AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

October 26, 2021

The Honorable Anna Eshoo
Chairwoman
Subcommittee on Health,
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health,
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairwoman Eshoo and Ranking Member Guthrie:

On behalf of the American Academy of Family Physicians (AAFP) and the 133,500 family physicians and medical students we represent, I applaud the committee for its continued focus on the health care workforce. I write in response to the hearing: "Caring for America: Legislation to Support Patients, Caregivers, and Providers" to share the family physician perspective and the AAFP's policy recommendations for ensuring that we have a robust primary care workforce to address our nation's current and future health care needs.

The AAFP has long been concerned about the shortage of primary care physicians in the U.S., particularly the supply of family physicians, who provide comprehensive, longitudinal primary care services for patients across the lifespan, including chronic disease management, treatment of acute illnesses, and preventive care. It is projected that we will face a shortage of up to 48,000 primary care physicians by 2034.[1] We know most physicians are trained at large academic medical centers in urban areas, and evidence indicates physicians typically practice within 100 miles of their residency program.[2] As a result, the current distribution of trainees leads to physician shortages in medically underserved and rural areas.

Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. In 2016, Americans made nearly 900 million visits to office-based physicians with almost half of those visits made to primary care physicians.[3] Despite being the largest specialty in the U.S. health system, primary care accounts for a mere 5-7 percent of total health care spending.[4] The COVID-19 pandemic has also highlighted the urgency of building and financing a robust, well-trained, and accessible primary care system in our country.

The AAFP urges the committee to consider these recommendations:

- **Design federal GME programs to meet the health care needs of our nation, including assessing how funds are allocated or whether they are effectively addressing physician shortages.**

- **Invest in efforts to diversify the physician workforce to improve access to health care, reduce spending, and better meet the needs of our diverse population.**

- **Permanently authorize and expand the Teaching Health Center GME Program by passing the Doctors of Community Act (H.R. 3671).**

- **Ensure financial stability to strengthen the primary care physician pipeline, especially in rural and underserved communities to eliminate health disparities and improve access for all populations.**

- **Strengthen the family physician pipeline by investing in federal programs that reduce medical student debt.**

- **Address the burnout of physicians, whose impact has been accelerated by the COVID-19 pandemic, by passing the Dr. Lorna Breen Health Care Provider Protection Act (H.R. 1667).**

Modernize Medicare GME

Congress recently took action to address physician shortages by creating 1,000 additional Medicare GME slots in the Consolidated Appropriations Act of 2021 (CAA). The AAFP was pleased that Congress directed some of these slots to hospitals in rural and Health Professional Shortage Areas (HPSAs) that CMS proposed to prioritize the distribution of new slots to hospitals caring for underserved populations. To more comprehensively leverage the GME program to address physician maldistribution, we recommended the agency also consider which hospitals were training the highest proportion of residents that ultimately go on to practice in rural areas.

While the slots allocated in the CAA were a positive first step, additional action is needed to address disparate access to care in rural and other medically underserved areas. Merely expanding the existing Medicare GME system will not fix the shortage and maldistribution of physicians. **Any expansion of Medicare GME slots should be targeted specifically toward hospitals and programs in areas and specialties of need, including by considering which ones have a proven track record of training physicians who ultimately practice in physician shortage areas.**

One barrier to creating a more equitable and effective Medicare GME program is the lack of transparency in how funds are used. Medicare as the largest single payer – spends about $9.5 billion annually on GME - but it does not assess how those funds are ultimately used or whether they actually address physician shortages. CMS has indicated their authority is limited to making payment to hospitals for the costs of running approved GME residency programs. **Congress should pass legislation granting the Secretary of HHS and the CMS Administrator the authority to collect and analyze data on how Medicare GME positions are aligned with national workforce needs.**

Prioritize Training Primary Care and Underrepresented Physicians

Today's 59 Teaching Health Centers play a vital role in training the next generation of primary care physicians and addressing the physician shortage. To date, the Teaching Health Center GME (THCGME) program has trained more than 1,148 primary care physicians and dentists, 65 percent of whom are family physicians. THCGME graduates are more likely to continue practicing primary care medicine and serving in medically underserved communities than those in Medicare GME-supported programs. **Congress should permanently authorize and expand the THCGME program by passing the Doctors of Community Act (H.R. 3671)**

The lack of a diverse physician workforce has significant implications for public health. Physicians who understand their patients' languages and also understand the larger context of culture, gender, religious beliefs, sexual orientation and socioeconomic conditions are better equipped to address the needs of specific populations and the health disparities among them. Several studies show that racial, ethnic and gender diversity among physicians promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.[5, 6] Improving quality of care for the most vulnerable groups can improve a patient's health outcome, which in turn can reduce health care costs over the long run. Studies also show that students from backgrounds currently underrepresented in medicine are more likely to care for underserved populations in their careers, and more likely to choose primary care careers.[7]

While primary care specialties fare better than other specialties in representation of racial and ethnic minorities in the workforce, the entire physician workforce lags significantly behind the racial and ethnic diversity of the U.S. population. Today, Black and Hispanic Americans account for nearly one-third of the U.S. population, but just 11 percent of physicians.[8, 9] **Congress should invest in efforts to diversify the physician workforce to improve access to health care, reduce spending, and better meet the needs of our increasingly diverse population.**

Invest in Primary Care

Despite evidence suggesting that additional investments in primary care would improve population health and advance health equity, primary care has been historically underfunded in the U.S. This underinvestment has strained our primary care system and led to physicians choosing other specialties. The AAFP is concerned that COVID-19 has further exacerbated these challenges and will worsen primary care shortages. Less than 30 percent of primary care practices participating in an August 2021 survey were able to report that their practices were financially healthy, and more than 30 percent reported they had been unable to recoup revenues lost in 2020.[10]

Congress should act to bolster the primary care physician pipeline by enacting Medicaid payment parity. On average Medicaid, pays just 66 percent of the Medicare rate for primary care services and can be as low as 33 percent in some states.[11] These low rates negatively impact primary care physicians' overall compensation and deter medical students and residents from choosing to practice primary care. A recent analysis found that the median annual compensation rate for family physicians was almost half of the median compensation rate for some specialists.[12] Increasing Medicaid payment rates for primary care would help address this compensation disparity and encourage more trainees become primary care physicians. **The AAFP urges Congress to pass the Kids' Access to Primary Care Act of 2021 (H.R. 1025) to raise Medicaid payment rates for primary care services to at least Medicare rates.**

The average student loan debt for four years of medical school, undergraduate studies and higher education is on average between $200,000 and $250,000.[13] Research has shown that loan forgiveness or repayment programs directly influence physician practice choice. **Congress should expand funding for federal programs, including the National Health Service Corps Program, that target primary care, support the deferment of interest and principal payments on medical student loans until after completion of postgraduate training, and we recommend that the interest on medical student loans be deductible on federal tax returns.**

Address Clinician Burnout and Mental Health Needs

Even prior to the pandemic, burnout among health clinicians was a pervasive public health concern, with some studies reporting burnout in more than 50 percent of clinicians. According to the American Board of Family Medicine, primary care physicians have experienced the highest rate of death (26.9%) among health provider specialties during COVID-19.[14] Physician burn out during the COVID-19 pandemic has only become worse, negatively impacting happiness, relationships, career satisfaction, and patient care. A January 2021 report showed that 47 percent of family physicians are burnt out, and 20 percent of all physicians are clinically depressed.[15] **We applaud the Committee for considering the Dr. Lorna Breen Health Care Provider Protection Act (H.R. 1667) and urge its enactment to make critical investments in the mental health needs of our nation's doctors, particularly during the pandemic, and fight the stigma around seeking necessary treatment.**

Thank you in advance for consideration of our recommendations. The AAFP looks forward to working with the committee to develop and implement policies to strengthen the primary care workforce. Should you have any questions, please contact John Aguilar, Manager of Legislative Affairs at jaguilar@aafp.org.

Sincerely,

Ada D. Stewart, MD, FAAFP
Board Chair, American Academy of Family Physicians

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