AMERICAN ACADEMY OF FAMILY PHYSICIANS

April 19, 2023

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

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

Dear Chairman Guthrie and Ranking Member Eshoo:

On behalf of the American Academy of Family Physicians (AAFP) and the 129,600 family physicians and medical students we represent, I applaud the committee for its focus on the health care workforce. I write in response to the hearing: "Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care" 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] Additionally, the lack of transparency in how federal graduate medical education (GME) funds are spent undermines efforts to address physician shortages. For example, Medicare spends about $16 billion annually on GME – but CMS does not assess whether they address physician shortages.[2]

Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes.[3] In 2019, Americans made 1 billion visits to office-based physicians with over half of those visits made to primary care physicians.[4] Despite the significant role that primary care plays in our health system, primary care accounts for a mere 5-7 percent of total health care spending.[5] The COVID-19 pandemic has also further emphasized the urgent need to build and finance a robust, well-trained, and accessible primary care system in our country.

As Congress considers policy solutions to address our growing health workforce shortages, especially in primary care, the AAFP offers the following recommendations:

- ***Strengthen and target federal graduation medical education (GME) programs*** **by permanently authorizing and expanding the Teaching Health Center Graduate Medical Education Program, ensuring transparency and accountability of the Medicare GME program, and creating additional federally funded GME slots targeted at primary care and rural/underserved areas.**

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- ***Address the burden of medical student debt*** **by expanding the National Health Service Corps program and other programs to provide student debt relief for physicians serving in high-need roles.**

- ***Invest in primary care*** **by ensuring Medicare and Medicaid physician payment is adequate and sustainable.**

- ***Diversify the physician workforce*** **by providing federal support and incentives for future and current clinicians from underrepresented and low-income backgrounds and extending the Conrad 30 Program for international medical graduates.**

- ***Support physician-led team-based care and integration of behavioral health and primary care*** **by funding the Primary Care Training Enhancement Program (PCTE) and other federal grant programs, and by enacting policies that incentivize comprehensive care provided by a physician-led care team.**

- ***Strengthen and sustain our health care safety net*** **by funding community health centers.**

- ***Enact telehealth policies that extend the capacity of our health care workforce*** **by ensuring patients and clinicians have the flexibility to choose the most appropriate modality of care while protecting patient safety and the patient-physician relationship.**

- ***Stop anti-competitive contracting practices that harm clinicians and patients*** **by banning noncompete clauses in employment contracts.**

- ***Increase investment in primary care research*** **to identify trends and best practices.**

Strengthen and Target Federal Graduation Medical Education Programs

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.[6] As a result, the current distribution of trainees leads to physician shortages in medically underserved and rural areas.

Today's 72 Teaching Health Centers (THCs) 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 1,730 primary care physicians and dentists, 63 percent of whom are family physicians. Data shows that, when compared to traditional postgraduate trainees, residents who train at THCs are more likely to practice primary care (82 percent vs. 23 percent) and remain in underserved (55 percent vs. 26 percent) or rural (20 percent vs. 5 percent) communities. This demonstrates that the program is successful in tackling the issue of physician maldistribution and helps address the need to attract and retain physicians in rural areas and medically underserved communities.

The THCGME program's authorization expires in FY 2024, and we strongly caution against a short-term extension since it does not provide the needed stability for current and future residents. In fact, flat funding of the program would mean a 40-50 percent reduction in per resident allocation for THC programs, putting them at risk of closure and making it more difficult to retain faculty as well. **Congress should permanently authorize and expand the THCGME program by passing the Doctors of Community Act (H.R. 2569)**.

While the new Medicare GME residency slots approved in the previous Congress were very much appreciated, 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 is the largest single payer – spending about $16 billion annually on GME – but it does not assess how those funds are ultimately used or whether they actually address physician shortages.[7] CMS has indicated their authority is limited to making

payments 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 and publish an annual report.**

The nationwide shortage and maldistribution of family physicians and other primary care physicians is particularly dire in rural communities. While 20 percent of the U.S. population lives in rural communities, only 12 percent of primary care physicians and 8 percent of subspecialists practice in these areas. **We urge Congress to pass the Rural Physician Workforce Production Act (S. 230 / H.R. 834), which would provide invaluable new federal support for rural residency training to help alleviate physician shortages in rural communities**. Specifically, the bill would remove caps for rural training and provide new robust financial incentives for rural hospitals, including critical access and sole community hospitals, to provide the training opportunities that the communities they serve need.

Unlike Medicare and Medicaid, the Department of Veterans' Affairs (VA) does control the type of residents it trains and where these residents are located. A recent VA report projected that by 2033, there will be an estimated nationwide shortage of between 21,400 and 55,200 primary care physicians.[8] Additionally, it was identified that 57 VA facilities had severe primary care shortages.[9] **We urge Congress to designate additional VA GME slots for primary care specialties to address the current and projected shortages at VA facilities.**

Address the Burden of Medical Student Debt

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.[10] Research has shown that loan forgiveness or repayment programs directly influence physician practice choice. The rising level of educational debt disproportionately affects underrepresented and low-income students and limits their representation in the health workforce but reducing student debt will diversify the physician pipeline and help reduce physician shortages. **Congress should expand funding for federal programs, including the National Health Service Corps Program, that incentivize physicians to go into primary care practice by providing loan forgiveness.**

As such, we urge passage of the Restoring America's Health Care Workforce and Readiness Act (S. 862), which significantly increases investment in the National Health Service Corps Program and reauthorizes the program for another three years – current authorization expires on September 30**. We also urge the passage of the Resident Education Deferred Interest (REDI) Act (S. 704)**

to allow medical residents to defer their student loans without interest during residency, and we recommend that the interest on medical student loans be deductible on federal tax returns.

Invest in Primary Care

Despite evidence indicating that additional investments in primary care would improve population health and advance health equity, primary care has been historically underfunded in the U.S. Medicare and Medicaid have historically undervalued primary care. In the short-term, inadequate payment rates mean that primary care physicians lack the resources needed to provide comprehensive, continuous care for their patients and may be forced to accept fewer Medicare or Medicaid patients. In the long-run, payment distortions between primary and specialty care will continue to drive more physicians to go into higher paid specialties, worsening the maldistribution of the physician workforce. A recent Medicare Payment Advisory Commission (MedPAC) analysis highlighted that the median compensation remains much lower for primary care physicians than for physicians in certain other specialties, such as radiology and surgical specialties – underscoring concerns about the mispricing of fee schedule services and its impact on the primary care pipeline.[11]

Medicare's current physician payment system is undermining physicians' ability to provide high-quality, comprehensive care – particularly in primary care. Statutory budget-neutrality requirements and the lack of annual payment updates to account for inflation will, without intervention from Congress, continue to hurt physician practices and undermine patient care. **We urge Congress to pass the Strengthening Medicare for Patients and Providers Act (H.R. 2474), which provides for an annual update to the Medicare Physician Fee Schedule based on the Medicare Economic Index (MEI) to ensure that payment rates keep pace with rising practice costs, enabling practices to keep their doors open.** The AAFP also strongly supports the Centers for Medicare and Medicaid Services (CMS) regulations implementing a new add-on code for complex evaluation and management (E/M) visits that are part of continuous care: G2211. The G2211 code recognizes the inherent complexity of providing continuous, whole-person primary care and provides commensurate Medicare payment. We were dismayed when Congress elected to delay implementation of that code, and **we urge Congress to support full implementation of G2211 in the CY 2024 Medicare physician fee schedule.**

Congress must also 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.[12] This severely reduces the number of physicians who participate in Medicaid and limits access to health care for children and families. Increasing Medicaid payment rates will improve access to care for Medicaid patients, lead to better health outcomes, and reduce longstanding health disparities. **The AAFP urges Congress to pass the Kids' Access to Primary Care Act of 2023 (H.R. 952) to permanently raise Medicaid payment rates for primary care services to at least Medicare levels.**

Support Physician-Led Team Based Care

The ability to deliver high-quality primary care depends on the availability, accessibility, and competence of a primary care workforce working as a team to effectively meet the health care needs of all patients. **We urge Congress to increase investment in primary care training programs, such as HRSA's Primary Care Training and Enhancement (PCTE) Program, that strengthen the physician-led care team and increase patient access to comprehensive care.**

The PCTE program strengthens the primary care workforce by funding enhanced training for future primary care clinicians, teachers, and researchers through five-year grants. Current PCTE grants are supporting programs to integrate dental care into primary care, integrate behavioral health in primary care, provide enhanced training in prevention and maternal health, and enhanced primary care

training for non-physician primary care providers. The PCTE program improves the capacity of the existing primary care workforce by equipping primary care clinicians and educators with additional skills. Lessons learned from the evaluation of PCTE grants can be used as the foundation for larger scale federal workforce training programs.

It is important to highlight that the most efficient patient care is provided by physician-led team-based care. A July 2018 survey conducted on behalf of the American Medical Association found that more than four out of five patients prefer a physician-led health care team. Nine out of ten respondents said that a physician's additional years of education and training are vital to optimal patient care, especially for complex or emergency conditions. There have been efforts to expand the scope of practice for non-physicians to address workforce shortages. However, it has not solved the access problem. In fact, research shows that since 2004, the number of nurse practitioners entering primary care has dropped by 40 percent.[13,14]

The AAFP recognizes non-physician providers (NPP), such as nurse practitioners and pharmacists, as an integral part of physician-led health care teams. However, NPPs cannot substitute for physicians especially when it comes to diagnosing complex medical conditions, developing comprehensive treatment plans, ensuring that procedures are properly performed, and managing highly involved and complicated patient cases. **The AAFP opposes federal efforts to inappropriately expand NPP and pharmacist scope of practice that undermine physician-led care teams, potentially leading to fragmented care and worse quality of care.**

Diversify the Physician Workforce

The lack of a diverse physician workforce has significant implications for public health. Physicians who understand their patients' languages and 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.[15,16] Improving quality of care for the most vulnerable groups can improve a patient's health outcomes, 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 are more likely to choose primary care careers.[17]

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.[18,19]

The **AAFP supports federal programs, such as Title VII workforce training programs, that are crucial in increasing underrepresented minority participation in the health professions.** Unfortunately, sustainable federal funding for pathway programs has not been consistent over the years. **Congress should invest in efforts to diversify the health care workforce to improve access to health care, reduce spending, and better meet the needs of our increasingly diverse population.**

International Medical Graduates (IMGs) play an important role in not only addressing the physician shortage but in increasing the racial and ethnic diversity of the physician workforce. The Conrad 30 Waiver Program has brought more than 15,000 foreign physicians to underserved and rural communities. With communities across the country facing physician shortages, the Conrad 30 Waiver

Program ensures that physicians who are often educated and trained in the U.S. can continue to provide care for patients. **We urge Congress to pass the Conrad State 30 & Physician Access Act (S. 665) to provide immigration certainty to the thousands of international medical graduates caring for patients in underserved communities.**

Strengthen and Sustain our Health Care Safety Net

Community Health Centers (CHCs), including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), provide comprehensive primary care and preventive services to some of the most vulnerable and underserved Americans. Family physicians are the most common type of clinician (46%) practicing in CHCs, and thus are well-positioned to ensure accessible and affordable primary care and reduce racial, ethnic, and income-based health disparities.[20] FQHCs also play an important role in training family physicians, and research shows that CHC-trained family physicians are more than twice as likely to work in underserved settings than their non-CHC-trained counterparts.[21] **We urge Congress to increase investment in FQHCs, including a long-term authorization for CHCs, to meet the health workforce needs of the underserved and to increase access to comprehensive primary care in our most vulnerable communities.**

Support Integration of Behavioral Health and Primary Care

Family physicians provide comprehensive mental health services and are a major source for mental health care in the U.S. While psychiatric and other mental health professionals play an important role in the provision of high-quality mental health care services, primary care physicians are the first point of contact for most patients. Nearly 40 percent of all visits for depression, anxiety, or cases defined as "any mental illness" were with primary care physicians, and primary care physicians are more likely to be the source of physical and mental health care for patients with lower socioeconomic status and for those with comorbidities.[22] Given the dire shortage of behavioral health clinicians, especially in many rural and underserved communities, equipping primary care clinicians to provide frontline mental health and substance abuse disorder treatment is essential for ensuring patients have timely access to care.

The AAFP urges the reintroduction and passage of the bipartisan Improving Access to Behavioral Health Integration Act. The bill makes necessary changes to existing federal programs to ensure primary care practices can integrate behavioral health care services by providing grant funding that covers the steep start-up costs. This initial financial support is critical to improving access to integrated services and ensuring patients and payers can achieve the long-term cost savings that behavioral health integration often provides. **We also urge passage of the Better Mental Health Care for Americans Act (S. 923)**, which, most notably, supports the integration of behavioral health into primary care by increasing Medicare reimbursement and establishing a Medicaid demonstration to ensure all children enrolled have access to integrated care.

Additionally, to improve access to integrated tele-mental and behavioral health care in primary care settings, **the AAFP encourages Congress to establish a new program for adults that mirrors HRSA's Pediatric Mental Health Care Access Program (PMHCA)**. This program, recently reauthorized in 2022, promotes behavioral health integration into pediatric primary care by using telehealth, and has a proven track record of addressing mental and behavioral health needs despite ongoing workforce shortages by meeting children and adolescents where they are. Given the well-documented shortage of mental and behavioral health clinicians and the growing demand for specialized care, a HRSA-funded program that provides primary care clinicians with virtual access to specialists could increase timely access to care for adult patients.

Enact Telehealth Policies that Extend the Capacity of Our Health Care Workforce

The increased use of telehealth during the COVID-19 pandemic has shown that it may help address some acute physician shortages, but it is important to note that it is just an extender and not a substitute for more physicians. Telehealth offered by a patient's usual source of care can expand timely access to care while also improving care continuity and quality. For example, primary care physicians often connect patients to community-based services to address unmet health-related social needs and coordinate care across various physicians and other clinicians. Standalone telehealth services, such as those provided by direct-to-consumer companies, are not connected with resources in patients' communities nor are they positioned to follow-up with other clinicians involved in a patient's care. The AAFP recently raised concerns about telehealth providers engaging in unscrupulous business practices that claim to improve access to treatment but in fact jeopardize patient safety and privacy. **As Congress contemplates long-term changes to telehealth policy, it is critical to recognize that telehealth is one modality of providing care but cannot and should not fully replace in-person primary care. The AAFP also calls on Congress to make investments in broadband, digital literacy training, and digital health tools to bridge the digital divide and equitable access to telehealth.**

Stop Anti-Competitive Contracting Practices that Harm Clinicians and Patients

Noncompete agreements in health care impede patient access to physicians, limit physicians' ability to choose their employer, and stifle competition. Despite projected physician shortages, many health care employers still intentionally restrict physician mobility and workforce participation via noncompete agreements. Currently, noncompete agreements are enforced through a patchwork of state laws. Twelve states deem noncompete agreements unenforceable and against public policy; however, public awareness of these laws remains low, and employers still intimidate employees with the threat of legal action. Thirty-eight states allow noncompete agreements in some form, judging enforceability on factors including job type, legitimacy of business interests, and reasonableness of duration, scope, and distance. Family physicians from across the country have expressed deep concerns about how noncompete agreements are forcing them to remain in undesirable employment situations which harm their financial and mental health or abandon their patients and travel long-distances or uproot their families to practice in a new geographic area. **The AAFP urges Congress to pass legislation to ban noncompete clauses in physician employment contracts to ensure patients have access to their physicians and to allow physicians to freely practice medicine in their communities.**

Increase Investment in Primary Care Research

Despite primary care being the only segment of health care where an increased supply is associated with better population health and more equitable outcomes, federal support for primary care research has not increased over the years, with primary care research comprising less than 0.4 percent of NIH's budget.[23] **We urge Congress to increase federal funding for primary care research.**

Many states are working to measure primary care spending. However, the lack of national definitions and benchmarks, methodological differences across states and challenges with obtaining data across payer types create measurement challenges and make comparisons difficult. Relatedly, a National Academies of Science, Engineering, and Medicine (NASEM) report recommended the development of a national scorecard to provide accountability for the nation's progress in high-quality primary care implementation. The Milbank Memorial Fund and The Physicians Foundation partnered with the AAFP's Robert Graham Center recently created a scorecard to meet this need. **We urge Congress to invest in federal data improvements to enable more accurate measurement of primary care spend and changes in the primary care workforce – such as the impact of COVID-19 on primary care.**

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 and sustain our nation's health care workforce. Should you have any questions, please contact David Tully, Vice President of Government Relations at dtully@aafp.org and Natalie Williams, Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

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Board Chair, American Academy of Family Physicians

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