.g. in the case of infants and children, immunizations and other evidence-based preventive services, prenatal care, and well-child care), without patient cost sharing. The AAFP believes that universal health care also should include services outside the medical home (e.g. hospitalizations) with reasonable and appropriate cost sharing allowed, but with protections from financial hardship. Supporting universal access to care is also consistent with the "triple aim" of improving patient experience, improving population health, and lowering the total cost of health care in the United States. Research supports the AAFP's view that having both health insurance and a usual source of care (e.g., through an ongoing relationship with a family physician) contributes to better health outcomes, reduced disparities along socioeconomic lines, and reduced costs.[7]

The AAFP urges Congress to pass a "clean" extension of CHIP with a minimum of unnecessary policy changes. Accordingly, Congress should extend the current enhanced federal medical assistance percentage (FMAP), as well as the current maintenance of effort (MOE) provisions, which are both in effect through September 30, 2019, to align with an extension of CHIP funding. For example, if Congress extends CHIP funding for 5 years, then it should extend the enhanced FMAP and MOE provisions for 3 years. The AAFP also supports maintaining the enhanced FMAP on policy grounds: Maintaining the enhanced FMAP allows states to more easily devote scarce resources to their Medicaid programs, which collectively cover some 70 million low-income Americans. Destabilizing the enhanced FMAP in CHIP could also discourage the 19 "non-expansion" states from expanding their Medicaid programs and covering yet more uninsured children and adults.

Unlike Medicare and Medicaid, which provide stable and reliable federal funding under current law, CHIP funding is contingent upon Congressional action at regular intervals.

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[5] *Id.*

[6] AAFP, Health Care For All (2014), *available at* http://www.aafp.org/about/policies/all/health-care-for-all.html.

[7] *See, e.g.*, The Robert Graham Center, The Importance of Having Health Insurance and a Usual Source of Care, Am. Fam. Physician (Sept. 15, 2004), *available at* http://www.aafp.org/afp/2004/0915/p1035.html.

Given the importance of the program to almost 9 million children from low-income families, the AAFP urges the Committee to swiftly extend and stabilize the program on a long-term basis.

Congress Should Also Provide Long-Term Support for the Teaching Health Center Graduate Medical Education Program.

As an additional note, the AAFP would like to emphasize to the Committee the importance of providing long-term support for the Teaching Health Center Graduate Medical Education (THCGME) program, which will also expire on September 30, 2017, absent Congressional intervention. THCGME is a successful primary-care training program, currently financing training for 742 medical and dental residents in community-based ambulatory settings. Residents in the THCGME program train exclusively in primary-care specialties.

Of relevance to the legislative process surrounding CHIP, two-thirds of the THCGME residents are training in family medicine and pediatrics.[8] The THCGME program, administered by the Health Resources and Services Administration (HRSA), accounts for less than one percent of the annual federal spending devoted to graduate medical education, yet it is the only GME program that is devoted entirely to training primary-care physicians and dentists. Residents in the program train in community health centers (including federally qualified health centers), and tend to be concentrated in rural and underserved areas that need access to more providers, particularly primary-care physicians. American Medical Association Physician Masterfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location.[9] By comparison, fewer than 5 percent of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas.[10] Thus, the most effective way to get family and other primary-care physicians into rural and underserved areas is not to recruit them from remote academic medical centers but instead to train them in these underserved areas.

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[8] Health Resources and Services Administration, Teaching Health Center Graduate Medical Education Program, Academic Year 2014-2015, *available at* https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/teaching-health-center-graduate-highlights.pdf.

[9] E. Blake Fagan, M.D., et al., Family Medicine Graduate Proximity to Their Site of Training, Family Medicine, Vol. 47, No. 2, at 126 (Feb. 2015).

[10] Candice Chen, M.D., MPH, et al., Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions, Academic Medicine, Vol. 88, No. 9, p. 1269 (Sept. 2013).