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30 MILLION NEW PATIENTS AND 11 MONTHS TO GO: WHO WILL PROVIDE THEIR PRIMARY CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON PRIMARY HEALTH AND AGING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

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FIRST SESSION

ON

EXAMINING PRIMARY CARE

JANUARY 29, 2013

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C O N T E N T S

STATEMENTS

TUESDAY, JANUARY 29, 2013

ADDITIONAL MATERIAL

30 MILLION NEW PATIENTS AND 11 MONTHS TO GO: WHO WILL PROVIDE THEIR PRIMARY CARE?

TUESDAY, JANUARY 29, 2013

U.S. SENATE,
SUBCOMMITTEE ON PRIMARY HEALTH AND AGING,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:03 a.m. in Room 430, Dirksen Senate Office Building, Hon. Bernie Sanders, chairman of the subcommittee, presiding.

Present: Senators Sanders, Casey, Hagan, Franken, Whitehouse, Warren, Baldwin, Murphy, and Enzi.

OPENING STATEMENT OF SENATOR SANDERS

Senator SANDERS. Let's begin our hearing, which is going to cover, I believe, an enormously important issue.

I want to thank Ranking Member Mike Enzi for his work. He and I have worked together on a number of issues over the years, and I look forward to a productive working relationship. Vermont is a rural State. I know something about rural problems. His State is a lot more rural, so we will see how we can go forward together.

Let me thank all of our panelists for being here. We have a great set of panelists from all over the country, and we very much appreciate them being here, and we thank them for the work they do every day, providing health care and doing research.

In our country today, I think as many people know, we spend almost twice as much as do the people of any other country per capita on health care. That is about 18 percent of our GDP, and yet our health care outcomes in terms of life expectancy, infant mortality, and disease prevention are not particularly good in terms of international comparisons.

One of the reasons for that is that we have a major crisis regarding primary health care access, which results in lower quality health care for our people and greater expenditures. Lower quality health care, and yet we end up because of the crisis in primary health care, spending substantially more than we should.

Today, 57 million people in the United States, 1 in 5 Americans, cannot see a doctor when they need to. Lack of access to a primary care provider is a national problem, but those who are most impacted are people who are low-income, minority, seniors, and people who live in rural communities whether it is Vermont or Wyoming.

As we have seen time and time again with dental care, mental health, and other health care issues, the groups that need health care the most are the least likely to receive it.

The good news is that just 11 months from now, we will be providing health insurance to 30 million more Americans through the Affordable Care Act. The bad news is that we don't know how we are going to be providing primary health care to those Americans who now will have health insurance.

Let me just rattle off some statistics that, I think, should be of concern to the Congress and, in fact, to all Americans.

Not widely known, but maybe Dr. Wilper will talk about this when he testifies, approximately 45,000 people every single year die in the United States of America because they do not have health insurance and they do not get to a doctor on time; 45,000 Americans.

According to the Health Resources and Service Administration, we need 16,000 primary care practitioners to meet the need that exists today with the ratio of 1 provider to 2,000 patients. Over 52,000 primary care physicians will be needed by 2025.

In 2011, about 17,000 doctors graduated from American medical schools despite the fact that over half of patient visits are for primary care, only 7 percent of the Nation's medical school graduates now choose a primary care career; 7 percent. Nearly all of the growth in the number of doctors per capita over the last several decades has been due to a rise in the number of specialists. Between 1965 and 1992, the primary care physician to population ratio grew by only 14 percent, while the specialists to population ratio exploded by 120 percent.

The average primary care physician in the United States is 47 years of age, and one-quarter are near retirement.

In 2012, it took about 45 days for new patients to see a family doctor, up from 29 days in 2010. In other words, even if you can find a provider, it often takes a lot longer than it should to see him or her.

Only 29 percent of U.S. primary care practices provide access to care on evenings, weekends, or holidays as compared to 95 percent of physicians in the United Kingdom. In other words, our culture is, "Don't get sick on Saturday, Sunday, or at night. 9 o'clock to 5 o'clock works pretty good."

Half of emergency room patients would have gone to a primary care provider if they had been able to get an appointment at the time one was needed. In other words, we are wasting billions of dollars because people end up in the emergency room for non-urgent care because they cannot find a primary health care physician.

In my view and, I think, the view of all of the experts who have studied the issue, primary care is intended to be, and should be, the foundation of the U.S. health care system. In 2008, Americans made almost 1 billion office visits to the doctor, 50 percent of those visits were to primary care doctors; half. According to virtually every study done on this issue, access to primary health care results in better health outcomes, reduced health disparities, and lower spending by not only reducing emergency room visits, but when you get people to the doctor when they should, they don't get

sicker than they otherwise would be and end up in the hospital at great cost.

The problem we are discussing is clearly a national problem existing in 50 States in the country, but it is even worse for particular geographic regions. The ratio of primary care doctors in urban areas is 100 per 100,000 people, double the ratio in rural communities where it is 46 per 100,000. So urban communities clearly have problems, rural communities have even greater problems.

Of primary health care professional shortage areas, 65 percent are in rural counties. In my own State, we do much better than the rest of the country in terms of primary health care providers per 100,000. And yet, I can tell you that in the State of Vermont, people often have difficulty getting to the primary care provider they need. Although 20 percent of Americans live in rural areas, only 9 percent of physicians practice there.

One of the significant differences between the U.S. health care system and the health care systems of other highly developed countries—which could significantly explain why we spend so much more than other countries around the world—is the ratio of primary care physicians to specialists. In the United States, roughly speaking, 70 percent of our practitioners are specialists, 30 percent are primary health care providers. Around the rest of the world, that number is exactly the opposite, about 70 percent of their practitioners are primary health care providers, 30 percent are specialists.

What can Congress do to address this very serious issue? Let me just rattle off a few points, and give the microphone over to Senator Enzi.

First and foremost, clearly, we must address the issue of primary care reimbursement rates. Specialists earn as much as $2.8 million more than primary care providers for their lifetime of practice. So if you are going into medicine, if you are a specialist, you can earn throughout your lifetime almost $3 million more than a primary care practitioner. Radiologists and gastroenterologists, for example, have incomes more than twice that of family physicians.

The system for setting physician reimbursement in this country is largely determined by the 31 physicians who sit on the American Medical Association Committee called the Relative Value Scale Update Committee, generally called the RUC. The RUC, whose payment recommendations are accepted by the Centers for Medicare and Medicaid services over 90 percent of the time and are adopted by many private insurers, is dominated by specialists. So specialists sitting on the committee determine reimbursement rates. We have to look at that issue.

Medicare has promoted the growth of residencies in specialty fields rather than primary health care by providing significant sums, $10 billion each year to teaching hospitals, without requiring any emphasis on training primary care doctors; a serious issue.

Third, unlike other nations which provide significant financial support for medical school education we, by and large, do not do this in this country, and the result is the median debt for medical students upon graduation is more than $160,000 and almost one-third of medical school graduates leave school more than $200,000

in debt. Now, if you are leaving school $200,000 in debt, what are you going to do? You are going to try to figure out how I make as much money as possible to deal with that debt, and you are going to gravitate toward those fields which pay you higher incomes.

If we are going to attract young people into primary health care, we must make that profession more financially attractive. In other words, we must address the issue of how reimbursement rates are set for Medicare, which impacts reimbursement rates for all physicians.

In recent years—and I have worked on this issue, other members have worked on this issue—we have greatly expanded community health centers around the country, and community health centers provide very good quality, cost-effective health care. We need to do more than that. We have made progress. We need to make more progress.

In addition, we have significantly increased funding for the National Health Service Corps, which says to somebody that if you are graduating medical school $200,000 in debt, we are going to help you address that debt and help you pay it off if you practice in underserved areas. It is working. It has worked. We have made progress. We need to make more progress in that.

Teaching Health Centers: studies have shown that residents trained at community health centers or rural communities are more likely than those trained in other settings to make a career practicing in underserved or rural areas. The THC program was an important new investment in graduate medical education in the Affordable Care Act, and the 5-year funding was only $230 million. We have got to expand that concept.

We have also got to take a hard look at the role of allied health providers, nurse practitioners, and others. How do we better utilize those people in the provision of health care?

We have a very, very serious problem; the lives of thousands of people depend upon what we do. I am very excited about the wonderful panelists that we have at this hearing.

Now, I would like to hear from Senator Enzi, who has done so much work in this area.

OPENING STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you, Mr. Chairman. Thank you for holding this hearing, and I am glad to be joining you for my first hearing as Ranking Member of this subcommittee, and I look forward to working with you.

I would also like to thank the witnesses for taking time out of their schedules to be with us. I would particularly like to welcome Toni Decklever from Cheyenne. She has worked with me and my staff on health care workforce issues for a number of years, and I appreciate that she made the long trip across the country to be here. It is a pleasure to welcome all the witnesses to our hearing.

The issue of improving access to primary care services, and aligning our health care workforce, is one that is important to all of us, but one that is especially significant given the obstacles that people face in Wyoming.

Nearly the entire State is considered a frontier or rural county. Forty-seven percent of the population lives in a county with fewer

than six residents per square mile. According to the Wyoming Department of Health, approximately 200,000 residents live in health professional shortage areas with inadequate access to primary or dental care.

There are serious access challenges in Wyoming that require creative solutions to resolve. We have one hospital that is served by a physician that, every time we lose that physician, the hospital closes. To that end, the State has developed a number of programs that are tailored to meet the specific needs of a frontier State where distance presents the biggest barrier to accessing a doctor. We say that we have miles and miles of miles and miles, and recruiting health care professionals to live and work there is an ongoing challenge.

The Wyoming Department of Health operates its own Health Professional Loan Repayment Program along with a Physician Recruitment Grant Program. These programs work to reduce the high cost of health professional graduate and training programs, which is often a deterrent to working in primary care or other lower income medical fields. The Wyoming Health Resources Network represents another innovative approach to improving access and reducing primary care workforce shortages.

This collaborative arrangement between the major medical and health professional societies, the University of Wyoming, and other key partners maintains an extensive data base on Wyoming health care facilities and their need for professionals. Sharing information more effectively allows for a better allocation of resources and manpower at a time when the fiscal climate limits our ability to spend money on the problem.

There is more that can be done to better align Federal programs to meet the needs of rural and frontier States. The criteria that determine eligibility for Federal funds to support rural health programs are based on factors that make it difficult to prove the needs of the underserved in rural and frontier areas. For example, one provider for 3,500 people in New York City is entirely different than 3,500 people living in Fremont or Campbell County.

In addition, we need to think more creatively about how to use technology services to improve telemedicine capabilities, so that where a person lives has less impact on the level of care they are able to receive. The advancement of more powerful wireless technology has substantial potential to remotely link individuals across the country to deliver health care in more accessible settings. We have had quite a bit of success with that with some of the veterans outreach clinics, where they use telemedicine extensively with nurse practitioners being in charge of handling the equipment and a doctor on the other end of the telemedicine.

I hope this hearing will make it clear that we need to think more creatively and figure out ways in which all Americans can better access primary care services, and ways to ensure health care professionals are employed where they are most needed.

I look forward to hearing from our witnesses on what needs to be done to solve these problems at the Federal, State, and local level.

Again, I want to thank the witnesses for their participation. I want to thank the Chairman for his great list of suggestions on

things that need to be done. And I am sure that we have the capability to come up with some solutions through this committee.

Senator SANDERS. Senator Enzi, thank you. Thank you very much.

Senators will get 5 minutes. Senator Warren was here first.

Senator Warren.

STATEMENT OF SENATOR WARREN

Senator WARREN. I just want to thank you very much for holding this hearing, Mr. Chairman.

I am very interested in the question about how we equalize access for all of our citizens, and particularly interested in the question about how we make the right investments to lower the overall cost of health care. I think the Chairman said it best when he said,

> "What we are looking for is better outcomes at lower costs, and that that is the peculiar role that the Federal Government can take if it makes the right up front investment."

So I am looking forward to hearing from each of the panelists.

I also want to thank the Ranking Member. I think the comments about access, and the reminder that it is very different in a large city than it is from a very rural area are comments that are well-taken and one for us to remember carefully.

Also, the reminder that that can have very different consequences, even in a State like Massachusetts where, obviously, we have very extensive health care services in some areas, but it still leaves us with parts of the population in Massachusetts, with difficulties in accessing care. Sometimes distance is less the challenge, but costs can remain the challenge and transportation, even within close areas, can be a serious challenge. So I appreciate the reminder of the diversity of issues that we face in making sure that all of our citizens have good access.

Thank you, Mr. Chairman.

Senator SANDERS. Thank you very much, Senator Warren.

Senator Baldwin.

STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman.

I will not use the allotted time in its entirety, and apologize to the panel that I am going to have to sneak out to attend another committee meeting and return, I hope, for the Q and A. But I appreciate, Mr. Chairman, your focus on this broad, but very critical, issue that has so much relevance seeing through the implementation of the Affordable Care Act.

I represent a State that has urban concentrations as well as, perhaps not as large spaces of rural areas as Vermont, but certainly has the array of challenges that are the subject of this hearing, and I appreciate the attention that is going to be focused on it.

One of the things that I hope that we will hear some elaboration on, aside from issues that compensation plays in this, is the question of lifestyle for primary care practitioners; things like the differences between the amount of time that somebody might be on-call as a specialist versus a primary care physician. As we look at larger payment reforms, how the flexibility in their practice of

being able to spend the adequate time with a patient, for example, with multiple chronic conditions that is necessary versus seeing folks in 15-minute increments, et cetera. What impact will those policy changes have on the number of primary care practitioners in this country?

Mr. Chairman, thank you for focusing attention on this issue, and I hope to return to hear more from the witnesses and ask my questions.

Senator SANDERS. Thank you very much.

Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Thank you, Mr. Chairman, for this incredibly important hearing.

We will have 30 million more Americans covered, we hope, if Medicaid expansion is adopted by the States, leaving some people still uninsured. I read the testimonies last night, and it is very clear that when you insure people their health care outcomes are better. It actually costs us money when people aren't insured.

Sometimes you hear, "Well, we have health care in this country. You can just go to the emergency room." Well, that is the most expensive health care and it doesn't mean that you get treated after the emergency room. It doesn't mean that you get what you need to treat a chronic condition. All of your testimonies put the lie to that, and I appreciate that.

In Minnesota, we do health care, relative to the rest of the Nation, extremely well. HHS has rated us No. 1 in high quality health care. And we, like Wisconsin, have kind of a combination of urban centers and not the miles and miles of miles and miles, but we have miles and miles. The Ranking Member, who I would like to welcome to this subcommittee and I am looking forward to his partnering on this. I admire his work on rural health, which is so important in my State because there are people that are underserved.

One of the things that the Chairman talked about was the student loans and graduating from medical school with a typical loan debt of $160,000 sometimes more. And then talking about the tendency for doctors who have just graduated to say, "How am I going to make this money?"

And we have MedPAC, and this is an issue that you talk about in your testimony. In our country, we pay specialists a ratio more than primary care physicians than they do in other countries that do their health care very successfully, and cheaper, and less expensively than we do.

One of the things about student loans, to me, is that there is nothing good about the high cost of college and of graduate school in my mind, except that the only probably good thing is that it creates some tool for us to motivate people to go into the things that we need. One question that I would like the panel to think about is—I know you are going to give your testimony, and we are going to do the questions—what is the return on investment?

If we say to doctors graduating medical school, we are offering some loan forgiveness. We are especially offering loan forgiveness for primary care physicians in a rural area or an underserved

urban area. But what would be the return on investment if we really, really encouraged—by loan forgiveness—doctors to go into primary care? In other words, what is the calculus there? What is the equation? If we say, "My goodness, it is such a benefit to society and such a cost benefit to have a higher ratio of primary care physicians," that if we said, "For anybody who goes into primary care medicine we will, it's $100,000 right there." Boom. What is the cost benefit there?

It is good to see you, Dr. Reinhardt. Dr. Reinhardt and I have talked a number of times. He is a health care economist, so maybe that is something you can mull over.

Thank you, Mr. Chairman, for this unbelievably important hearing. Thank you.

Senator SANDERS. Thank you, Senator Franken.

Senator Murphy.

STATEMENT OF SENATOR MURPHY

Senator MURPHY. Thank you very much, Mr. Chairman.

I am excited to be a member of this committee and excited to be here with a fantastic panel. I will get out of the way, so that you can provide us with your testimony.

Let me just say this. Having chaired the health committee in the State legislature in Connecticut for years, we grappled with this problem year after year. I remember specifically one meeting that I had with about maybe 15 or 20 medical students at the University of Connecticut. At some point in the meeting we were, I think, talking about the Affordable Care Act and how it could help medical students. We were talking a lot about this issue of the high level of indebtedness.

I asked them, "How many of you are considering, not committed to, but considering going into primary care?" And of the 15 students around the table, one of them raised their hand. Only one was even considering it.

Then we started to examine this question as to why they didn't even have it on their mind, and certainly the dollars were the first thing that they mentioned. All of them are going to have extreme levels of indebtedness, even coming out of a State university. They just really could not figure out how they were going to make that work with the salary that they were going to make as a primary care physician.

But as you started to tease a deeper answer out from each one of them, the second thing that came up was prestige. That they didn't feel that there was real prestige any longer in being a primary care physician. That if you really wanted to practice cutting edge medicine that you had to go into the specialties, and they all had an ego to them that wanted to put them on the frontlines of new medicine.

I hope that that's part of our hearing as well today, how do we put the practice of medicine back into primary care? How do we allow them to be more than just gatekeepers? I think that there is a perfect opportunity as we start to rollout these new delivery system models, as we envision a world where accountable care organizations and interconnected multispecialty practices are the rule rather than the exception while we invest in things like medical

home models. You allow for primary care physicians to, once again, control a lot more medicine than they used to control. The prestige comes back, maybe not so much in the medicine that they are practicing, but in the control they have over the health care system writ large.

So I think that as we build a new delivery system it is an opportunity not just to address what I think is still the most critical question which is, how do they just make their family's budget work, if they decide to go into primary care, but how do they get to feel really good about the medicine that they are practicing, and the value that they are adding to their profession? Because that has been lost as well over the years, as the prestige has moved to the specialists rather than the primary care doctors, and I imagine we will examine that topic today as well.

Thank you very much, Mr. Chairman.

Senator SANDERS. Thank you, Senator Murphy.

Senator Casey.

STATEMENT OF SENATOR CASEY

Senator CASEY. Mr. Chairman, I will submit a statement for the record.

I just want to thank you for calling this hearing. It is a critically important issue, and we are grateful that you did the work.

I guess the one quick comment I would make is when we go to the Attending Physician as Members of Congress, we have a doctor available to us here in the Capitol, and that doctor, in a sense, is our quarterback who can make determinations about our health and can refer us to all kinds of specialists and others that help us.

And we hope that one of the conclusions that results, or one of the goals here I guess is a better way to say it of all this work in this hearing and otherwise, is that everyone has that primary care doctor, that quarterback in their life who can treat them, but also get them access to specialists and the best care.

Thanks.

[The prepared statement of Senator Casey follows:]

PREPARED STATEMENT OF SENATOR CASEY

I want to thank Chairman Sanders for scheduling this important hearing today and for his work in this area, especially around Community Health Centers. His commitment to guarantee that health care is available for everyone is a model for all of us. I would also like to welcome our new Ranking Member, Senator Enzi, and I look forward to working with him.

Ensuring an adequate health care workforce is an issue that is important to Pennsylvania and one of the key aspects of this issue is having a strong primary care workforce. The Health Resource Services Administration estimates that 16,000 primary care practitioners are currently needed today in shortage areas around the country and 52,000 additional primary care physicians will be needed by 2025. To meet these needs we must not only protect our current training programs, but also look for new and creative ways to provide primary care training.

In 2011, the baby boom generation started turning 65 and by 2030, all 78 million will have reached that age. Guaranteeing our older citizens have access to primary care is a key part of ensuring we have the workforce to care for an aging America. The Affordable Care Act ensured every Medicare beneficiary could have an annual physical. For our older citizens, having the medical home a primary care provider affords is paramount to staying healthy and active. And this is our responsibility. We must ensure this generation that fought in our wars, worked in our factories, taught our children and who gave us life and love are cared for. This will require an investment in the health care workforce that was begun under health care reform and must continue into the coming decades.

Another area I have spent time working on is the pediatric workforce and the role of freestanding children's hospitals and the Children's Hospital Graduate Medical Education (CHGME) program. Prior to the enactment of CHGME, the number of residents in children's hospitals' residency programs had declined over 13 percent. The enactment of CHGME has enabled children's hospitals to reverse this trend and to increase their training by 35 percent. Pediatricians are the primary care providers for our children who we must nurture and care for as they are our future. Accordingly, we have an obligation to work to ensure this program continues and remains strong.

I look forward to hearing from our witnesses today on where we are and what more we must do to ensure we have the workforce we need and to continuing to work on this important issue.

Senator SANDERS. Thank you very much, Senator Casey.

Senator Hagan.

STATEMENT OF SENATOR HAGAN

Senator HAGAN. Thank you much, Mr. Chairman and Ranking Member Enzi. Thank you for holding this hearing today.

I think this is a critical issue facing our country today. I know that in my State of North Carolina, we have more than a million people who don't have access to primary health care because of a shortage of providers. I know that when patients can see a primary health care doctor, they frequently end up getting care, obviously. But what happens when they don't have that access, they go to the hospital and that is where emergency care and treatment is so expensive, and it is currently helping to drive up the cost of health care. Also, if you have a chronic disease and you can manage that disease, it is much less costly, because otherwise they will develop into acute care episodes.

I know that there are innovations going on in this area, and one of them is in North Carolina: the Blue Ridge Community Health Services, which is a community health center in the western part of our State. It received a grant just this past November under the Teaching Health Center Program. In the Blue Ridge, they have served 20,000 patients last year through 70,000 encounters with two primary care sites, four school-based health centers, and one dental center, and they do outreach at a local domestic violence shelter.

This funding that they were given has allowed them to increase the number of residents at this facility in Hendersonville. I think those new residents are really critical to helping with providing more primary health care physicians. Blue Ridge is one of 34 federally qualified health centers in North Carolina that do provide that high quality, cost-effective care to so many people across our State.

I know that there is another provision that is important, and that is the Rural Physicians Pipeline Act that was included in the Affordable Care Act. It gives the medical schools the resources to recruit students from rural communities. So much of this primary care access is lacking in our rural communities. If we can train physicians from those rural communities, they tend to stay in rural communities, which I think is certainly a highlight of this provision. So programs like that, I think, have a significant role to play in relieving this current primary care shortage.

I am delighted to have this committee hearing. I look forward to hearing the testimony of all of our witnesses today.

Thank you.

Senator SANDERS. Thank you, Senator Hagan.

Senator Whitehouse.

STATEMENT OF SENATOR WHITEHOUSE

Senator WHITEHOUSE. Thanks very much, Senator Sanders, for holding this hearing. You have drawn a big crowd, I think, because it is an important issue.

We are all gearing up here in Washington for "Son of Fiscal Cliff," which is going to be coming in a couple of weeks. With that looming, we are beginning to hear the usual refrain about how important it is to cut Medicare benefits, and to limit access to Medicare for seniors, and that that is the responsible thing to do to save money; which, of course, is a preposterous and ill-informed idea, particularly in the context of a health care system that is 100 times more expensive than it was in 1960.

If you look at the graph, it is an accelerating curve of upward costs. When you look at a $2.7 trillion annual expenditure on health care that is probably 50 percent higher because of the inefficiency of our health care delivery system; there is a 50 percent inefficiency penalty that we pay in the United States compared to all of our industrialized competitors. Our most inefficient industrialized competitor spends 12 percent of its GDP on health care; we spend 18 percent of GDP on health care. It is $800 billion a year spent unnecessarily.

You look at the scope of this, you look at the accelerating, skyrocketing pace of the increase and you think you are going to solve that by cutting Medicare? It is simply not right. As the CEO of Kaiser Permanente, George Halvorson said, "That is an inept way of thinking about health care." He said, "It's not just wrong, it's so wrong, it's almost criminal."

Hearings like this point out that there really is a problem with costs and with the delivery system in the United States, and that we really have to address that problem if we are not going to misdiagnose what we have. Once you have a misdiagnosis, you usually don't get the right cure.

It is really important that we not throw seniors and Medicare under the bus because we have failed to address the real problem in health care, which is wild inefficiencies and skyrocketing costs that aren't just in Medicare. Indeed, Medicare is probably the most efficient deliverer of health care in our health care system.

If we get this right, 40 percent of the savings will come back into the Federal budget, but the rest will go to Kaiser, to Blue Cross, to United, to businesses and families all across the country.

We have a real fight on our hands to try to make sure we steer this in the right direction. And I hope this hearing helps make sure we make the right choice.

Senator SANDERS. Senator Whitehouse, thank you very much.

I want to remind members of the Senate and viewers on C-SPAN that the report that we have done, "Primary Care Access," is available at my Web site *www.Sanders.senate.gov*.

Panelists, you have been extremely patient, but the good news is that what you have seen today is that there is an enormous amount of interest in this issue. We are delighted that you are here and we thank you, again, for the work that you do.

Let's begin with Dr. Fitzhugh Mullan. Dr. Mullan is the Murdoch Head Professor of Medicine and Health Policy at the George Washington University School of Public Health, and professor of pediatrics at the George Washington University School of Medicine.

Dr. Mullan, thanks so much for being with us.

STATEMENT OF FITZHUGH MULLAN, M.D., MURDOCK HEAD PROFESSOR OF MEDICINE AND HEALTH POLICY AT THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF PUBLIC HEALTH AND PROFESSOR OF PEDIATRICS AT THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE, WASHINGTON, DC

Dr. MULLAN. Thank you, Chairman Sanders, Senator Enzi, and colleagues. It is a great privilege to be here.

As a primary care physician and pediatrician who was in the first class of the National Health Service Corps in 1972, subsequently ran the National Health Service Corps, it is not only a privilege but an astounding development in history to hear a committee of the U.S. Senate speak with such clarity about the often orphan issues of primary care and service delivery in poor, rural, and underserved communities. So if I can get over my daze, I will try to be cogent, but thank you so much for convening and for the thought that has gone into this.

I am going to run through. Chairman Sanders, you gave my talk. I was supposed to be the expert. You are clearly the expert, so I will stint on some of the things that I was going to bring up, but try to focus on the issues of education and system-building around primary care.

The demand clearly is in front of us—the aging of the population, the advent of the Affordable Care Act and the terrific entitlement that it provides, but that does present us with a challenge. Just a few demographics.

We have about 280 physicians per 100,000 in the United States, which puts us in the middle, roughly, of the developed world. UK

and Canada have less; Germany and France, for instance, have more. But we are roughly in the middle.

We have about 800,000 physicians, but additionally, we have 190,000 nurse practitioners, physician assistants, and certified nurse midwives. So we have almost a 25 percent add-on of providers that did not exist 30 or 40 years ago. And a point on that, important to remember, when our workforce was lean, I am talking in the 1960s and 1970s, we were very short. And everybody including the U.S. Congress agreed and began a variety of programs that have lived on very powerfully today.

Among those were the development of the nurse practitioner and the physician assistant that did not exist before, and the National Health Service Corps. Lean is not necessarily bad in terms of how we function, if we want a more efficient system. There are systems that are used to the payments that they currently get, and they are not going to change until there is a real sense of need, and we are at that point. While I am not for holding where we are now, I think we need to think about the advantages, perhaps, and the creativity that can come from this period.

In terms of the primary care challenge, I look at it in two ways. One is within the factory, the medical school, the teaching hospital, and the other is in the market. Clearly, we have had eloquent testimony as to the pay parity gap that exists. In simple general terms, a specialist will make twice what a generalist makes, a generalist being a pediatrician, family doctor, general internist, and other disciplines that are generalist in nature and poorly paid. That is a huge problem.

While education and training is very important, what I do believe in, is that you can do the best education and training, and if you put them out in the market with those kind of incentives, you will get what we are getting now. We have got to deal with that.

Speaking on the educational side, the challenges are both at the medical school level and the residency level. As you know, this prolonged adolescence we call residency is very important, and also very influential, in the nature of the type of physician and the location of the physician that comes out of the education pipeline.

There is in medical schools a culture that is heavily, at this point in time, specialty focused; a natural dominance of the more research-oriented and the subspecialty sciences, which are well represented for good reasons, in medical school. But the primary care culture is often put in the back of the bus, and you will not find a primary care physician who hasn't been told at some point in their training career by a professor, "You're too intelligent. You're too smart to go into primary care." That culture is toxic, and it is out there, and we need to worry about it.

The young doctor today is, as suggested, drawn to lifestyle specialties. This is a problem too, with limited hours, clear and rather refined knowledge requirements, and a predictable life. One can understand those draws, but we need to work on that.

Then finally, you have the sense of social purpose and social mission. Our medical schools have been well-treated by the NIH that provides about $17 or $18 billion a year to research in medical schools; by Medicare, which provides $10 billion a year to teaching hospitals for residency programs, $10 billion a year about $100,000

per resident; very, very strong influence with no requirements in terms of workforce product at the other end. And given those two pay streams, we put about $300 million into primary care, family medicine, nurse practitioners, PAs, and about $300 million into the National Health Service Corps.

So you have $27 billion on one side that is generally specialty-oriented and about $600 million that is promoting primary care careers. A huge imbalance, again, not surprising the outcome that results from that.

The teaching health centers, which have been referenced, a very important innovation; it moves the paradigm out of the hospital into the community. And importantly, it needs to guarantee a pay stream. You cannot run a residency without predictability. That is a very, very important outcome and it is something that needs attention.

The nurse practitioner, PA, is a very important asset. As I say, almost 190,000. We need more. They are more nimble. They are more easily trained in larger numbers, and that is a very, very important feature as we look at scaling up quickly our workforce.

Finally, data and planning. We have a National Health Care Workforce Commission finally voted in through the ACA. It has not been funded. It has not met. We need a better brain in our somewhat anencephalic system; our system without a good brain to lead it. That would be very helpful.

In conclusion, we have a moral triumph in the ACA in the entitlements that it brings, but also a technical challenge. In terms of legislative issues, the main permanence of the THCs is important. The full funding and greater funding of the National Health Service Corps will be essential. Bringing the National Health Care Workforce Commission to life is important. And perhaps most important, is Medicare GME, we need to get a handle and use that $10 billion in a more constructive, pro-primary care fashion.

Thank you.

[The prepared statement of Dr. Mullan follows:]

PREPARED STATEMENT OF FITZHUGH MULLAN, M.D.*

My name is Fitzhugh Mullan. I am a professor of Health Policy and a professor of Pediatrics at the George Washington University. The first 23 years of my medical career were spent as a Commissioned Officer in the United States public health service, beginning as a National Health Service Corps physician in a community clinic in northern New Mexico. Subsequently, I served as Director of the National Health Service Corps, Director of the Federal Bureau of Health Professions, and Secretary of Health and Environment for the State of New Mexico. In recent years, I have studied and written about medical education, health professions workforce, and health equity. I am pleased to be here today to talk about the challenges of primary care as set within a changing health care system. I will address health workforce adequacy, the National Health Service Corps, Teaching Health Centers, nurse practitioners, physician assistants, certified nurse midwives, and workforce data and planning.

GETTING IT RIGHT: CHALLENGES TO BUILDING A STRONG HEALTH WORKFORCE

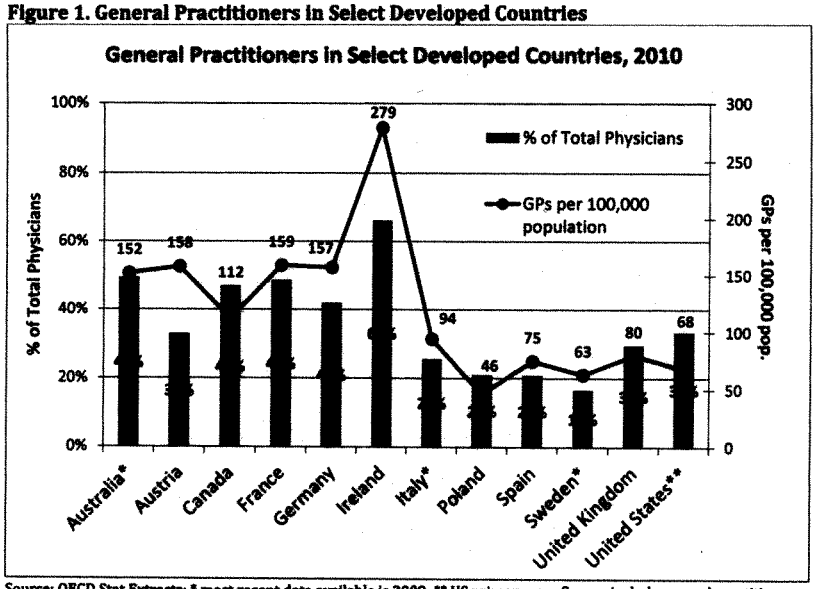
We are facing a period of enormous challenge in building our health care system to improve access and quality while managing costs. All evidence points to the demands on the current system rising appreciably based on the aging of our population and the extension of health insurance to 30,000,000 Americans under the Af-

*The author wants to thank Hannah Wohltjen, MA, for her assistance in the preparation of this testimony.

fordable Care Act. What does this mean for our health care workforce and where do we stand now?

The United States has about 280 physicians/100,000 people, which puts us in the middle ranks of developed nations—somewhat above Canada and the UK and somewhat below Germany and France. Roughly one third of our physicians work in primary care, which makes us disproportionately specialist-heavy as compared to many other developed nations (Figure 1).

Figure 1. General Practitioners in Select Developed Countries



Source: OECD Stat Extracts; * most recent data available is 2009; ** US primary care figures include general practitioners, family physicians, general internists, general pediatricians, and geriatricians (source: AHRQ)

Additionally, and importantly, we have approximately 106,000 nurse practitioners, 70,000 physician assistants, and 13,000 certified nurse midwives providing clinical services side-by-side with 835,000 physicians.[1] [2] [3] This means that for every four physicians we have one non-physician clinician providing services as well—a rich asset that no other nation enjoys. A critically important and much debated question today is whether we have an adequate number of clinicians to meet our national needs. There has been a lot of scholarly debate on this issue. In my judgment, we have a reasonable range of clinical providers (physicians and non-physician clinicians) to address our current needs. These needs will increase slowly as our population grows and ages and there will clearly be an appreciable increase in demand for service in 2014 when the insurance provisos of the ACA kick in. All of these challenges will call on us to be resourceful and strategic in the use of our current resources and will require us to consider new and different strategies to address educational and practice needs to build our future clinician workforce. Toward that challenge, we should plan gradual and thoughtful growth in our physician workforce aiming to increase the number of physicians entering practice in high need specialties.

However, well-established evidence points to the fact that pure increases in physician numbers are associated with higher costs and not associated with better distribution of physicians or improved patient outcomes. In fact, our national experience points to certain benefits of a "leaner" physician workforce. Examples of this include the development of the physician assistant and nurse practitioner professions as well as the legislative birth of the National Health Service Corps during

[1] AHRQ. *Primary Care Workforce Facts and Stats No. 2*. October 2011. Retrieved from *http://www.ahrq.gov/research/pcwork2.htm*.

[2] American Midwifery Certification Board, *http://www.midwife.org/Essential-Facts-about-Midwives*.

[3] Kaiser Family Foundation. *Total professionally active physicians, November 2012*. Retrieved from *http://www.statehealthfacts.org/comparemaptable.jsp?ind=934&cat=8*.

earlier periods of physician shortage. Moreover, the experience of organized health systems, ranging from Kaiser Permanente to the Mayo Clinic that employ significantly fewer physicians per population than the national average, suggest that excellent care can be provided by better practice organization and payment incentives.

THE PRIMARY CARE CHALLENGE—MEDICAL SCHOOL REFORM NECESSARY BUT NOT SUFFICIENT

The education and maintenance of a strong primary care sector is important to all aspects of excellence in health care—access, quality, and affordability. Robust and consistent data from the United States and global studies affirm the association of strong primary care systems with better outcomes, lower costs, and better patient satisfaction.

The United States has traditionally undervalued primary care in both education and practice, which is a core problem that needs resolution as part of overall health care reform. Our current physician reimbursement system is effectively hard-wired to Medicare payment policies—policies that compensate specialists (on average) twice as much as primary care physicians. The culture of medical education is, likewise, tilted toward specialties, both because of Federal funding streams and the predominance of specialists on faculty. Primary care physicians report time after time that, when they were medical students, faculty members told them they were "too smart to go into primary care." Ten of our elite medical schools yet today do not have family practice departments despite the panoply of specialties represented on their campuses.[4]

In addition to the lower pay for primary care work, many medical students and young physicians consider primary care practice hard work and are opting in large numbers for what are euphemistically called "lifestyle specialties." These are medical specialties that have predictable hours, well-bounded knowledge requirements, and good pay.

The challenges that bedevil primary care—pay equity, medical school culture, and "lifestyle" preferences—represent long-term problems that will not be corrected by a single reform or strategic initiative. Rather, there will need to be a variety of approaches undertaken at a governmental level as well as at institutional and individual levels in an effort to rebalance our provider complement and maintain a strong primary care presence. This cannot be done in medical schools alone. Pro-primary care reforms in medical schools will not be sufficient if the "pay equity gap" in practice is not narrowed. In the United Kingdom, for instance, where specialists and general practitioners have similar career earnings, there are no problems filling the ranks of the Nation's general practitioners. The advent of the Affordable Care Act and the aging of the baby boom generation represent a challenge to the Nation—but also an opportunity for medical educators to revisit the mission of their institutions, examining opportunities to promote primary care and the general social mission of medical education. There are a number of established features of medical schools that are associated with recruiting and graduating physicians who are more likely to work in shortage areas, to choose primary care careers, and to address issues of prevention and population health. A commitment by the Nations' medical schools and teaching hospitals to promote the social mission of medical education and practice would launch more graduates into careers dedicated to the oncoming problems of access, quality, and affordability.

TEACHING HEALTH CENTERS—INNOVATION IN GRADUATE MEDICAL EDUCATION

The Teaching Health Center Program (THC), initially enacted in the ACA, is a new residency model that will promote better training of more physicians in community-based primary care settings. The principal funding source for residency programs has been Medicare Graduate Medical Education (GME) payments, which are paid to hospitals based largely on the number of residents that they train. Not surprisingly, hospitals recruit residents who fulfill the needs of the hospitals. This tilts residency heavily toward medical and surgical specialties and subspecialties. The vast majority of trainees spend little or no time outside of the walls of the hospital. Studies have demonstrated that only 1 percent of patients are hospitalized in major teaching hospitals in any 3-month period and yet that is where virtually all teaching and role modeling take place.

THCs are community-based. Residents are recruited to community health centers that, in turn, arrange teaching rotations in regional hospitals. The teaching program

[4] Krupa, C. (2012, December 17). Will physician shortage raise family medicine's profile? *American Medical Association American Medical News.* Retrieved from *http://www.ama-assn.org/amednews/2012/12/17/prl11217.htm.*

itself, the clinical training provided, and values imparted are all community-oriented. THCs are funded through modest, dedicated ACA support for 5 years. To date 22 THC residency programs training 140 residents are up and running. Another 17 health centers have recently received awards and it is anticipated that THCs will soon be graduating almost 200 community-trained primary care physicians annually. However, despite enormous interest and major reform implications, the THC program, as currently legislated, is effectively a demonstration program whose funding ends in 2014. The absence of Medicare or Medicare-like permanent funding jeopardizes this small but enormously important new model of primary care education. This is a critical, near-term legislative challenge.

NATIONAL HEALTH SERVICE CORPS—TRIED, TRUE, AND ESSENTIAL

The National Health Service Corps, enacted in 1970, has proven to be a powerful instrument for primary care career development and a brilliant example of service learning in the national interest. Using scholarships and loan repayments as incentives, the program has been able to match large numbers of primary care clinicians to shortage-area delivery sites, year after year. Thanks to the leadership of Senator Sanders and the ACA, the NHSC has doubled its annual appropriation from $150,000,000 to $300,000,000 (Figure 2) and, as we speak, deploys almost 10,000 physicians, nurse practitioners, physician assistants, social workers, mental health workers, and others in thousands of sites in every State in the Nation.

Figure 2. National Health Service Corps Funding Levels

Source: Data provided by the Health Resources and Services Administration

In return for educational debt relief, National Health Service Corps health care workers are "doctors" to resource-poor communities all over the country. The 40,000 clinicians who have served in the NHSC over 40 years is a tribute to good legislation and good will.[5] With the advent of the ACA, the program will need to expand its clinical participants and communities served.

NURSE PRACTITIONERS, PHYSICIANS ASSISTANTS, AND CERTIFIED NURSE MIDWIVES

Nurse practitioners (NPs), physicians assistants (PAs), and certified nurse midwives (CNMs) are key providers of health care in general and primary care in particular throughout the country. Currently, as noted above, there are estimated to be 190,000 of them working clinically throughout the country. It is estimated that

[5] National Health Service Corps. Retrieved from *http://nhsc.hrsa.gov/corpsexperience/aboutus/index.html*.

52 percent of NPs and 43 percent of PAs work in primary care.[6] CNMs are important providers of women's health in general. Scope of practice laws and prescriptive authority have expanded over time in most States with the result that NPs and PAs can provide, augment, and supplement services that were previously limited to physicians. This availability, as well as the spectrum of clinical capabilities within these groups of clinicians, makes them extremely important resources in service delivery in all settings. Moreover, the length and expense of their training is less than that of physicians and they are able to choose and modify their career courses in a far more nimble fashion than physicians. Their presence, skills, and numbers are an important contribution to primary care today and the ability to expand their educational programs quickly will make them crucial players over the next decade as the demand for services increases. As documented above, the majority of PAs and a growing number of NPs are working in specialty settings. I believe this to be an important asset for the health system and not, as some believe, an abdication of their "primary care role." If we are to develop a balanced workforce where specialty services are used appropriately, NPs and PAs are positioned to support specialists and perform clinical tasks in a way that attenuates the need to train larger numbers of specialty physicians. This will be an important contribution to recalibrating the specialist/generalist mix of the workforce of the future.

THE WORKFORCE WILL NOT MANAGE ITSELF

Generalist and specialist physicians as well as NPs, PAs, and CNMs require lengthy basic education, including graduate level practice-focused training. Key clinicians such as these cannot be produced quickly, and their education and training require educational "infrastructure" (schools, specialized classrooms and labs, faculty, and clinical training sites) and substantial educational financing (for schools, faculty, and students). Public policies relating to practice are also important and, often, intricate. New practice models (Primary Care Medical Homes and Accountable Care Organizations), reimbursement policies, scope of practice laws, and loan repayment options—to name a few—have an impact on career choices and service patterns of physicians and other clinicians.

While many career decisions will be made by individuals and will call on them to use their own financial resources, public policy at the Federal and State level will contribute greatly to individual choices about where and how to practice. The pressures of the system in the near future will reinforce the importance of the public role in health workforce policy. However, the history of public planning in the area of health workforce is spotty at best. No senior agency of government is charged with policy planning in this area. Data on health professions workforce is limited and dispersed among Federal agencies (HRSA's National Center for Health Workforce Analysis, the Bureau of Labor Statistics, the Veterans' Administration), private associations (AMA, AAMC, AACON), and State boards of nursing and medicine.

As a first step to providing better Federal leadership in health workforce planning, the ACA enacted a National Health Care Workforce Commission charged with the responsibility of drafting and promulgating periodic reports on the workforce as a whole and specific workforce issues in particular. It was to bring focus to the many issues of health workforce analysis and planning. The State of that endeavor is that Commissioners were appointed but no funds have been appropriated to allow the commission to meet or function. The continued absence, then, of any focal effort in workforce planning at the national level will only become more problematic as the challenges of access, quality, and cost continue to increase as the demographics of the country evolve and the programs of the ACA come into play.

CONCLUSION

This is an exciting time. We are at the brink of expanding the benefits of health insurance to most of those currently uninsured in our population. This is a moral triumph but also a technical challenge. Meeting this need will require educational and clinical resourcefulness and both public and private investment. There are a number of areas in which Federal legislative action will be needed including the conversion of the THCs to a permanent program, extending and expanding the NHSC, operationalizing the National Healthcare Workforce Commission, funding HRSA's National Center for Health Workforce Analysis so that it becomes the robust center that is required for incisive public policymaking. A serious examination

[6] AHRQ. *Primary Care Workforce Facts and Stats No. 2.* October 2011. Retrieved from *http://www.ahrq.gov/research/pcwork2.htm*.

of Medicare GME is overdue in regard to what can be done to make the program more accountable and responsive to national physician workforce needs.

I hope that these remarks have helped to point out the opportunities and challenges that face us. I very much appreciate the chance to testify today, and would be happy to be of assistance to you and the committee in any way I can in the future.

Thank you.

[Note: The author wants to thank Hannah Wohltjen, MA, for her assistance in the preparation of this testimony.]

Senator SANDERS. Thank you very much, Dr. Mullan.

In order for us to have a good, vigorous question and answer period, if people could keep their remarks to 5 or 6 minutes, that would be appreciated.

The next witness is Tess Kuenning. She is the executive director of Bi-State Primary Care Association, whose members include the Federally Qualified Health Centers in Vermont and New Hampshire.

Ms. Kuenning, thanks very much for being with us.

STATEMENT OF TESS STACK KUENNING, CNS, MS, RN, EXECUTIVE DIRECTOR, BI-STATE PRIMARY CARE ASSOCIATION, MONTPELIER, VT

Ms. KUENNING. Chairman Sanders, Ranking Member Enzi, and distinguished members of the subcommittee.

My name is Tess Kuenning, and I am the executive director of Bi-State Primary Care Association located in Montpelier, VT and Concord, NH. On behalf of the entire health center community, including more than 22 million patients nationwide, and the National Association of Community Health Centers, I want to thank you for the opportunity to testify on the role of community health centers in addressing our Nation's pressing primary care access needs.

As the committee is aware, two important events have significantly altered the health care financing and delivery systems of our Nation, the Patient Protection and Affordable Care Act, and the Supreme Court's decision about the same.

As a result of these events, it is estimated that as many as 30 million Americans will gain coverage through Medicaid and/or the health insurance exchange. Yet another 30 million will still remain uninsured.

We strongly support these coverage expansions, which open the door to a broader health care system for many of our patients. However, we know well that coverage alone does not equate to access. It is access to regular care that makes coverage meaningful.

We also believe to achieve a truly reformed health system, our Nation needs sustainable solutions to increase our primary care capacity, lower and manage our health care costs, and assure quality outcomes. It is for this reason, in my view, that any efforts to increase access to insurance must grow and expand our primary care infrastructure.

Community health centers offer a unique and proven solution to these challenges. By statute and mission, community health centers are located in medically underserved areas, and serve medically underserved populations and care for everyone regardless of your ability to pay. Community health centers also are directed by

patient majority boards insuring care is locally controlled and responsive to each individual community's needs.

It might surprise you to learn that the Community Health Center of Burlington in Burlington, VT provides translation for patients from the Sudan, Bosnia, Somalia, Burundi, Tibet and Nepal, Bhutan and Burma, to name only a few. The ability to receive care in one's native language removes a major access barrier and improves the health of these families and our communities.

From my years of clinical practice as a nurse in Nepal, I am able to speak Nepali with our increasing immigrant and refugee population from Nepal and Bhutan, and I see firsthand the benefits of this type of enhanced provider-patient relationship can yield.

Without access to primary care many people, including these families, might delay seeking treatment until they are seriously ill and require hospitalization or care in the emergency room at a much higher cost to themselves and to the health care system.

The literature backs up these real world experiences. For example, "The Journal of Rural Health" article found that counties with a community health center had 25 percent fewer emergency room visits. Other data demonstrates that the community health centers save the entire health system, including government and taxpayers, approximately $24 billion annually by keeping patients out of these costlier health care settings.

Fortunately Congress, with the leadership of this subcommittee's Chair, had the foresight to include mandatory funding to expand the reach of the Nation's community health centers in the Affordable Care Act to ensure that the promise of coverage was met with the reality of care. We believe that seeing this plan through is essential. Unfortunately, the community health center expansion is not currently on-track.

A recent HRSA solicitation for New Access Point grants anticipates spending only $20 million of the $300 million in new fiscal year funding for fiscal year 2013. The administration has instead proposed spreading out the community health center growth over a much longer period of time, and we urge that the full Affordable Care Act provided increase for fiscal year 2013 be immediately extended to care for 2½ million new patients as Congress intended.

The demand for community health centers continues to outpace the growth, and more than 60 million Americans still lack access to primary care. In Vermont and New Hampshire in the near term, all of our 19 health centers have identified needs in their areas.

I would be remiss if I failed to cite another vital program that supports the goal of creating medical homes for underserved Americans and that is the National Health Service Corps. The Corps places trained health professionals in health shortage areas and remains a key partner in ensuring that community health centers can meet the demand for primary care that is looming just around the corner with the ACA implementation.

Community health centers around the country are ready, they're willing, they're able to be leaders in reforming our health system community by community from the ground up.

We appreciate your leadership and look forward to your, and the committee's, continued support as we work to provide meaningful health care access to all.

Thank you, Mr. Chairman.
[The prepared statement of Ms. Kuenning follows:]

PREPARED STATEMENT OF TESS STACK KUENNING, CNS, MS, RN

INTRODUCTION

Chairman Sanders, Ranking Member Enzi, and distinguished members of the subcommittee, my name is Tess Kuenning, and I am the executive director of Bi-State Primary Care Association located in Montpelier, VT, and Concord, NH. On behalf of the entire health center community, including more than 22 million patients served by Community Health Centers, as well as the National Association of Community Health Centers, I want to say thank you for the opportunity to testify today before the committee on the efforts of Community Health Centers to provide and expand access to primary care services in medically underserved communities.

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

Two important events have radically altered the health care financing and health care delivery systems of our Nation: The Patient Protection and Affordable Care Act (ACA) which was signed into law on March 23, 2010; and the Supreme Court's June 28, 2012, landmark decision about same. It is estimated that 30 million people will gain public coverage through Medicaid and/or the Health Insurance Exchanges. There will be increased coverage through a number of mechanisms, but another 30 million will remain uninsured.

In my view, any efforts to increase access to insurance must also include investments to grow and expand the primary care safety net infrastructure. Primary and preventive care must be central to any efforts to achieve its goals of increasing access, managing total patient costs and producing quality patient outcomes.

As this committee is aware, the ACA created significant Federal investments in expanding public coverage and private insurance reforms. However, coverage does not equate to access. It is access that makes coverage real. We need sustainable solutions to increase our primary care capacity, lower and mange our health care costs and assure quality outcomes, patient satisfaction and patient accountability.

Community Health Centers are the Nation's primary and preventive health care safety net. Community Health Centers hold the promise to fulfill access to care for our Nation's communities. Community Health Centers historically have, and will continue to care for all patients in their community, but will extend their expertise in caring for our most vulnerable; the uninsured and the Medicaid population.

HEALTH CENTERS—GENERAL BACKGROUND

Community Health Centers are community-owned non-profit entities providing primary medical, dental and behavioral health care. In addition, many Community Health Centers also provide pharmacy and a variety of enabling and support services. To date, there are over 1,200 Community Health Centers located at more than 9,000 urban and rural locations nationwide serving as patient-centered medical homes for more than 22 million patients. For over 45 years, the Nation's Community Health Center infrastructure has grown.

In 2000, Vermont had only 2 Community Health Centers with 7 sites serving just over 18,000 patients. Currently, Vermont has 8 Community Health Centers with 43 clinical sites in 12 counties caring for the whole family from prenatal care to pediatrics, to adult and elder health care, providing a medical home over the past 3 years to more than 158,000 Vermonters. Vermont Community Health Centers have a significant market share serving one in four Medicaid, one in four uninsured, one in five Medicare enrollees and one in eight commercially insured Vermonters. Over the past 10 years in New Hampshire, Community Health Centers have grown to 12 organizations across the State serving approximately 76,000 patients in underserved areas.

By statute and mission, Community Health Centers are located in medically underserved areas or serve a medically underserved population. Community Health Centers see patients regardless of their ability to pay or insurance status and offer services based on a sliding fee discount; thereby, easing one of the greatest barriers to care, the financial burden.

Community Health Centers are also directed by patient-majority boards. This unique model ensures care is locally controlled, responsive to each individual community's needs and, at the same time, reducing barriers to accessing health care through various services. In some communities, Community Health Centers provide or arrange for transportation to ease the geographic barriers. In other communities,

Community Health Centers provide care targeted to reduce various cultural barriers by providing culturally competent care including translation services.

At the Community Health Centers of Burlington in Burlington, VT, they provide translation for patients from the Sudan, Bosnia, Somalia, Burundi, Tibet, Nepal, Bhutan and Burma to name a few. At the Manchester Community Health Center in Manchester, NH, of their 8,000 patients, only 51 percent speak English. There are 62 languages spoken and 49 require interpretation. My training as a nurse and my various roles in clinical practice has allowed me a greater appreciation to understand a successful patient/clinician relationship. From my years of clinical practice in Nepal, I am able to speak Nepali with our increasing immigrant and refugee population from Nepal and Bhutan. I have found myself in Community Health Center waiting rooms speaking Nepali to children, teens, parents and grandparents. They greet this with wonderment and genuine gratitude that someone knows their language. All care at Community Health Centers is tailored to assure patients are welcome and treated with respect.

Community Health Centers are more than a safety net, they have a demonstrated track record of improving the health and well-being of their patients using a locally tailored health care home model designed to coordinate care and manage chronic disease. This distinctive model of care has enabled us to save the entire health system, including the government and taxpayers, approximately $24 billion annually by keeping patients out of costlier health care settings, such as emergency departments.[1] As a result of their timely and appropriate care, Community Health Centers save $1,263 per person per year, lowering costs across the delivery system—from ambulatory care settings to the emergency department to hospital stays.[2] Nationally, approximately 39 percent of Community Health Center patients are covered by Medicaid and another 36 percent are uninsured.[3] In return, Community Health Centers bring significant value to the Medicaid program, serving 14 percent of Medicaid patients for only 1 percent of Medicaid spending.[4]

In addition to reducing health care costs, Community Health Centers can also serve as small businesses and economic drivers in their communities. In 2012, Community Health Centers employed 153,000 individuals[5] and in 2009 generated $20 billion in total economic benefits in poor urban and rural communities.[6] Vermont Community Health Centers employed 753 individuals and generated nearly $108 million in total economic benefits; while New Hampshire Community Health Centers employed 537 individuals and generated over $77 million in total economic benefits in their communities.

COMMUNITY HEALTH CENTERS CAN IMPROVE HEALTH CARE OUTCOMES AND REDUCE HEALTH CARE COSTS

Numerous published studies over many decades have demonstrated that Community Health Centers are a proven cost saver. Studies have also proven that Community Health Centers improve the health status in communities, reduce emergency room use and eliminate barriers to health care.

A recent Journal of Rural Health article entitled: *Presence of Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties*, written by Dr. George Rust, et al., found that counties with a Community Health Center site had 25 percent fewer uninsured emergency department visits.[7] Without access to primary care, many people delay seeking health care until they are seriously ill and require inpatient hospitalization or care at an emergency room at a much higher cost. Community Health Centers can help reduce those unnecessary costs by serving as health care homes for the underserved.

Barriers to care make it difficult for individuals to access primary care and the demand for primary care far exceeds the supply across the Nation, but Community Health Centers can play a role in solving this crisis. The National Association of Community Health Centers (NACHC) recently released a report entitled: *Health Wanted, the State of Unmet Need for Primary Health Care in America ("Health Wanted")*,[8] which states that barriers to accessible care include affordability, accessibility and availability can diminish access to primary care. *Health Wanted* shows when Community Health Centers are located in these medically underserved areas, communities are able to overcome these barriers to care and are able to improve health care outcomes, as well as reduce health care costs. However, the demand for Community Health Centers continues to outpace growth. *Health Wanted* also highlights the fact that at least 25 percent of U.S. counties in greatest need do not have a Community Health Center.

Underserved communities all across the country are seeking competitive Federal grant support to build or expand their primary care infrastructure. In Vermont, there are three communities that are fully poised to apply for competitive Federal

funding to bring medical, dental and behavioral health services to communities in need. As well, of the eight current Vermont Community Health Centers, seven of them have plans to further expand their medical, dental and behavioral health services to either their existing sites or to new towns if only there were sufficient Federal funding. This scenario plays out the same in New Hampshire, in that each of the 12 Community Health Centers could expand their primary and preventive services to thousands more patients if resources were available.

GROWTH OF THE COMMUNITY HEALTH CENTER PROGRAM

Community Health Center expansion, championed by Members of Congress and Presidents of both parties, has improved access to primary care in rural and urban medically underserved communities in every State and territory and brought enormous economic value and improved health to the entire system. Since 2002, Community Health Centers have expanded care from 11 million patients to 22 million patients through the efforts of both Republicans and Democrats. Despite the growth of the Community Health Center program over the years, more than 60 million Americans still lack access to a primary care provider.[9]

Our most recent expansion under the Affordable Care Act (ACA) was championed by the distinguished Chairman of this subcommittee, Senator Sanders. The Health Center Trust Fund provides $9.5 billion in funding to support the expansion of Community Health Centers across the country to reach and serve an additional 40 million people.[10] The expansion of the Community Health Center program to new sites and for expansion of services at existing locations will continue until 2015. The goal of the Trust Fund is to ensure that existing Community Health Centers are thriving and new Community Health Centers are ready to provide primary care access to the newly insured in 2014.

We believe the continued expansion of Community Health Centers is essential to ensuring access to primary care in medically underserved communities. Unfortunately, efforts to continue that expansion have faltered recently. The President's proposed fiscal year 2013 Health Resources and Services Administration (HRSA) budget provides $1.58 billion in discretionary funding for the Community Health Centers program. Together with the $1.5 billion in fiscal year 2013 mandatory ACA funding available, Community Health Centers could receive a net increase of $300 million in total programmatic funding for fiscal year 2013 equaling total funding of $3.1 billion.

We strongly support the President's proposed funding level of $3.1 billion for Community Health Centers, but we are concerned about the Administration's proposal to hold back $280 million of the total proposed increase of $300 million and instead spread out health center growth over a longer period of time.

HRSA's January 16, 2012 solicitation for New Access Point grants will only expend $20 million of the $300 million in available funding under the ACA to establish 25 new Community Health Centers and only expand care to 60,000 new patients. Instead of holding back funding, we propose that the entire increase be used immediately to provide for the expansion of care to 2.5 million new patients. This planned minor expansion will fall far short of addressing the pressing need for primary care services that has clearly been demonstrated in communities nationally and will not provide the access to primary care that was promised in the ACA. Next year, when several critical provisions of the ACA begin, we should do all we can to assure we have a strong, stable and growing primary care infrastructure with additional sites for patients to access care.

I would be remiss if I failed to cite another vital program that supports the goal of creating medical homes for underserved Americans, the National Health Service Corps (NHSC). The NHSC, which places trained health professionals in Community Health Centers and other settings located in shortage areas, continues to serve as a vital partner to the Community Health Center program. Half of the approximately 10,000 health professionals placed by the NHSC are at Community Health Centers. That program, too, was expanded in the ACA thanks to your leadership, Mr. Chairman, with $1.5 billion provided to it over 5 years, enough to train and place some 17,000 health professionals by 2015. And even though it also suffered a reduction in funding last year, the NHSC has been, and remains, a key partner in the expansion of care in preparation for the coming coverage expansions under the ACA.

CONCLUSION

Without their local Community Health Center, many communities and patients would often be without any access to primary care. Community Health Centers have proven time and time again that access to a health center translated to improved

health outcomes for our most vulnerable Americans and reduced health care expenditures for this Nation. Continued expansion of our program will result in the ability for Community Health Centers to reach a sizable portion of the medically underserved individuals who would otherwise be forced to seek care in emergency departments, or delay care until hospitalization is the only option.

Mr. Chairman, we stand ready to meet the demand among those in need of primary care. However, Community Health Centers can only meet these primary care demands if we can provide access to care. This means leveraging the funds available under the ACA to expand the number of Community Health Centers throughout the country to ensure we are able to address the Nation's primary care shortage.

We look forward to working with you and the other members of this subcommittee to accomplish our shared goal of improving access to primary care while reducing overall health care costs across the country.

Thank you, Mr. Chairman.

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Senator SANDERS. Thank you, Ms. Kuenning.

Senator Enzi is going to introduce our third witness.

Senator ENZI. Thank you, Mr. Chairman.

It is my pleasure to introduce Miss Toni Decklever. She is a resident of Cheyenne, which is our biggest city. It is 66,000 people. We have 259 towns, but we only have 14 towns where the population exceeds the elevation.

[Laughter.]

She is familiar with all of those, and she currently wears several different professional hats. She is the Government Affairs Liaison for the Wyoming Nurse's Association, and has visited Washington, DC previously to advocate for her fellow nurses.

Ms. Decklever is the State director for SkillsUSA, helping improve the country's workforce by recruiting and preparing individuals for careers in trade, technical, and skilled service occupations including health occupations.

Finally, she is an independent consultant who helps train individuals in CPR, first aid, medication administration, and how to become first responders.

She has a Bachelor of Science degree in Nursing from the University of Northern Colorado in Greeley, and is a certified EMT. She has received a number of awards for outstanding service on behalf of Wyoming's nurses and workforce development groups, and we are pleased to have her here today. And I know from my weekly trips to Wyoming, that it took 13 hours in airplanes and airports for you to be able to get here.

Senator SANDERS. Ms. Decklever, thanks very much for being with us.

STATEMENT OF TONI DECKLEVER, MA, RN, GOVERNMENT AFFAIRS, WYOMING NURSES ASSOCIATION, CHEYENNE, WY

Ms. DECKLEVER. Good morning, Chairman Sanders and Ranking Member Enzi, members of the committee. Thank you for the opportunity to testify today.

As Senator Enzi stated, I do represent the Wyoming Nurses Association. I have been a registered nurse for almost 30 years, and I have worked in acute care, long-term care, education, and administration.

Wyoming is the ninth largest State in the United States with almost 100,000 square miles of land, but population is the smallest in the Nation with just a little over half a million people. Wyoming's frontier and rural environment impacts our health care system. Wyoming has 25 hospitals with 16 designated as critical access hospitals, 25 beds or less. There are also two veteran's hospitals, and 16 rural health clinics. Wyoming has eight community health centers, three are special population health centers, and three are satellites of larger health care centers.

When dealing with the expanded number of patients and the barriers to care for these patients, several components need to be considered. One is the ability for providers to be able to practice to the full scope of their education and licensure. Another is addressing the shortage of providers due to retirement, and a shortage of qualified faculty to educate new providers. Others include the perception of quality of care and support funding for rural areas.

With Baby Boomers turning 65 at the rate of 10,000 a day, there will be an increase in the demand for health care in traditional acute care settings along with expansion of nonhospital settings, such as home health care and long-term care.

Wyoming's Nurse's Practice Act allows Advanced Practice Nurse Practitioners to practice independently in our State. This ability helps nurses provide patients in rural areas access to primary care. Unfortunately, some Federal laws and regulations limit the nurse's ability to practice at their full scope.

A quirk in Medicare law has kept APRN's from signing home health plans of care and from certifying Medicare patients for a home health benefit. In areas where access to physicians is limited, this prohibition has led to delays in home health services. Moreover, the delays in care inconvenience patients and their families, and can lead to increased costs to the Medicare system. This occurs when patients are unnecessarily left in institutional settings or readmitted after discharge because they did not receive proper home care.

A sufficient supply of nurses is critical in providing our Nation's population with quality health now and into the future. Registered nurses and Advanced Practice Nurses are the backbone of hospitals, community health clinics, school health programs, home health, and long-term care programs, and serve patients in many roles and settings.

According to the 2008 National Sample of Surveyed Registered Nurses, over 1 million of our Nation's 3.1 million nurses are over the age of 50 with one-quarter of these nurses over the age of 60. Much like world populations and that of Wyoming, the provider population is aging and near retirement age. This runs counter to the increasing need of growing older population and a regional or sporadic growth of younger populations. Studies have identified the retirement of providers as one of the obstacles to providing comprehensive care.

Wyoming responded to the increasing need for nurses by creating a funding stream that would assist nurses to continue their education and work as faculty at the community colleges and university. This allowed the nursing programs to increase their enrollment numbers and thus educate more registered nurses. RN's are encouraged to continue their education into the Advanced Practice Nursing level.

Wyoming has a small amount of State incentives and loan repayment money for students, but the dollar amounts do not meet the demand through each biennium. To fill this void in funding, some students are able to receive funds from title VIII and title VII.

The perception that health care also is delivered in bigger health centers equals quality is not easily overcome. Many residents are using health services in surrounding States who could have been served in Wyoming. To address this issue, one report suggested ways to re-characterize the system by:

(1) having a stable supply of primary care providers,

(2) have appropriately located tertiary centers,

(3) integrate services at the point of care—medical home concept—collaborative planning and policy implementation,

(4) effective use of pooled financial services or resources,

(5) shared reasonability for achieving goals for individual health, and

(6) organized leadership that keeps the State responsive to changing needs.

Federal designations provide eligibility for Federal programs like HRSA 330 funding and enhanced reimbursements to rural health clinics. Health provider shortage areas, medically underserved areas, and medically underserved populations are based on factors that make it difficult to prove the needs of the underserved in rural and frontier areas. As noted by Senator Enzi, one provider per 3,500 people in an urban setting is entirely different than 3,500 people living in a county that is almost 10,500 miles of land mass.

Wyoming's economy is based primarily on energy production, coal, natural gas, oil, uranium, and even wind making it a boom and bust economy. Many people working in the energy industry make a sufficient salary when they work, but in some cases, these salaries are significant enough that it can skew the average income for families based on statewide data. Though some families do very

well financially, there is still a number of people struggling to make ends meet. This income disparity can be another challenge to meeting designation guidelines.

Committee members, thank you for your time and attention to this very, very important matter, and I look forward to any questions you may have.

[The prepared statement of Ms. Decklever follows:]

PREPARED STATEMENT OF TONI DECKLEVER, MA, RN

It is well known that Wyoming is the eighth largest State in the United States with almost 100,000 square miles of land, but has the Nation's smallest population of a little over half a million people. Wyoming's frontier and rural environment impacts our health care systems. The State is a patchwork of rural health clinics, county-owned critical access hospitals, for-profit hospital networks, and a handful of community health centers. Wyoming does not have a medical college at the University, but through partnerships with other State education programs, medical students can receive their education. In terms of other healthcare educational opportunities, Associate, Bachelor and Advance Practice nursing programs are offered through the Wyoming Community College network and the State's only university.

Wyoming has 25 hospitals, with 16 designated as critical access hospitals. There are also 2 veteran's hospitals and 16 rural health clinics—half of which are associated with hospitals in their communities. Wyoming has eight community health centers, three are special population health centers and three are satellites of larger health centers. Even with these safety-net providers, many small towns and huge areas of Wyoming are without access to primary care.

Distance to medical care is one of the biggest barriers of access to care for many people in the State. This also includes the considerations of terrain and weather. For instance, Sweetwater County is the largest county, having 10,490 square miles within the county lines. This is approximately the same size as the entire State of Massachusetts. There are two major towns of over 10,000 people, and more than 10 "tiny towns" (population under 200) in this county. These residents have to travel, over some 120 miles to reach healthcare services from a town closest to the eastern border of the county.

Many of Wyoming's residents who live in these small towns have the same issues of needing to travel to care. A small town near the Colorado border had a rural health clinic with an automated pharmacy that provided medications for the common problems like providing antibiotics for ear infections. The residents of this community were used to traveling to a larger Colorado town for care beyond the basics. Last summer the road washed out, resulting in longer travel to other Wyoming towns to access care. The road was under repair for many months.

Wyoming's health care system is fragile. **Outmigration of medical care** to larger regional medical centers within Wyoming and to neighboring States is a common occurrence. A report done for the Wyoming Health Care Commission in 2007 by the Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis stated:

> "One of Wyoming's advantages in health care delivery is an adequate array of facilities offering inpatient services, hospitals and skilled nursing facilities (nursing homes). Despite the availability of these institutional services and the presence of qualified clinical personnel, our analysis shows that many Wyoming residents are using health services in [surrounding states] who could have been served in Wyoming. We recommend convening a health care provider group to assess patient migration patterns and implement a plan to achieve optimal use of services in Wyoming (including across locations in the state)."

http://www.wyominghealthcarecommission.com/images/reports/07-24-07RUPRI%20Summary%20Report%20Final%20July%2019,%202007.pdf.

The perception that health care delivered in bigger health centers equals quality is not easily overcome. That should not stop leaders at all levels of government from examining ways to support health care systems internal and external to State borders.

As the only non-legislative coalition to address comprehensive health issues in the State, the Wyoming Health Care Commission was legislatively founded in 2003 and sunsetted in 2009. The Commission compiled volumes of research by national experts and heard hours of discussion and testimony by State leaders and stakeholders on important facets of healthcare including patient safety, provider recruitment and retention, including specific nursing shortages, and expanding health in-

surance coverage in rural health settings. In spite of this work, not one policy recommendation from the Health Care Commission became law.

In spite of many analysts' recommendations that the research and coalition work continue to make Wyoming stronger and more efficient, the Wyoming Legislature has again taken its place as the only organization to tackle health care issues. Wyoming's citizen legislature meets as a body only 60 days in the biennium and has some interim study opportunities. As a result, it should not be surprising that many individual legislators work from a piecemeal understanding of health care. If they do not have the opportunity to serve on a health committee or attend national health-focused conferences like National Council of State Legislatures, they often do not understand the complexity of this system.

In the RUPRI report, the following (in order) was suggested as ways "to re-characterize the State's health care delivery system by 2030:

• A stable supply of health care professionals to support primary and secondary care everywhere in the State (including dental, behavioral, and geriatric health providers).

• Appropriately located tertiary care services in Wyoming that are preferred (as compared to the same services in neighboring States) by residents of the State.

• Integration of services at the point of care; all providers involved in any episode of care are fully informed of the actions of other providers and disparate services are bundled for purposes of patient-centered care and reasonable payment.

• Collaborative planning and policy implementation within regions of the State that include all services affecting health, including but not limited to education, criminal justice, transportation, economic development and land use planning.

• Effective use of pooled financial resources to extend financial access to all citizens.

• Shared responsibility for achieving goals for individual and population health among public and private organizations and with individuals who are responsible for their own health.

• Organized leadership, through a public-private partnership, that keeps the State responsive to changes in national policy, health care practice, and the demographics of the State." *http://www.wyominghealthcarecommission.com/images/reports/07-24-07RUPRI%20Summary%20Report%20Final%20July%2019,%202007.pdf*.

Across the State, there is a **shortage of primary care providers.** Using Sweetwater County as an example, the large majority of people who qualify for Medicaid and/or who have Medicare have no access to providers within the county. Much of the research completed by the Wyoming Health Care Commission is still on the Commission's Web site, but efforts like the statewide Health Professionals Database have not been updated since 2009. The database was one of the first efforts to quantify the availability of providers in each of the 23 counties undertaken by the Commission and is crucial to any ongoing decisions about recruitment and retention of health care providers. Many legislative and ad hoc discussions have centered on what would help small Wyoming communities recruit physicians and mid-level practitioners.

Much like all rural populations and that of Wyoming, the provider population, is aging and nearing retirement age. This runs counter to the increasing needs of a growing older population and a regional or sporadic growth of younger populations. Studies have identified the retirement of providers as one of the obstacles to providing comprehensive care. According to a study by the National Rural Health Association, "nonmetropolitan areas typically can neither afford the duplication necessary to bridge an expected transition in health workforce, such as the retirement of a provider, nor the fluxuation or innovation of new service requirements." *http://www.ruralhealthweb.org/index.cfm?objectid=153C1CCF-3048-651A-FEB03612F7316078*.

Wyoming has a small amount of **State incentive and loan repayment money,** and the dollar amounts do not meet the demand through each biennium. It is less than effective for recruitment when the Web site announcing the grant program becomes inactive in the second year of biennium because the funds have been expended. Federal incentives for recruitment and retention that focuses on rural States could help in this area.

The Health Care Commission studied nursing staffing issues and in a report in 2008 projected nursing demand:

> "Assuming no changes to the current policy scenario, R&P projections show that Wyoming's health care industry will need a total of 3,307 more nurses by 2014 than were employed in 2006 (estimated at 3,145) to fill the projected demand. This represents more than double the number of RNs working in health

> care between 2006 and 2014. Assuming that growth as a result of recent staffing pattern trends can be held constant at current levels through policy changes, Wyoming's health care industry will need only an additional 2,935 nurses by 2014 to fill projected demand. The policy change scenario represents a savings of approximately 400 nurses."

http://www.wyominghealthcarecommission.com/images/reports/nursing__demand__08.pdf.

Wyoming responded to this by creating a funding stream that would assist nurses wanting to continue their education and work as faculty at the community colleges and university. This allowed the nursing programs to increase their enrollment numbers, and thus educate more registered nurses. RN's are encouraged to continue their education into the Advanced Practice Nursing level. The Wyoming Nurse Practice Act does allow Advanced Nurse Practitioners to practice independently in the State, which helps with access to primary care. However, there are still underserved areas and many people that still struggle to find a primary care provider.

Wyoming's **population and demographics do not adequately represent health care barriers** when measured by practices, certifications and Federal designations. For example, in the report on recruitment and retention by the National Rural Health Association, quality measurements and Patient Centered Medical Home certifications are different in rural communities:

> "One component of health quality is dependent upon the entirety of the system and is particularly interwoven in a collaborative nature in rural systems. This may be particularly amplified in rural areas due to the relative lack of duplication of services and the coexisting relationships among the local health care providers themselves. For this reason, providers find natural collaboration within models that may look similar to modern concepts such as the Patient Centered Medical Home while the administration of such models may appear different. Creativity and flexibility have been necessary to develop what works best in individual community circumstances while serving similar purposes."

http://www.ruralhealthweb.org/index.cfm?objectid=153C1CCF-3048-651A-FEB03612F7316078.

The Wyoming Integrated Network (WY–ICN) is one effort to network health care systems and is a hospital and provider driven effort that offers patients in Wyoming information about cost and quality of primary care. This ongoing effort recently received Federal funding through the Health Care Innovation grant to expand efforts across the State by educating communities about the Medical Home model. It is anticipated that initial outcomes will provide useful information to our State and other rural States.

Federal designations that provide eligibility for Federal programs including HRSA 330 funding, enhanced Medicare and Medicaid reimbursement like Health Provider Shortage Areas, Medically Underserved Areas and Medically Underserved Populations are based on factors that make it difficult to prove the needs of the underserved in rural and frontier areas. For example, one provider (physician or mid-level) per 3,500 people in an urban setting is entirely different than 3,500 people living in Sweetwater County, which is over 10,000 square miles of land mass.

Wyoming is also not ethnically diverse as measured by the Federal guidelines. Only one county, which is home to the Wind River Reservation, has a large number of non-white residents. Based on how grants are scored, this would prevent Wyoming from meeting these guidelines.

Wyoming's economy is based primarily on energy production, coal, natural gas, oil, uranium, and even wind, making it a "boom and bust" economy. Many people working in the energy industry make a sufficient salary when they work. In some cases, these salaries are significant enough that it can skew the average income for families based on statewide data. Though some families do very well financially, there are still a number of people struggling to make ends meet. This income disparity can be another challenge to meeting designation guidelines.

Additionally, younger retirees have an impact on the overall income, which is a measure of underserved designations. Working with rural organizations to better define "rural" as it applies to health care and eligibility for Federal designations would be one way to more effectively provide safety-net care.

These are some but not all of the current and past efforts to address access to health care for all Wyoming residents. Considerable time has been put forth to create programs and provide funding in an attempt to meet the needs of the citizens of Wyoming. Progress has been made in some areas and the work continues in many others. The geographical terrain accompanied by the low population is challenging, but not impossible. Wyoming will continue to develop programs and interventions that will provide our citizens with the care they need.

Senator SANDERS. Miss Decklever, thank you so much for being with us, and thanks for your testimony.

Our fourth witness is Dr. Andrew Wilper, he is the acting chief of medicine at the VA Medical Center in Boise, ID. Dr. Wilper is a practicing general internist. He is the associate program director for the Boise Internal Medicine Residency program and the assistant director of the Boise VA Center of Excellence in Primary Care Education.

Dr. Wilper, thanks very much for being with us.

STATEMENT OF ANDREW P. WILPER, M.D., MPH, FACP, ACTING CHIEF OF MEDICINE, VA MEDICAL CENTER, BOISE, ID

Dr. WILPER. Thank you, Chairman Sanders, Ranking Member Enzi, and members of the committee. It is a great honor to be able to testify here today.

I was asked by Senator Sanders about my insight, two insights specifically. One about the lack of health insurance in the United States and its effect on health and health care outcomes, and also to share my thinking on practical solutions to the primary-care physician workforce shortage that we face.

To start off, there is an enormous literature that has accrued over decades demonstrating that a lack of health insurance is associated with decreased access to health care and worse health outcomes.

The Institute of Medicine summarized these findings in a six-volume series earlier this century and the conclusions were quite clear. Subsequent work has built on this evidence, including some of my own that Senator Sanders mentioned in his opening statement, specifically, a paper we published in 2009 in "The American Journal of Public Health," linking lack of insurance to nearly 45,000 deaths among adults in the United States annually. The research is consistent: health insurance leads to significant benefits and is good for your health.

Gaining health insurance does not guarantee access to medical care, which is the second part of my testimony, nor does it control costs. And perhaps the singular intervention that we could make at the national level to reduce costs and improve outcomes in our country with regard to health is to bolster our primary care workforce.

Now, there is an additional massive body of literature supporting the idea that primary care improves all sorts of health outcomes and lower costs. Nevertheless, we have not seen systematic changes to alleviate the shortage of PCP's in the United States in decades.

I will talk a little bit about three policy levers that I see that this committee could consider to increase the number of physicians entering into the primary care workforce, some of which have been referred to by Professor Mullan.

First, at the medical school level, this is the period of time after which people graduate from college and are in their undergraduate medical training. We could introduce additional educational debt reduction, change Federal funding streams to emphasize primary care, and increase funding for the National Health Service Corps. In addition, we could direct support to community health centers

to incentivize third and fourth year medical students to enter into primary care careers.

Second point would be the area of graduate medical education. First, title VII funding as specifically earmarked to go toward primary care programs. These are continuously under threat of congressional cut, and have been cut dramatically in the past 10 years. Reemphasizing that funding would be an important step.

Another piece would be direct payment by Medicare to teaching hospitals to offset the expense of training physicians. As we have heard today, nearly $10 billion is spent by the Federal Government to support these hospitals, but currently we have no planning in place to actually meet the needs of our population in the United States with regard to a physician workforce.

Medicare should direct funding to residency programs for education, instead of directing it through hospitals. Medicare should also require assessments of community and regional physician workforce for hospitals to qualify for this funding.

In its current form, graduate education is run by teaching hospitals to meet their own staffing needs or their historical staffing needs, and graduates select their field of practice based on their personal interests, to emphasize a point that Senator Murphy made moments ago. I have been personally told by a residency director that his concern is the professional desires of his trainees rather than population health needs.

Perhaps the most important policy reform that we could make to reinvigorate primary care would be to address the pay disparity between primary care physicians and specialists. This could be done by raising primary care physicians' pay or by decreasing that of specialists, and I feel that it is really the disparity that is the driving force in this workforce problem that we are facing today. Indeed, the American Association of Medical Colleges has declared that education and training cannot overcome the intense market incentives that influence physician choices.

A focal point for payment reform has been mentioned: a subcommittee of the American Medical Association called the Relative Value Scale Update Committee. This is a secretive group of doctors that wields tremendous influence over Medicare reimbursement rates and CMS adopts nearly all of their recommendations.

At a minimum, the public deserves transparency in decision-making from the RUC. Better yet, we should establish a process for rate-setting that is not encumbered by conflicts of interest and does not favor narrow specialties. A rational observer might conclude that the Federal Government and AMA are colluding to bring an end to the primary-care physician workforce in the United States.

In summary, it is eminently clear that health insurance affords better health outcomes including a decreased risk for death. Despite this, our current reform efforts through the Affordable Care Act will leave 30 million uninsured.

In closing, I have worked for over a decade in medical education as a student, resident, fellow, and now faculty member hospital and residency program leader. And it is my conviction that publicly sponsored training should be planned to meet the health care needs of our population rather than the staffing needs of hospitals or the lifestyle preferences of young doctors.

Thank you.
[The prepared statement of Dr. Wilper follows:]

PREPARED STATEMENT OF ANDREW P. WILPER, M.D., MPH, FACP

My name is Andrew Wilper. I am a practicing primary care physician (PCP) and researcher. In addition, I have substantial experience in medical education and care for the underserved. I am grateful to have been asked by Senator Sanders about my insights into the lack of health insurance in the United States and its effect on access to health care and health outcomes. I have also been asked to share my thinking on practical solutions to the primary medical care workforce shortage. I have divided my testimony into two parts. First, I will address the evidence that lack of health insurance impedes access to health care and degrades health outcomes. Second, I will discuss the primary care physician shortage in the United States and strategies to increase the number of primary care physicians.

I. THE EFFECT OF LACK OF HEALTH INSURANCE ON ACCESS TO CARE AND HEALTH OUTCOMES IN THE UNITED STATES

For decades, researchers have demonstrated the ill effects of the lack of health insurance on access to medical care. This body of literature is enormous, and the signal is clear; lack of insurance is definitively associated with decreased access to medical care and poorer health for those without such access. The Institute of Medicine (IOM) summarized these findings and their implications in a six-volume series in the early part of this century, identifying three mechanisms by which insurance improves health:

1. Getting care when needed.
2. Having a regular source of care.
3. Continuity of coverage.[1 2 3 4 5 6]

Research by myself and others has built on this work. The evidence continues to paint a clear and unambiguous picture. Lack of health insurance is associated with worse health status, decreased likelihood of having a usual source of medical care, and death.[7 8 9 10] In a 2009 article, we updated an older estimate produced by the IOM, linking 44,789 deaths in 2005 with lack of insurance, more than were estimated to die that year as a result of renal failure. Contrary to the popular notion that most uninsured are young and healthy, we found that roughly one-third of the uninsured had a chronic medical condition that would require medical care, and that the uninsured are more likely to suffer undiagnosed, and therefore untreated, chronic illness.[8 11] The uninsured are more likely to go without needed care than the insured, and to be admitted to the hospital for illness that could be prevented.[12 13] The data also supports the notion that when previously uninsured individuals gain coverage through Medicare, their decline in health reverses.[14 15] The research is consistent: health insurance leads to significant benefits and is good for your health.

These findings are borne out in my clinical practice. I have cared for many patients who delayed care as a result of lack of insurance. Perhaps the most poignant case was Mr. A, who worked as a delivery man. He was also a diabetic. I cared for this gentleman while I was in my residency training in Portland, OR. He was admitted to the hospital for a hypertensive crisis, which is usually the result of longstanding hypertension that has not been adequately treated. His blood pressure was so high that he bled into his eyes. The damage extended to his kidneys. We were able to stabilize and send him home with new medications. It turned out that his employer had dropped his coverage prior to our meeting in the hospital. As a result, he could no longer afford to go to his primary care doctor. He had been ordering his insulin from Canada, which would arrive by mail. He was using this without proper supplies or monitoring, and was without his blood pressure medications. This led to our meeting. Ultimately, his kidney function became so compromised that he needed permanent dialysis. As you know, this is an extremely expensive treatment, costing approximately $80K per year. What I find so shocking about this story, is that as a society we were willing to pay for his dialysis treatments through the Medicare End Stage Renal Disease program, but were not able to treat his chronic conditions that likely would have allowed us to avoid dialysis in the first place. This case drove home the fact that even routine treatments are out of reach for people who are uninsured. Mr. A. was not simply the victim of bad luck, nor was he an outlier. His situation was a result of policies that have left millions of Americans without insurance and access to medical care.

II. PRIMARY CARE IN THE UNITED STATES

Background

Good evidence supports the myriad benefits of a robust primary care workforce. Within the United States, States with larger proportions of specialists actually have lower quality care.[16] Others have demonstrated that increased proportions of PCPs are associated with significant decreases in health care costs.[17] Primary care is also linked to lower all-cause mortality, infant mortality, fewer low-birth weight babies, improved self-reported health, decreased costs, and decreased racial disparities.[18] Studies suggest an association between the availability of primary care and decreased emergency department (ED) use. Many patients using the ED report that they would be willing to use another source of care were one available. Nevertheless, we have not seen systematic changes to alleviate the shortage of PCPs in the United States. This is in spite of widespread calls for reform. Indeed, in 2006 the American College of Physicians predicted that without comprehensive reform by Congress and Centers for Medicare and Medicaid Services (CMS), primary care, the backbone of the U.S. Health care system, may collapse.[19]

The proportion of U.S. physicians practicing in primary care is low compared to other industrialized nations. The Kaiser Family Foundation estimates a total of 834,000 practicing physicians in the United States in 2012.[20] The proportion of physicians practicing in primary care in the United States is approximately 40 percent, with the remaining 60 percent practicing in sub-specialties. This specialist-dominated distribution has been linked to the high costs and poor health outcomes in the United States. This misdistribution occurs in the context of what many describe as a physician shortage. The Association of American Medical Colleges (AAMC), American College of Physicians, and the Council on Graduate Medical Education all estimate current shortages in the tens of thousands, and predict that these will continue to grow.[21] [22] [23]

Medical School

Numerous strategies exist to increase the number of medical students entering primary care. These include educational debt reduction, changes in Federal funding streams to emphasize primary care, and increased funding to the National Health Services Corps. In addition, direct support for Community Health Centers participating in teaching medical students would support our Nation's most vulnerable populations while training future PCPs.

Graduate Medical Education

Graduate medical education (GME) has been the focus of many federally supported programs to increase the primary care workforce. Funding for title VII programs, which support training for PCPs, is continuously threatened by congressional cuts. Only the title VII programs provide money directly to primary care training programs. Remarkably, for every title VII dollar there are about $1,000 Medicare GME dollars, and these Medicare GME dollars push training efforts toward inpatient and subspecialty care. Medicare spending for GME is directed toward hospitals, which is heavily tilted toward hospital-based specialty care.[24] Medicare should direct funding to residency programs for education instead of directing it through hospitals. Medicare should also require assessments of community and regional physician workforce for hospitals to qualify for GME funding. In effect, Medicare should begin requiring accountability in its subsidization of teaching hospitals. Remarkably, the Federal Government spends nearly $10 billion annually to produce a physician workforce without a workforce plan. As part of his testimony before the House Energy and Commerce Subcommittee on Health, Dr. Fitzhugh Mullan called for "requir(ing) teaching hospitals to undertake community or regionally oriented analyses of physician workforce needs and make application for training positions based on a fiduciary responsibility to train a complement of residents that corresponds to agreed upon regional needs."[25] In its current form, GME is run by teaching hospitals to meet their own staffing needs, and graduates select their field of practice based on their personal interests. I have been personally told by a residency program director that his concern is the professional desires of his trainees, rather than population health needs. Given the annual income of certain physician types, Medicare could consider limiting or defunding training programs that do not meet population needs, or that could be reasonably funded via trainee loans given future income expectations.

Practice and Payment Reform

Payment reform is the most critical element of change needed to re-invigorate primary care. Remarkably, it is explicit Federal Government policy to direct oversized payment toward specialists and thereby skew workforce statistics. Efforts to reform

the payment system in an effort to address the maldistribution of physicians by specialty have failed. The resource-based relative values scale has grossly distorted relative physician reimbursement since 1992. Now PCP compensation is 30 percent to 60 percent less than subspecialists.[24] Without payment reform, it is unlikely that efforts targeting medical students and residents will succeed in bolstering the primary care workforce. Indeed, the AAMC has declared that "education and training cannot overcome the intense market incentives that influence physician choices."[25] The income disparity could be addressed by increasing PCP reimbursement or by decreasing that of subspecialists.

A focal point for payment reform is a committee of the American Medical Association called the Relative Value Scale Update Committee, known as the RUC. This group of 31 doctors wields tremendous influence over physician pay in the United States, with CMS following nearly all of its recommendations. One estimate has the RUC directing $54 billion in Federal spending annually. Yet the group has no government oversight. This opaque group benchmarks reimbursement rates for physician services in the United States and does so in a way that favors surgeons and specialists. Only three seats on the committee are designated for primary care specialties.[26] Critics argue that RUC decisions are based on suspect data leading to systematic overstatement of time and work that favors surgery and subspecialty physicians.[27] [28] The playwright George Bernard Shaw commented that "any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting of your leg, is enough to make one despair of political humanity."[29] We have gone a step beyond what Shaw feared by allowing physicians to set their own rates. At a minimum, the public deserves transparency in decisionmaking from the RUC. Better yet, we should establish a process for rate setting that is not encumbered by conflicts of interest and does not favor narrow specialties.

Expanded patient access to PCP services could be achieved through strategies that reform current practice models. Expanded insurance via the Affordable Care Act will stress primary care supply. In the 2 years following health reform in Massachusetts, waits to see PCPs increased by 82 percent.[30] This has been linked to a mismatch between the supply and demand for primary care services. Policy efforts to implement the Patient Centered Medical Home will focus on risk-adjusted capitated payments, non-traditional visits such as telephone and email care, in addition to delegating physician decisionmaking to non-physician team members. This will require changes in our reimbursement system, workforce and the culture of medicine.

In summary, it is eminently clear that health insurance affords better patient outcomes, and that it has been associated with decreased risk of mortality. Despite this, our current reform efforts in the Affordable Care Act will leave as many as 30 million uninsured. The physician pipeline recommendations above have been made for years by health policy and workforce experts. Nonetheless, efforts to increase the number of PCPs have been frustrated by the funding mechanisms for medical education in the United States. This current system of funding is at best inefficient, meeting the needs of a narrow group of teaching hospitals and subspecialists. At its worst, the current GME funding stream acts as a principal driver for a workforce that meets the interests of physicians and hospitals rather than the health needs of the population. In addition, Medicare's grossly unequal fee payments to specialists and PCPs continues to discourage trainees from primary care careers. I have worked for over a decade in medical education as a student, resident, fellow, faculty member and residency program and hospital leader. My conviction is that publically sponsored training should be planned to meet the health care needs of our population rather than the staffing needs of hospitals or the lifestyle preferences of young doctors.

Thank you.

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Senator SANDERS. Thank you very much, Dr. Wilper.

My understanding is that Senator Franken has to leave, and you wanted to ask a brief question of Dr. Wilper, is that correct?

Senator FRANKEN. Thank you, Mr. Chairman. You are talking about compensation. You probably heard my comment earlier about the return on investment in terms of loan forgiveness for primary care physicians. What would that look like? I know we do some loan forgiveness in ACA. We do it for people serving in underserved communities. What would that look like, and how could you compute that in terms of what value you would get back over the course of a physician's career? If you said, "OK. If you're a GP, boom, $100,000 off of your loan." Have studies been done to do that? Has that been looked at?

Dr. WILPER. Senator Franken, thank you for the question.

To my knowledge, there is no systematic review of that specific question. I know in my State of Idaho, which is a neighbor to Wyoming and also exceptionally rural, we do have programs in place to help offset educational debt related to medical education, and those have been somewhat successful.

I would defer to my panelist to my left, Dr. Reinhardt, who may be able to comment on that question.

Senator FRANKEN. Dr. Reinhardt, since you are a medical economist, may I ask you that?

Dr. REINHARDT. If you have more primary care physicians, that will improve access. And the Institute of Medicine's studies that were cited shows that that will produce better health and life years, and we economists can covert that into quality adjusted life years. And usually, the assumption is a value is imputed to that.

Normally, I know David Cutler and others use $100,000 just to put a value on it. And then say by having more physicians in that field and providing better access, how many "qualies" have you produced, life years saved, or better quality of life, and you would get the return. I suspect it would be fairly high.

Senator FRANKEN. I would love if that could be done.

Dr. REINHARDT. It would be a nice senior thesis. I will ask a student.

Senator FRANKEN. Since I just have 2 minutes left, then I will just go.

Senator SANDERS. That's all you have left anyhow.

Senator FRANKEN. That's what I meant.

Senator SANDERS. You're not doing us a great favor here.

Senator FRANKEN. I was making the same point. I would like those 3 seconds back.

I would like, to Senator Murphy's question or comment about the status, I think your status is partly determined by your salary. So I do think that the Relative Value Board that you were talking about, I cannot remember the name right off, in other countries what is the compensation like in terms of general practitioner to specialist? Is it different? Is it lower? I mean, is the ratio higher from GP to specialist in other countries versus here?

Dr. REINHARDT. Specialists do earn more I know, for instance in Germany, but not as much as they do here. So GP's generally do have lower pay and occasionally protest about that. It happens over there. But I don't think the ratio is quite as large as it is here.

Senator FRANKEN. Yes.

Dr. REINHARDT. There's also a huge——

Senator FRANKEN. They have lower health costs and as good outcomes, if not better, right?

Dr. REINHARDT. Yes, about half, yes.

Senator FRANKEN. The health care costs. OK. I just wanted to do this.

Senator Murphy, again, brought this up, Accountable Care Organizations, which we have a lot of in our State and health care homes, medical homes, would they elevate the role of general practitioner in that model? In the sense that they would be sort of organizing this team that does the care?

Does anybody have an opinion on that?

Dr. WILPER. Specifically with regard to ACO's, unless fee for service payment mechanisms are changed, and there is a proposal to do that in these new medical home models to move to a capitated system, there is some chance that that would move the needle in terms of primary care physician reimbursement.

I would caution, however, I know this research fairly well. There is very limited evidence that patient-centered medical homes are actually going to reduce costs. I think that that intervention, while worthy—and we are working on it at the State level and within the VA—is still, in my view, experimental.

Senator SANDERS. OK.

Senator FRANKEN. Well, OK. I'm sorry. Thank you, rather, Mr. Chairman for that. And I just wanted, just one last thing.

Miss Decklever, I thought it was really off-base for the Ranking Member to use your willingness to come here to testify to moan about his weekly commute.

[Laughter.]

Senator SANDERS. Let me introduce a man who has already spoken—reintroduce him—and that is Dr. Uwe Reinhardt. He is the James Madison Professor of Political Economy, and professor of economics and public affairs at Princeton University, and contributing writer to "*The New York Times*" economics blog.

Dr. Reinhardt, thanks very much for being with us.

STATEMENT OF UWE E. REINHARDT, Ph.D., JAMES MADISON PROFESSOR OF POLITICAL ECONOMY AND PROFESSOR OF ECONOMICS AND PUBLIC AFFAIRS, PRINCETON UNIVERSITY, PRINCETON, NJ

Mr. REINHARDT. Thank you, Mr. Chairman for inviting me to this committee. I am very honored by it.

I should have added to my CV that I was delivered by a midwife and, of course, my mother. I once told that to a member of the American Medical Association and he said, "Well, it shows." And I'm not sure what he meant.

I divided my written statement into three parts. First, is our current workforce efficiently used? And I think you have already heard from the panel; the answer is no.

The second is, what public policy levers does the Congress have given that we want more primary care physicians to move them into that field and also to the practice where they are needed?

Then the third question is, to what extent can financial incentives be used, which you have already answered and talked about.

The traditional model of workforce forecasting has been the focus on physician population ratios, as if all the other people who work in the primary care team didn't matter. My whole career has been to say we should use non-physician workers far more imaginatively and let them practice independently in full competition with physicians. That was very controversial many years ago, less so now. Many States actually already allow that.

Congress has played a very large role in innovating in this field by funding the training of nurse practitioners and physician assistants, and also creating community health centers in other settings where they have very, very effectively been used.

There are issues of licensing that Congress could address. Usually licensing is excused, professional licensing, with an appeal to a patient's safety and quality. Usually the violins come out when I hear that. I think it is mainly over economic turf. It always has been.

I remember the fight over whether optometrists could dilate pupils. I think it was settled years ago, but those were the issues. It is almost like an insurgent war that has to be fought. I think Congress should simply make sure that licensing is driven by clinical and patient quality, and not by economic turf.

There is an issue of the SOP's, Scopes of Practice, which now States dominate and there are huge variations in that. I believe there should be. I agree with the nursing profession, there should be a standard SOP for the Nation which, in my view as I said, should allow nurses to practice independently. Physicians Assistants, by their nature, actually are supervised by physicians.

On the second question of how can you drive physicians to the extent you definitely need them in these teams into primary care, there is the issue of prestige; Senator Murphy mentioned that.

My view on that is the new models of primary care, medical home, the ACO's, et cetera, will quite naturally enhance the professional power. It is not just money, it is also power because they are not gatekeepers, but they are, nevertheless, traffic cops. And I think in those settings their prestige will rise.

I told that to our daughter, who is an internist, yesterday. I said, "I would be very excited to be a primary care physician now." The entrepreneurial opportunities are limitless there; much less in other specialties.

On the final point, I had some probably controversial things. Compensation is clearly an issue. Mr. Chairman, you mentioned that over a lifetime, a specialist gets $2 to $3 million more. Actually, it is such a small sum when you think of a Goldman managing director, if that were the annual bonus, they would be offended by it. But that probably would do something because it sort of signals value to people.

Debt forgiveness, I think, that should definitely be done. It is really sort of like the National Health Service Corps. I would say for every year you practice—or you could say, "If you go into a specialized field in primary care, we'll forgive you, say, $80,000 up front. And then for every year you specialize in a location that we

would like you to go, we'll forgive you $20,000," sort of to have that incentive out there.

Finally, I thought when I think that we are actually allowing private equity managers to take what is really just earned income, a commission, and get capital gains taxes on it, carried interest, I said, "Why don't we honor primary care physicians in America as we honor private equity managers, and give them the same rate if, say, they go to rural areas?", et cetera. The precedent exists. Congress says, "Well, carried interest. We want to encourage capital formation." Well, that is capital. Physicians are human capital, and we want to encourage them.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Reinhardt follows:]

PREPARED STATEMENT OF UWE E. REINHARDT, PH.D.

My name is Uwe E. Reinhardt. I am the James Madison Professor of Economics and Public Affairs at the Woodrow Wilson School of Public and International Affairs and the Department of Economics of Princeton University, Princeton, NJ.

My research over the last several decades has focused primarily on health economics and—policy, although I also teach or have taught at Princeton University general economics, financial accounting and financial management. Throughout my career, I have had an interest in issues surrounding the health workforce.

I would like to thank you, Mr. Chairman, and your colleagues for inviting me to testify before this committee on a matter of importance to the successful implementation of the Affordable Care Act (ACA) of 2010—the ability of our health system to absorb the additional demand for health-care services likely to be triggered by the extension of health-insurance coverage to an estimated 30 million or so Americans who would otherwise have remained uninsured.[1]

That challenge should prompt us once more to explore the following questions that have hovered over workforce issues in this country for at least half a century, to wit:

I. Is our current health workforce—especially in primary care—used as effectively and efficiently as it could be?

II. What public-policy levers are there to influence the choice of physicians on:

a. what medical specialty to enter, and
b. where to practice?

III. To the extent that financial incentives play a role in the choice of specialty and location, what policy levers are there in this respect?

I will order my remarks along this outline. Before proceeding, however, I would like to summarize here my various recommendations.

1. As an economist I have long favored the independent clinical practice of primary care by properly trained nurse practitioners without supervision by a physician, either in free-standing, nurse-led clinics of the sort pioneered by Mary Mundinger[2] or, better still in clinically integrated settings where the idea "supervision by a physician" would be replaced by "collegial collaboration with a physician."

2. I endorse the idea put forth by the *Advanced Practice Nurse* Practitioners (APNP) Consensus Working Group and the *National Council of State Boards of Nursing* to develop for use by the States a *national* scope of practice (SOP) for the nursing profession, to limit or perhaps even eliminate the current variation in SOPs across the States.

3. Evidently, the standardized national SOP should reflect the expertise of both, physicians and nurse practitioners. But, to avoid the inherent economic conflicts of interest both professions have in the matter, the standardized SOP should be developed by a carefully selected board that is not dominated by either nurse practi-

[1] Association of American Medical Colleges. *The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025* (June 2010).

[2] Mary O. Mundinger *et al*. "Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial," *Journal of the American Medical Association* (January 5, 2000) 283(1):59–68. *http://jama.jamanetwork.com/article.aspx?articleid=192259#qun defined*.

tioners or physicians, and that has significant representation by patients and those who pay for health care, including public payers.

4. As even the authoritative *Medicare Payment Advisory Commission* (*Medpac*) could not find a theoretical foundation for the existing payment differentials for identical primary care services rendered by primary care physicians and by non-physician primary care givers, I support calls for eliminating these differentials in public insurance programs and for calling upon private health insurers, whose clients also lament a shortage of primary care physicians, to recognize the role of non-physician primary care givers and to eliminate the payment differentials as well.

5. If Congress sincerely believes that there is and will be an acute shortage of *primary care physicians*, it should realign the levels of compensation of physicians under Medicare and Medicaid more in favor of primary care physicians. If Congress would like to see that realignment, it has no choice but to lead the way, as individual private insurers would find it difficult to effect the realignment by themselves.

6. Congress should fund experiments with rewarding the choice of a career in primary care, or to practice in an area with an acute shortage of primary care physicians, by forgiving for every year the physician works full-time in primary care part of the debt medical graduates have accumulated during their education and training.

7. As long as carried interest paid from long-term capital gains is accorded the dubious tax preference Congress has accorded it, Congress should extend that privilege also to primary care professionals, at least for some time of their careers.

I. EFFECTIVE AND EFFICIENT USE OF THE HEALTH WORKFORCE

Primary health care is still thought of among the laity as the health care rendered by a particular subset of *physicians* who tend to serve as the patient's primary contact with the health-care system. It naturally leads to hand-wringing over projected physician-population ratios for physicians in primary care.

A much superior definition of primary care has been offered by the Institute of Medicine in a report "Primary Care: America's Health in a New Era [3]:

> Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

This definition undoubtedly leans on the even more expansive definition offered in the World Health Organization's *Declaration of Alma Alta of* 1978:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.[4]

I recite these definitions of primary care—presumably very well known to members of this committee—to highlight the fact that the provision of primary care in a community and in the Nation should be a *team effort*, ideally within an organizational structure that encourages teamwork and the efficient delegation of tasks among members of the team.

Physician-Population Ratios: Research over the years has shown that there is actually much more flexibility in the substitution among types of health professionals than has traditionally been presumed among health workforce planners who think in terms of ideal physician-population ratios.

Indeed, it is remarkable how widely physician population ratios vary among advanced economies and even within countries. Figure 1 illustrates this phenomenon

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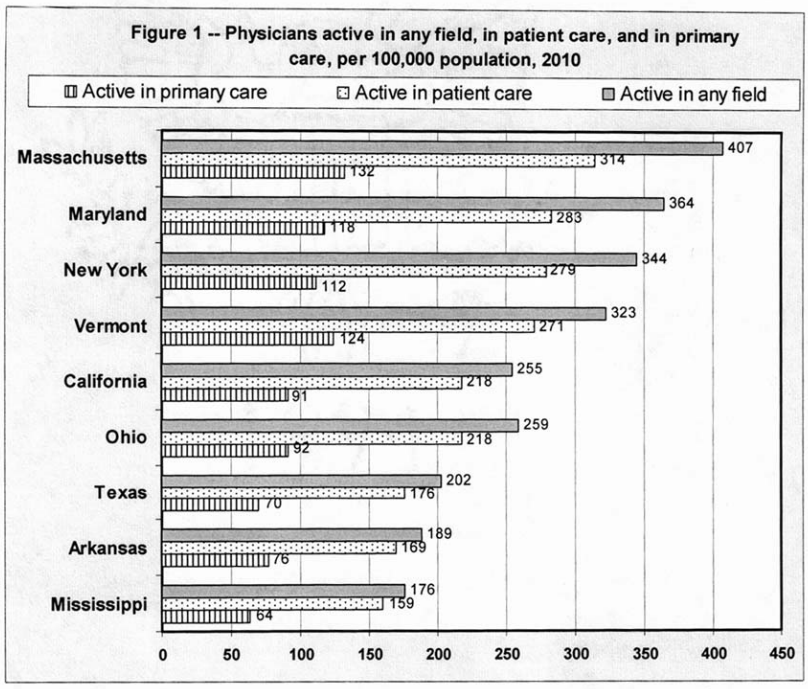
[3] Molla S. Donaldson, Karl D. Yordy, Kathleen N. Lohr and Neal A. Vanselow, eds. Primary Care: America's Health in a New Era (1996). Washington, DC: Committee on the Future of Primary Care, Institute of Medicine, 1996. *http://www.nap.edu/openbook.php?isbn=0309053994*.

[4] World Health Organization, Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. *http://www.who.int/publications/almaata__declaration__en.pdf*.

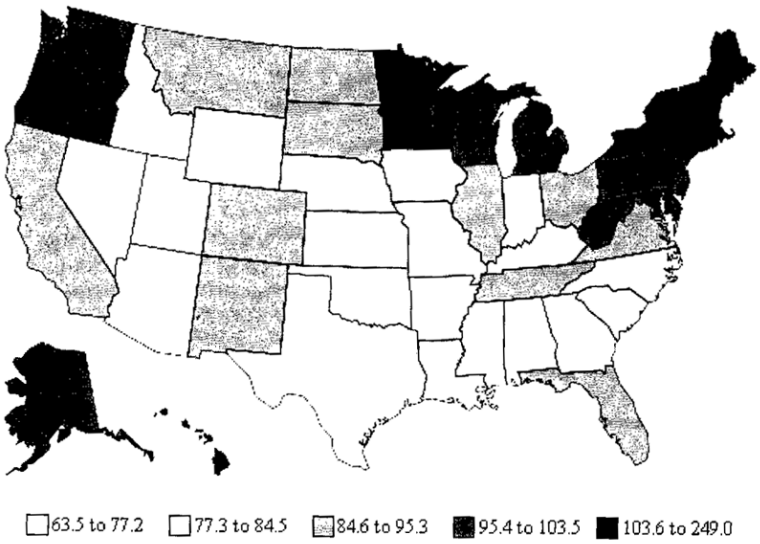
for the United States with data published by the American Association of Medical Colleges (AAMC) in its report *2011 State Physician Workforce Data Book*.[5]



The map overleaf, taken directly from the AAMC report, illustrates the geographic pattern of the ratio of primary care physicians to population. Evidently, the northeastern States are relatively much better endowed with primary care physicians than are many of the southern States. Yet in these States one also constantly hears laments over a prevailing or impending physician shortage.

[5] American Association of Medical Colleges (AAMC). *2011 State Physician Workforce Data Book*. Washington, DC: AAMC, November 2011. *https://www.aamc.org/download/263512/data/statedata2011.pdf*.

Figure 2—Map of Primary-Care Physicians per 100,000 population, 2010



The AAMC data raise the following question. If the ideal endowment with primary care physicians is to be gauged by some ideal physician-population ratio, which of the many different ratios across the United States should it be? How should one arrive at the answer?

I addressed myself to this question years ago in my doctoral dissertation with the now politically incorrect title *Physician Productivity and the Demand for Health Manpower*, at a time when the earlier enactment of Medicare gave rise to laments of a serious overall physician shortage.[6] Using a cross-section data base on medical practices, I found that the feared shortage could be substantially mitigated through more judicious task delegation from physicians to support staff with clinical training short of a physician's, but also with much lower costs per hour of work.

In the meantime, modern technology and improved training of non-physician clinical personnel has made possible even more extensive task delegation. Most prominently mentioned among the non-physician health professionals are advanced practice nurse practitioners (APRNs or simply NPs) and physician assistants (PAs). A more comprehensive definition would include pharmacists providing pharmaceutical care services and certified nurse midwives. Some would include even dentists.

The Growing Role of Non-Physician Primary-Care Professionals: The consensus in the literature[7] is that the traditional primary care model relying almost exclusively on primary care physicians is a thing of the past.[8] It had physicians perform many task for which, in effect, they were overqualified, as has been vividly described by primary care physician Lawrence P. Casalino in his "A Martian's Prescription for Primary Care: Overhaul the Physician's Workday."[9]

The traditional model is being replaced by new models of primary care in which advance practice registered nurses, physician assistants and other professionals will play a much larger role. Some authors have recently argued that the perceived pri-

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[6] Uwe. E. Reinhardt, *Physician Productivity and the Demand for Health Manpower*. Boston, MA: Ballinger Publishing Company, 1975.

[7] For syntheses of this literature, see Robert Wood Johnson Foundation, *Primary care workforce in the United States*. Policy Brief No. 22. July 2011, or Julia Paradise, Cedrik Dark and Nicole Bitler, *Improving Access to Adult Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. March 2011, *http://www.kff.org/medicaid/upload/8167.pdf* or Mary D. Naylor and Ellen T. Kurtzman, "The Role of Nurse Practitioners in Reinventing Primary Care." *Health Affairs*. (May 2010) 29(5): 893–99.

[8] David Margolius and Thomas Bodenheimer, "Transforming Primary Care: From Past Practice to the Practice of the Future." *Health Affairs*. (May 2010) 29(5): 779–84.

[9] Lawrence P. Casalino, "A Martian's Prescription for Primary Care: Overhaul the Physician's Workday." *Health Affairs* (May 2010) 29(5): 785–90.

mary care shortage could be all but eliminated through the use of primary care teams relying heavily on non-physicians and modern electronic communication.[10]

In fact, non-physician primary care professionals have been by far the fastest growing component of the primary care workforce in this country. During 1995–2005, for example, the number of primary care physicians per capita grew by only 1.1 percent per year while that of nurse practitioners grew by 9.4 percent and that of physician assistants by close to 4 percent. To be sure, physicians still made up three-quarters of the primary care workforce by 2005,[11] but only about 60 percent by 2009.[12] That fraction is bound to fall further in the decades ahead as models relying on non-physician primary care professionals develop further and proliferate, especially in areas less popular with primary care physicians. In those areas non-physician primary care professionals already make up a greater share of the primary care workforce.[9]

Although the barriers to greater reliance on non-physician primary care professionals do not strike me as overwhelming, there remain some that could and should be removed by government. These barriers are (a) State-regulated scopes of practice (SOPs) and (b) differential payment levels.

Scope of Practice (SOP) Restrictions: Like any other health professionals, nurse practitioners, physician assistants and other non-physician professionals working in primary care—e.g., pharmacists providing a valuable service called "pharma-care" or "pharmaceutical care services (PCS)[13]—are subject to formal scopes of practice (SOPs) that require a specified content of education and training, prescribe limits on the scope of services the professional may deliver and also dictate whether or not they may practice independently of a physician or must be supervised by a physician.[14]

Society has traditionally granted licensed physicians an extraordinarily wide SOP, including the off-label prescription of potentially harmful drugs that have not been approved for these off-label indications by the Food and Drug Administration.

The SOPs for non-physician primary care givers are reasonably narrower than those granted physicians—as the former undoubtedly would be the first to agree. But for reasons that evidently have much more to do with a penchant for protecting economic turf and the political power of State medical societies than with safety standards of patient care, the SOPs for non-physician primary care professionals still vary considerably among States[15]—and that in the land that originally invented and grew powerful on the idea that "one-size-fits-all" (think of McDonalds, the Holiday Inn, and the many other national and now global franchises for which America is famous.) Furthermore, in some States these restrictions are narrower than they need to be.[16]

The most contentious issue in this regard is the clinical independence of nurse practitioners. The conceptual model for the work of physician assistants has always been to work with and under the supervision of a physician, and the profession seems comfortable with that restriction. Nurse practitioners, on the other hand, could and do practice independently of physicians and in quite a few States as can be seen in this map taken directly from the previously cited Kaiser Commission on Medicaid and the Uninsured.[9]

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[10] Linda V. Green, Sergei Saving and Yina Lu, "Primary Care Physician Shortages Could Be Eliminated Through the Use of Teams, Nonphysicians and Electronic Communication." *Health Affairs*. (January 2013). 32(1): 11–19.

[11] A. Bruce Steinwald, Primary Care Professionals: Recent Trends, Projections, and Valuation of Services. Washington, DC: General Accountability office, February 12, 2008: Table 1, p. 7.

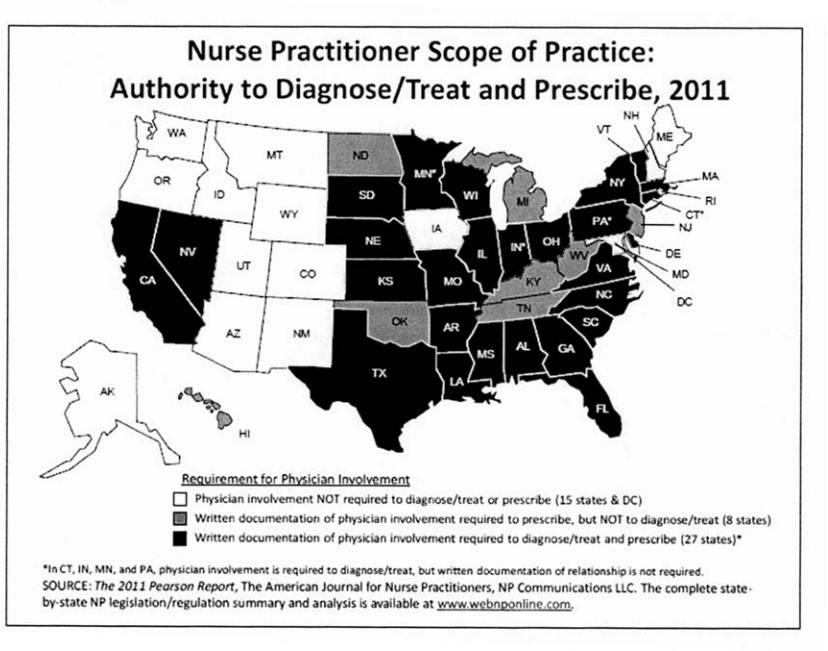
[12] Julia Paradise, Cedrik Dark and Nicole Bitler *op. cit*.: 3.

[13] Carole W. Cranor, Barry A. Bunting and Dale B. Christensen, "The Asheville Project: long-term clinical and economic outcomes of a community pharmacy diabetes care program." Journal of the American Pharmaceutical Association. (May–April 2003) 43(2): 173–84. *http://healthmaprx.com/yahoo_site_admin/assets/docs/Cranor31.90105431.pdf*.

[14] American Medical Association, AMA Scope of Practice Data Series. (October 2009). *http://www.tnaonline.org/Media/pdf/apn-ama-sop-1109.pdf*.

[15] Joanne M. Pohl, Charlene Hanson, Jamesetta A. Newland and Linda Cronenwett, "Unleashing Nurse Practitioners' Potential to Deliver Primary Care and Lead Teams." *Health Affairs*. (May 2010): 29(5): 90–905.

[16] Mary D. Naylor and Ellen T. Kurtzman, "The Role of Nurse Practitioners in Reinventing Primary Care." *Health Affairs*. (May 2010) 29(5): 896.



The foregoing leads me to the following recommendations:

As an economist I have long favored the independent clinical practice of primary care by properly trained nurse practitioners without supervision by a physician, either in free-standing, nurse-led clinics of the sort pioneered by Mary Mundinger [17] or, better still in clinically integrated settings where the idea "supervision by a physician" would be replaced by "collegial collaboration with a physician."

I endorse the idea put forth by the *Advanced Practice Nurse Practitioners* (APNP) Consensus Working Group and the *National Council of State Boards of Nursing* to develop for use by the States a *national* scope of practice (SOP) for the nursing profession, to limit or perhaps even eliminate the current variation in SOPs across the States.

Evidently, the standardized national SOP should reflect the expertise of both, physicians and nurse practitioners. But, to avoid the inherent economic conflicts of interest both professions have in the matter, the standardized SOP should be developed by a carefully selected board that is not dominated by either nurse practitioners or physicians, and that has significant representation by patients and those who pay for health care, including public payers.

Payment for Non-Physician Primary-Care Givers: Most economists probably would subscribe to the principle that the same price should be paid for identical goods or services, regardless of who produced it. A truly competitive market of textbook fame would actually yield that result.

The available research suggests that the quality of the care rendered by nurse practitioners—measured along several dimensions, including process, clinical outcome and patient satisfaction—is as good as that rendered by primary care physicians for the services allocated to nurse practitioners under existing SOPs.[18] That circumstance suggests that nurse practitioners should receive for the services they render the same fees paid to physicians for those same services.

In fact, however, the current practice has been to pay nurse practitioners less. Medicare and Medicaid, for example, pay them 75 to 85 percent of the comparable

[17] Mary O. Mundinger, *et al*. "Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial," *Journal of the American Medical Association* (January 5, 2000) 283(1):59–68. *http://jama.jamanetwork.com/article.aspx?articleid=192259#qun defined*.

[18] Julia Paradise, Cedrik Dark and Nicole Bitler, *op cit*.: 3–4.

physician fee, unless the nurse practitioner practiced under the direct supervision of a physician in which the payment is 100 percent.

Could such a differential in payment be defended? The only explanation I can think of is that with a visit to a physician, the patient purchases two things: (a) the delivery of the service in question and (b) a conveniently available stand-by capacity in the form of the physician's wider technical competence in health care. The higher fee paid physicians thus could be construed as payment for that stand-by capacity. This may not be a convincing argument, but it is that, that presumably has driven the differential payment.

Do private insurers have a more sophisticated approach in this regard? On the contrary. According to the literature, many of them erect much higher financial barriers to nurse practitioners by refusing to recognize and credential them as primary care providers or, if they do credential them, paying them less than they pay physicians.[19]

> As even the authoritative *Medicare Payment Advisory Commission* (*Medpac*) could not find a theoretical foundation for the existing payment differentials for identical primary care services rendered by primary care physicians and by non-physician primary care givers, I support calls for eliminating these differentials in public insurance programs and for calling upon private health insurers, whose clients also lament a shortage of primary care physicians, to recognize the role of non-physician primary care givers and to eliminate the payment differentials as well.

Government's Role in Primary-Care Innovation: Although popular folklore has it that government rarely innovates in health care—even though it was the first to introduce bundled payments for health care in the form of DRGs and developed the Medicare fee schedule whose underlying relative-value scale is now used by most private insurers—Medicare, Medicaid and several State governments actually have been quite progressive in supporting the development of the more modern primary care models.

On the *supply side*, the Federal Government as early as the 1960s started to provide financial support to the education and training of non-physician primary care professionals through the National Health Service Corps (NHSC) which also, of course has supported physicians. It can be argued that the NHSC has never been as large as it should have been, or ought to be in the future; but it was important in recognizing early the value of these non-physician health professionals.

The ACA of 2010 further enhances Federal institutional support to expand the supply of these professionals, along with individual support through the NHSC program.

Finally, the U.S. Veterans Administration health system has long demonstrated the successful use of non-physician primary care professionals in the delivery of health care.[20] [21]

On the *payment* side the Medicare program at the Federal level and the Medicaid program at the State level have since the 1970s recognized the role of these professionals in primary care, in contrast to private health insurers. As noted, however, they do pay nurse practitioners lower fees for given services than they pay physicians.

On the *delivery* of primary care, the Federal and State Governments have encouraged the development of nurse-led clinics in primary care which, as noted, I endorse. That development is further encouraged in the ACA through demonstration projects.

The Federal Government also has long supported the establishment of qualified community health centers of which the Nation now has over 2,000. They have demonstrated their value in making primary care accessible especially to otherwise underserved, low-income populations. Non-physician primary care givers play important roles in these centers.

The ACA of 2010 encourages the further development of the *Patient Centered Medical Home*, thought of as a clinically integrated primary care facility that should

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[19] Tine Hansen-Turton, Ann Ritter and Rebecca Torgan, Insurers' Contracting Policies on Nurse Practitioners as Primary Care Providers : Two Years Later. *Policy Politics Nursing Practice* 2008 9(4): 241–8.

[20] Perri M. Morgan, David H. Abbott, Rebecca B. McNeil and Deborah A. Fisher, "Characteristics of primary care office visits to nurse practitioners, physician assistants and physicians in U.S. Veterans Health Administration facilities, 2005 to 2010: a retrospective cross-sectional analysis." *Human Resources for Health*. 2012. 10: 42. *http://www.human-resources-health.com/content/pdf/1478-4491-10-42.pdf*.

[21] D. Buzdi, S. Lurie and R. Hooker, "Veterans' perceptions of care by nurse practitioners, physician assistants, and physicians: a comparison from satisfaction surveys." *Journal of the American Academy of Nurse Practitioners*. (March 2010) 22(3): 170–6.

facilitate collaboration among teams of primary care professionals and would facilitate further by the use modern electronic information systems. Part of these establishments task would be maintenance of a personal electronic health record.

Finally, a number of State governments have been active on their own in promoting innovative primary care models that rely heavily on non-physician primary care workers—e.g., Minnesota, Pennsylvania and Vermont.[22] Vermont's *Blueprint for Health* legislation created Community Health Teams of nurses, social workers and behavioral counselors that work with participating medical practices to help coordinate and monitor the primary care of patients. They now serve over half of the State's population in this capacity.

All told then, although high-performing private-sector health-care delivery systems also have experimented and innovated in this area—e.g., Kaiser Permanente or the Virginia Mason health system[23] to mention but two of many—it is fair to say that governments at both the Federal and State levels have actively encouraged innovation in enhancing the supply of primary care services through innovative models of health care delivery. It is appropriate and fair to acknowledge from time to time this role of government as an innovator in U.S. health care.

II. INFLUENCING THE SPECIALTY AND LOCATIONAL CHOICES OF PHYSICIANS

Even if innovation in the delivery of primary care that relies on non-physician professionals were pushed to the acceptable limit, there would undoubtedly remain the need for a sizable supply of primary care physicians. There is the possibility that the future demand for such physicians would still outstrip the future supply of them—certainly in traditionally underserved inner-city and rural areas.

It raises the question what public-policy levers there are to influence the specialty and locational choices of physicians in general, and especially of primary care physicians.

A very comprehensive survey on this question can be found in a 2009 report by the Josiah Macy, Jr. Foundation, which specializes in health workforce issues.[24] The report notes that specialty and location choices are related in complex ways to many factors other than financial incentives, among them the characteristics of medical students themselves, the mentoring of students during residency training and the medical school attended.

Women graduates appear to be less likely to practice in rural areas, and men less likely in primary care. Other things being equal, however, rural birth, a declared interest in serving underserved populations, and residency training in inner-city facilities increase the likelihood that graduates will choose primary care and locate in underserved areas. Students graduating from public medical schools appear to be more likely to chose primary care. Finally, medical graduates are more likely to choose primary care if during training they had mentors encouraging that choice or, in general, if the culture of their medical education encouraged it. Beliefs about and attitudes on the control over life style implied by different career choices also have been found to be highly influential.[25]

Remarkably, research on the influence of accumulated debt by medical graduates on career choice has yielded mixed results.[24] One would have thought it to be a major factor driving career choices.

Because the compensation of primary care physicians is substantially lower than that of most medical specialists, there does seem to be wide agreement that financial incentives could be used to influence these choices. There certainly is empirical support for that theory.[26] As the authors of a Josiah Macy, Jr. Foundation report conclude:

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[22] Robert Wood Johnson Foundation, How Nurses are solving some of primary care's most pressing challenges. Policy Brief No. 18 (July 2012) *http://www.pcpcc.net/2012/08/21/rwjf-report-how-nurses-are-solving-some-primary-cares-most-pressing-challenges*.

[23] C. Craig Blackmore, Jordan W. Edwards, Carly Searles, Debra Wechter, Robert Mecklenburg, and Gary S. Kaplan, "Nurse Practitioner—Staffed Clinic at Virginia Mason Improves Care and Lowers Costs for Women with Benign Breast Conditions." *Health Affairs*. (January 2013). 32(1): 20–6.

[24] Josiah Macy, Jr. Foundation, Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Students and Resident Choices? (March 2, 2009). *http://www.graham-center.org/online/etc/medialib/graham/documents/publications/mongraphs-books/2009/rgcmo-specialty-geographic.Par.0001.File.tmp/Specialty-geography-compressed.pdf*.

[25] E. Ray Dorsey, David Jarjoura and Gregory W. Rutecki, "Influence of Controllable Life Styles on Recent Trends in Specialty Choice by US Medical Students." *Journal of the American Medical Association*. (September 3, 2003) 290(9): 1173–8.

[26] James Thornton, "Physician choice of medical specialty: do economic incentives matter?" *Applied Economics*. 2000. vol. 32:1419–28.

> The income gap between primary care and subspecialists has an impressively negative impact on choice of primary care specialties and of practicing in rural or underserved settings. At the high end of the range, radiologist and orthopedic surgeon incomes are nearly three times that of a primary care physician. Over a 35–40 year career, this payment disparity produces a $3.5 million gap in return on investment between primary care physicians and the midpoint of income for subspecialist physicians.

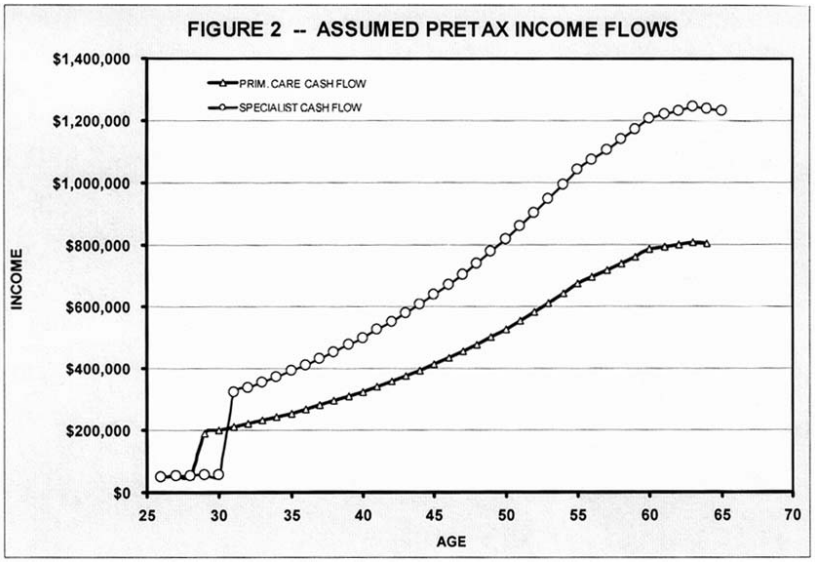
There is something odd in the fact that for at least two decades health-workforce experts and health-policymakers have wrung their hands over an acute shortage of primary care physicians, all the while paying primary care physicians so much less than is paid their specialist colleagues. To an economist, it comes across as insincerity over the alleged shortage. If primary care physicians are deemed so essential to the health of Americans, why are they not paid more?

Be that as it may, in the next section I explore how the financial incentives facing medical graduates could be changed in favor of primary care.

III. CHANGING FINANCIAL INCENTIVES TO ENCOURAGE A CHOICE OF PRIMARY CARE

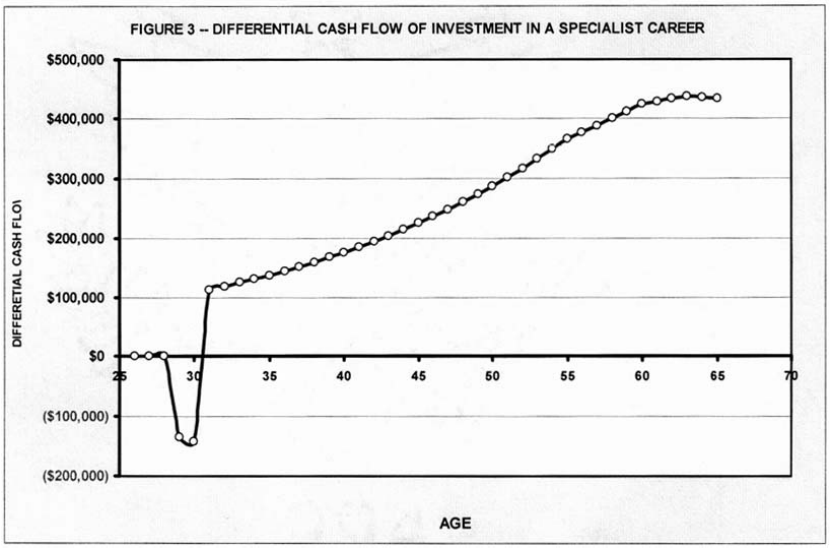
Although economists recognize the complex set of factors that drive choices of a medical specialty and a practice location, it is natural that they concentrate on financial incentives.

A compact way to model the impact of these financial incentives, in the minds of economists, is to think of the choice of a professional career as the perfect analogue of any other investment decision that requires an initial investment in the hope of a positive subsequent return on that investment. Figures 2 and 3 illustrate this so-called "human capital" model as it is exposed in the classroom.



In Figure 2 it is imagined that a medical-school graduate is aware of the two lines in that graph. The top line represents the typical future net cashflow, after practice expenses and income taxes, from practice in a medical specialty. The bottom line represents the analogous cashflow faced by a primary care physician. It is assumed here that a specialist career requires some additional years of low-paying residency training. The foregone income that could have been earned in primary care is the up-front investment in a specialist career, relative to a primary care career.

The decision to enter a specialist career, rather than one in primary care, can then be represented by subtracting the primary care cashflow from the specialist cashflow, to obtain the differential cashflow shown in Figure 3. It is the cashflow from which one calculates the net-present-value (NPV) or the internal rate of return (IRR) of the decision to become a specialist rather than enter primary care practice. Economists believe that medical graduates respond to these summary metrics in choosing their specialty.



It is immediately apparent from figures 2 and 3 that to enhance the financial attractiveness of a career in primary care, other things being equal, one could either shift down the projected cashflow to specialists or by shifting up the life-cycle cashflow to primary care or do both. The effect would be to shift down the cashflow line in Figure 3, that is, to decrease the relative financial attractiveness of specialty training.

How could that be done?

Changing compensation: The most obvious method of doing so would be either to raise the compensation of primary care physicians (fees, capitation, or salaries), or to lower the compensation of specialists, or to do both.

It has been attempted before, most notably when Congress established the Medicare fee schedule in 1992. At that time the fees of primary care physicians were raised substantially and those to many specialists were lowered relative to the previously prevailing fees.

For some reasons, however, it has proven difficult to maintain this tilting of the fee schedule over time, for reasons many observers attribute to the manner in which the relative value scale underlying the Medicare physician-fee schedule has proceeded.[27] It is in good part a problem of intra-medical-profession politics and power, and also one of congressional politics.

It can be asked next why private insurers have not led the way to raise the fees they pay primary care physicians relative to those paid specialists. Many and probably most of them simply have adopted the Medicare relative value scale underlying their fee schedules, although their absolute level of fees may be higher than Medicare fees.

Insurance executives answer this question by pointing out that Medicare must lead the way. First, private insurers cannot act in unison, as that would violate antitrust laws. Second, if one of them individually raised substantially the payments to primary care physicians, that insurer would have a cost disadvantage relative to competitors and yet would not be able to move the overall supply of primary care physicians. On the other hand, if the individual insurer wanted to achieve cost neutrality by paying specialists less, the insurer's enrollees might lose access to specialty care and move to competing insurers. I find that reasoning persuasive.

Lowering the Amortization of Medical-School Debt: In other industrial nations, tuition in medical school is low or zero. By contrast, American medical students pay substantial annual tuition charges, ranging in 2012–13 from a median of

[27] In this connection, see Uwe E. Reinhardt, "The Little-Known Decision-Makers for Medicare Physician Fees." *The New York Times Economix* (December 10, 2010). *http://economix.blogs.nytimes.com/2010/12/10/the-little-known-decision-makers-for-medicare-physicians-fees/*.

$32,414 in public medical school to a median of $50,309 in private medical schools.[28] Including other costs of attendance, but excluding the much higher opportunity cost of not earning a regular income in another job, the total cost of attending medical school ranged from a median of $53,685 in public medical school to a median of $72,344 in private medical schools.

Over 85 percent of medical students borrow to finance part or all of this huge investment in human capital. In 2012, 17 percent of them had an accumulated debt of $250,000 or more upon graduating from medical school. The average accumulated debt per graduate was $166,750 and the median $170,000.[24]

It may be noted in passing that the amortization of this huge investment in human capital cannot be deducted from taxable income as would be an investment in physical capital—e.g., in a haberdashery. Our tax code has a distinct bias in favor of physical capital, even though it is now widely agreed that the wealth of modern nations depends crucially on its human capital.

Curiously, as already noted, the literature on the influence of debt on the career choices of medical-school graduates has yielded mixed results.[24] It does not seem to be a major factor-driving career choices. Even so, it may be worth exploring what potential policy levers a medical graduate's accumulated debt might offer.

Table 1 below illustrates the fraction of a physician's pretax net practice income (or salary) that would be absorbed by the amortization of debt for a hypothetical medical school graduate choosing either a primary care career or entering a specialty.

Table 1—Percentage of Pretax Net Practice Income
Absorbed by Annual Debt Repayments under 20-Year Amortization

(Assumed annual growth in practice income 3.5 percent; Borrowing rate 7.9 percent)

Starting annual income	$150,000		$300,000	
Year	Equal payments [percent]	Growing payments at 3.5 percent per year [percent]	Equal payments [percent]	Growing payments at 3.5 percent per year [percent]
1	10.1	7.8	5.1	3.9
10	7.2	7.8	3.6	3.9
20	5.1	7.8	2.5	3.9

It is assumed in this table that debt amortization takes place over 20 years with either fixed annual loan repayments or, alternatively, payments that grow annually at 3.5 percent, the same rate at which the net practice income (or salary) of both types of physicians is assumed to grow. The assumed borrowing rate is 7.9 percent.

The tables show the absorption rates, in percent of net income, in practice years 1, 10 and 20. As would be expected, these absorption rates are sensitive to the borrowing rate students must charge on their debt. At a borrowing rate of only 4 percent, for example, the entries in the table would be as those in Table 2 below.

Table 2—Percentage of Pretax Net Practice Income
Absorbed by Annual Debt Repayments under 20-Year Amortization

(Assumed annual growth in practice income 3.5 percent; Borrowing rate 7.9 percent)

Starting annual income	$150,000		$300,000	
Year	Equal payments [percent]	Growing payments at 3.5 percent per year [percent]	Equal payments [percent]	Growing payments at 3.5 percent per year [percent]
1	7.4	5.4	3.7	2.7
10	5.2	5.4	2.6	2.7
20	3.7	5.4	1.8	2.7

Evidently, one way to enhance the future cashflow from primary care relative to that accruing to a specialty career would be to mitigate the burden of this debt amortization.

[28] Association of American Medical Colleges, Medical Students Education: Debt, Cost and Loan Repayment Fact Card. (October 2012). *https://www.aamc.org/download/152968/data/debtfactcard.pdf.*

It could be done by lowering the borrowing rate for primary care physicians, but not for specialists.

An alternative would be a loan-forgiveness program contingent on practicing full-time in primary care. For example, for every year a physician works full-time in primary care, X amount of dollars of his or her debt would be forgiven.

There might be arguments by specialists that some of their work involves primary care as well, for which they would seek pro-rated loan forgiveness; but such objections should not stand in the way of the general idea. One could work around it or simply reject the argument.

Manipulating the tax code: A final method to alter the future life cycle cashflow from a choice of primary care, relative to that from a specialty career, would be changes in the tax code, much as economists dislike, as a matter of principle, the now widely practiced use of the tax code for social engineering, in lieu of more forthright subsidization of activities preferred by government.

As one such manipulation of the tax code, Congress has long extended to the managers of private equity funds and hedge funds the tax-preference under which carried interest stemming from the long-term capital gains earned by the fund for investors in the fund is taxed at the low capital gains rate. Carried interest is distinct from any long-term capital gains these managers have earned on whatever their own investment in the fund may be. Carried interest basically is a cash bonus paid by other investors to the managers of funds for superior management of the funds. This tax preference has always been justified on the ground that it encourages capital formation, although like other economists,[29] [30] I personally find that justification unpersuasive.

But as long as this dubious tax preference continues to exist, it might as well be used in health policy. In one of my posts on *The New York Times* blog *Economix* [31] I had proposed that, if policymakers really do believe that the Nation faces an acute shortage of primary care physicians, they might come around to the view that this particular type of human capital is socially as meritorious as is general physical capital, be it factories or golf resorts. On that notion, the practice income of primary care physicians might be taxed, at least for some duration, as if it were the equivalent of carried interest.

To sum up at section III of this statement on financial incentives. In view of the foregoing discussion, I would recommend that:

> If Congress sincerely believes that there is and will be an acute shortage of *primary care physicians*, it should realign the levels of compensation of physicians under Medicare and Medicaid more in favor of primary care physicians. If Congress would like to see that realignment, it has no choice but to lead the way, as individual private insurers would find it difficult to effect the realignment by themselves.
>
> Congress should fund experiments with rewarding the choice of a career in primary care, or to practice in an area with an acute shortage of primary care physicians, by forgiving for every year the physician works full-time in primary care part of the debt medical graduates have accumulated during their education and training.
>
> As long as carried interest paid from long-term capital gains is accorded the dubious tax preference Congress has accorded the managers of private equity and hedge funds, Congress should extend that privilege also to primary care professionals, at least for some time of their careers.

Senator SANDERS. Dr. Reinhardt, thank you very much.

And last, but very much not least, is Dr. Claudia Fegan. She is the chief medical officer for the John H. Stroger, Jr. Hospital, Cook County in Chicago, often referred to as Cook County Hospital. She was previously the associate chief medical officer for the Cook County Ambulatory and Community Health Network, and interim chief medical officer of the Cook County Bureau of Health Services. Dr. Fegan served as past president of Physicians for a National

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[29] Alan S. Blinder, "The Under-Taxed Kings of Private Equity." *The New York Times*. (July 29, 2007). *http://www.nytimes.com/2007/07/29/business/yourmoney/29view.html?ei=5090&en=973b345a4a0b4227&ex=1343361600&adxnnl=1&partner=rssuserland&emc=rss&_r=0.*

[30] N. Gregory Mankiw, "The Taxation of Carried Interest." Greg Mankiw's Blog. (July 19, 2007). *http://gregmankiw.blogspot.com/2007/07/taxation-of-carried-interest.html*.

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Health Program. She received her undergraduate degree from Fisk University, and her medical degree from the University of Illinois College of Medicine.

Dr. Fegan, thanks so much for being with us.

STATEMENT OF CLAUDIA M. FEGAN, M.D., CHCQM, FACP, CHIEF MEDICAL OFFICER, JOHN H. STROGER, JR. HOSPITAL OF COOK COUNTY, CHICAGO, IL

Dr. FEGAN. Thank you, Senator Sanders, Senator Enzi, and other distinguished Senators for affording me this opportunity to address the issue of inadequate access to primary care in the United States.

As the chief medical officer of John H. Stroger, Jr. Hospital in Chicago, known to most people outside of Chicago as Cook County Hospital, I confront on a daily basis our country's failure to provide universal access to health care as a right to which, I believe, everyone is entitled.

Every single day, people without a physician line up across the street from our hospital to be seen in our walk-in clinic. Hundreds of people a week, tens of thousands a year, stand out in the wee hours of the morning hoping to be one of the 120 to 200 people who will be seen that day. And even better, hoping to be one of the 12 patients who will be assigned a primary care physician and given an appointment so they won't have to come back; they hope to be one of the lucky ones who will be given a physician of their very own.

Our current influenza epidemic highlights the vulnerabilities of our current patchwork for health care delivery. Too few people in this country have access to a primary care provider. Their primary care provider could have educated them about influenza and the need for influenza vaccine, especially to vulnerable populations and those in contact with those populations. Then their primary care provider could have given them that vaccine. Instead, we are witnessing tens of thousands of people presenting to our emergency rooms sick and looking for help. At the peak, our emergency room at Stroger was seeing 450 people a day while hospitals around the city, and the country I might add, closed their doors and went on bypass. At Cook County we never go on bypass. We never close our doors.

We created the RBVS system to compensate physicians for their cognitive effort in the care of patients. It was hoped that that would begin to level the playing field between primary care physicians and procedure-based specialists. Yet, the RVS Update Committee, which is tasked annually, was reviewing how Medicare compensates physicians for care provided, has only a paltry few seats allocated for primary care when setting reimbursement rates.

We want to increase the number of primary care physicians, but when Medicare funds graduate medical education in hospitals, we disperse the same amount for a plastic surgeon as a primary care physician. If we increase hospital reimbursement for primary care physicians in training over specialists in training, we will have more primary care physicians. You could do that.

I have to say I have the privilege of being a primary care physician myself. I love taking care of patients. It is one of the most fun

things I do. My patients invite me into their lives as I teach them how to take care of themselves and get what they need.

The daughter of a labor union organizer and a social worker, I could have never been able to afford medical school. I was fortunate enough to be a member of the National Health Service Corps, which paid for my medical education. So I was free to make a decision to follow my passion and become a primary care physician without having to worry about how I would pay off my loans.

I would say to you if medical students know before they begin medical school they will have no debt upon completion of their studies, they will be more likely to make a decision to pursue a career in primary care rather than more highly compensated specialties.

The administrative burden we have placed on physicians is a product of our Nation's fragmented, dysfunctional system of financing health care with multiple private and public payers, including hundreds of private insurance plans each with its own set of rules, the costly paperwork and headaches inflicted upon our physicians, including primary care physicians is enough to drive many to distraction or exit from our profession.

If we would enact a single-payer national health care program where everyone was entitled to health care as a right, we could focus on delivering the best care in the world to our patients, and relieve physicians of the administrative hassles required to ensure proper billing services are provided.

The stresses on primary care physicians are tremendous, with the implementation of the Electronic Health Record that forced them to spend more time looking at the computer than at their patients. Most EHR systems today were designed to enhance efficient billing, not patient care. As a result, EHR has created a hideous documentation burden that robs precious time from the physician that they would rather spend engaging with their patients and understanding their needs. There is no question if we had designed the EHR to further clinical care, we would have developed a very different tool.

While it is true there are elements of EHR that will improve patient safety, they are far overshadowed by the demands for administrative documentation. We lose the narrative of the individual patient to improve the point-and-click documentation and make billing more efficient.

I urge you to work to make a difference, not for me or you, but for the patients I have the privilege of serving, who desperately need elected officials to care about what happens to them.

Thank you.

[The prepared statement of Dr. Fegan follows:]

PREPARED STATEMENT OF CLAUDIA M. FEGAN, M.D., CHCQM, FACP

Thank you Senator Sanders, Senator Enzi and other distinguished Senators for affording me this opportunity to address the issue of inadequate access to primary care in the United States.

The lack of adequate access to primary care speaks to the much larger issue of inadequate access to health care in this country as a whole.

As the chief medical officer of John H. Stroger, Jr. Hospital in Chicago, known to most people outside of Chicago as Cook County Hospital, I confront on a daily basis the reality of our country's failure to provide universal access to health care as a right to which I believe everyone is entitled.

Every single day, people without a physician line up across the street from our hospital to be seen in our walk-in clinic. Hundreds of people a week—tens of thousands a year—stand in line in the wee hours of the morning, hoping to be 1 of the 120–200 people who will be seen that day and even better, hoping to be one of the 12 patients who will be assigned to a primary care physician and given an appointment so they won't have to come back.

They hope to be one of the lucky ones who will be given a physician of their very own, who will get to know them and take care of them and be available when they have a problem or question, someone to help them meet their medical needs, someone to help them navigate our complicated health care system to get what they need. I have to admit I hesitate to refer to health care delivery in this country as a system, because so little is connected to anything else.

Every day I look at the charts of patients admitted to our public, safety net hospital who were told by another hospital to come to us because they are uninsured. They come from distances great and small. I see patients who come from other cities, other counties, other States, other countries and patients who come from just a few blocks away.

Sometimes they come with their films or slides and have been told they need surgery or chemotherapy or a diagnostic study and they would be better off at "the County." These patients come to us in a state of desperation with great expectations. We take care of them and do the best we can with the limited resources we have. This is as we prepare to absorb the beginning of the phaseout of Disproportionate Share Funds for Safety Net Hospitals on October 1 of this year. The elimination of DSH funds with the presumption that everyone will be insured is just another challenge as we continuously struggle to meet the needs of all who come to our doors.

I know the Affordable Care Act promises to provide insurance coverage to more Americans, but I know there will still be 30 million people who will remain uninsured even after the Affordable Care Act is fully implemented. So I know the need for the safety net and places like Cook County will remain. I also know there are not enough primary care providers to care for all the patients who will need them.

Whereas in 1930 the ratio of generalists or primary care physicians was about 80:20, today that ratio is reversed. It's not an exaggeration to say we are facing a crisis in this vital area.

Research show that primary care is the foundation of any high functioning health system. A well-developed primary care infrastructure makes access to care easier and more efficient; it contains cost, such as identifying and treating problems before they become more severe or advanced. It improves the coordination of resources and care; and most important, it yields better medical outcomes than when such an infrastructure is missing. It saves lives. I might add, studies have noted more expensive for-profit hospitals, do not have better outcomes than our public safety net hospitals. There is no correlation between the amount of money we spend on care and the quality of the outcomes.

Our current influenza epidemic highlights the vulnerabilities of our current patchwork for health care delivery. Too few people in this country have access to a primary care provider. Their primary care provider could have educated them about influenza and the need for influenza vaccine, especially in vulnerable populations and those in contact with those populations. Then their primary care provider could have provided them with that vaccine.

Instead we are witnessing tens of thousands of people presenting to our emergency rooms sick and looking for help. At the peak, our emergency room at Stroger was seeing 450 patients a day while hospitals around the city closed their doors and went on bypass. At Cook County, we never go on bypass, we never close our doors.

People don't understand that influenza vaccination is not just about you and whether you get sick, but about everyone you encounter and the risk you will infect them. After we had a patient in our hospital infected by a visitor and a pregnant patient who wound up on a ventilator, we were forced to limit access to the hospitals in our System for visitors who might be sick. People are dying, dying from influenza, a preventable disease. This is an example of our tendency in this country to be pennywise and pound foolish in our funding of health care.

There is no doubt that for many years we have undervalued primary care. It shows up in a variety of ways.

As a nation we provide little incentive for young physicians to become primary care providers. By contrast there are strong incentives for young clinicians to pursue higher compensated specialties.

A medical education is expensive and most young physicians leave medical school with hundreds of thousands of dollars in debt. Because primary care physicians are the lowest compensated of physicians, and because the prospect of a heavy, long-

term debt is so unappealing, medical students find themselves gravitating away from primary care toward higher paid specialties.

We say we value primary care physicians and yet we pay them half as much as we pay specialists. We say we appreciate the cognitive skills of primary care physicians so necessary to see patients as a whole and make decisions in the best interests of each individual, but we make it financially difficult for young clinicians to take this path.

Another example: We created the RBVS system to compensate physicians for their cognitive effort in the care of patients. It was hoped this would begin to level the playing field between primary care physicians and procedure-based specialists. Yet the RVS Update Committee, which is tasked with annually reviewing how Medicare compensates physicians for care provided, has only a paltry few seats allocated for primary care when setting reimbursement rates.

We want to increase the number of primary care physicians, but when Medicare funds graduate medical education in hospitals, we disburse the same amount for a plastic surgeon as a primary care physician. If we increase hospital reimbursement for primary care physicians in training over specialists in training, we will have more primary care physicians. You could do that.

I have to say that I have the privilege of being a primary care physician myself—previously in private practice and now at a large public hospital—and I love taking care of patients. It is one of the most fun things I do. My patients invite me into their lives as I teach them how to take care of themselves and get what they need. These experiences are often deeply moving and rewarding and they remind me why I chose medicine as a profession.

The daughter of a labor union organizer and a social worker, I would have never been able to afford medical school. I was fortunate enough to be a member of the National Health Service Corps, which paid for my medical education, so I was free to make the decision to follow my passion and become a primary care physician without having to worry how I would pay off my loans.

While the National Health Service Corps still exists, it is a shadow of its former self; more students receive funding in the form of loan repayment.

I would say to you: if medical students know before they begin school that they will have no debt upon completion of their studies, they are more likely to make the decision to pursue a career in primary care rather than a more highly compensated specialty.

There are other ways to make primary care more attractive to the next generation of physicians too.

The administrative burden we have placed on physicians is the product of our Nation's fragmented, dysfunctional system of financing care through multiple private and public payers, including hundreds of private insurance plans, each with its own rules. The costly paperwork and headaches inflicted on our physicians, including primary care physicians is enough to drive many to distraction or exit from our profession.

If we would enact a single-payer national health care program, where everyone was entitled to health care as a right, we could focus on delivering to our patients the best care in the world and relieve our physicians of the administrative hassles required to ensure proper billing for services provided.

As a primary care provider myself, I feel the external control in the exam room with me and my patient as I struggle to make sure I have completed all the required elements on the computer screen, sometimes at the cost of neglecting to ask what the patient's concerns are today.

Because of this onerous administrative burden, primary care physicians have lost something of their precious connection with their patients. Lifting that burden would help strengthen the doctor-patient relationship.

The stresses on primary care physicians are tremendous with the implementation of the electronic health record (EHR) that force them to spend more time looking at a computer screen than looking at the patient. Most EHR systems today were designed to enhance more efficient billing, not patient care. As a result, EHR's create a hideous documentation burden that robs precious time from physicians that they would rather spend engaging with their patients and understanding their needs.

There is no question, if we had designed the electronic health record to further clinical care we would have developed a very different tool. While it is true there are elements of the EHR that will improve patient safety, they are far overshadowed by the demands for administrative documentation. We lose the narrative of the individual patients to improve the point and click documentation and make billing more efficient.

It's just one more example of where we expect primary care doctors to address more and more issues, even as we expect them to see more and more patients.

I would say to the members of this committee, as Members of Congress you have the opportunity to increase the number of primary care providers in this country.

1. Adjust the funding for graduate medical education to reimburse hospitals more for the primary care physicians than specialists.

2. Insist the American Medical Association increase primary care representation on the RVS Update Committee.

3. Increase the National Health Service Corps scholarship program.

I urge you to work to make a difference, not for me or you, but for the patients I have the privilege of serving, who desperately need their elected officials to care about what happens to them.

Senator SANDERS. Dr. Fegan, thank you very, very much.

Let me begin the questioning. I want to ask two brief questions in my 5 minutes. My understanding is that if I have the flu or a non-urgent type of illness, and I walk into an emergency room, it will cost Medicaid something like 10 times more than me walking into a community health center to visit my primary health care physician.

My understanding is that there are millions of Americans who hesitate, I know this is true in Vermont. People get sick. They think it is going to get better. They don't go to the doctor. They wait months and months, they wait a year, they walk-in to a doctor. The doctor says, "Why weren't you here 6 months ago? You're really ill. I've got to get you to the hospital."

My question is how much money does it cost and how much human suffering is taking place in this country because people are unable to walk into a doctor's office when they need to? Who wants to respond to that?

Dr. Fegan.

Dr. FEGAN. I can just tell you about the faces of the patients who line-up to be seen at our walk-in clinic on a daily basis, and I don't know how you measure the cost of human suffering. But we see always—people come to County because you can see things you will never see anywhere else in the world, such advanced stages of disease, and people who with everything from brain tumors to breast lesions that are eroding from the skin. I mean, and you say, "Why did you stay home?" And they didn't have to.

I am going to tell you, these people are working folks. These are taxi drivers. They are college professors. They are accountants. They are attorneys. And the first thing they say to me is, "I never thought I'd be here. I never thought I'd be at the County." So I would say it has to be, and no exaggeration, millions of dollars we lose in workforce productivity, as well as in the suffering.

I see so many patients who get cancer, particularly breast cancer, and lose their jobs, and then wind up coming to us to get further treatment. And they've lost their homes, many of them, by the time they get to us, and we are trying to figure out how to get them started on their chemotherapy and find them some place to live.

Senator SANDERS. Other comments on that?

Ms. Kuenning.

Ms. KUENNING. Yes, thank you. I know from the stories from the community health centers just in Vermont, I can't put a dollar equation to it, but we have so many stories. We have a farm worker program that actually goes out to farms and works with, not

only seasonal farmers, but actually our farmers who aren't coming in for care.

We have a 50-year-old farmer who has a history in the family of diabetes and has never seen a doctor, comes in and actually doesn't know that they can get care at the community health center on a sliding fee discount because of their income.

So I think a lot of it is outreach and enrollment into understanding both their cultural issues, as well as being able to get them into care.

Senator SANDERS. OK. Let me switch gears for a moment and touch on another very important issue in terms of how we determine reimbursement rates for physicians. And that is the RUC, which I think probably is not a household word throughout America, and yet is an organization which plays an enormously important role in determining how much specialists will make, how much primary care physicians will make.

And apparently, we have an organization which is kind of loaded, top heavy, with people in the specialties and weak in terms of representing primary care physicians. Is this an important issue?

Dr. Mullan, do you want to take a shot at that?

Dr. MULLAN. I do. A key issue, when we talk globally about the idea of pay inequity, how do we get a handle on it?

Since Medicare is the largest single payer, and historically many private payers key off Medicare in a variety of ways, managing the Medicare conundrum around the pay gap would be central to reforming the whole system, and the RUC is at the center of it. It is well-wired in the sense that it has been this way a long time, and there are a variety of approaches to it, but I think just sunshine, daylight featuring, focusing on this.

You have lurking under it the question of, do you raise the floor or bring the ceiling down? Both will raise all kinds of issues for people involved, and philosophically, and politically as well.

I believe it is both. I mean, the point is we are not going to pay all our primary care physicians $500,000 a year. But I must say as a physician and a citizen, when I hear about a physician making $500,000 or $1 million a year, yes, there are people in business from their college class, et cetera, etc. I think it is a moral argument we need to engage as a country.

Senator SANDERS. Dr. Wilper, you had some strong words on that, and then we will get to Dr. Reinhardt.

Dr. WILPER. Thank you. So I do have some additional thoughts on this, and specifically the process by which the RUC evaluates billing codes between the different subspecialties and primary care. This process could be improved by reevaluating the evaluation and management, what are called, CPT codes.

An example of this is as follows: an ophthalmologist will bill the same code, a 99214, for a 10 minute exam with very little followup needed. A PCP, a Primary Care Physician, who bills the same code generally spends 25 to 30 minutes with a patient, face-to-face, has 25 to 30 minutes' post-care documentation and followup at an estimated 20 to 30 minutes between visits for the same patient. Now, the reimbursement for those two services are identical.

So what we need are new E&M codes in primary care. We need to update our knowledge base regarding this issue as current time

estimates for these codes are actually outdated and are dated to the 1980s, 20–25 years old, and they are based on very small sample sizes.

A proposal would be to develop an independent process for reviewing these codes that is transparent, peer-reviewed, and based on real world data.

Senator SANDERS. Dr. Reinhardt, do you want to comment? Briefly, please.

Dr. REINHARDT. Yes, the RUC determines relative values, not absolute levels, but it is a zero sum game if it is budget neutral.

One could put more primary care members on that board, and I think that would be a good idea. But MedPAC had also proposed that there be an outside committee, an independent committee of stakeholders who kind of audit and review the RUC recommendations. I don't know if that ever went anywhere, but I would encourage you to look at it, and maybe go that way.

Senator SANDERS. OK. Thank you very much.

Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman.

I will begin by asking Miss Decklever. In your testimony, you described some of the challenges that frontier States face in qualifying for Federal grants to improve primary care access and increase the health professional workforce.

What needs to be done at the Federal level to improve that grant process, and what can we do to make the process better?

Ms. DECKLEVER. Senator Enzi, members of the committee, the information that I received from the community health centers refers back to the number when they are looking at designations. So it is the number of people per provider rather than the amount of space where those people are located in.

The other thing that sometimes is a bit of a disparity is in States like ours where we have lower minority populations, just by the nature of our State that sometimes by those designations we are put out of the running, as it were, because we just don't have a high enough percentage of minority or different types of ethnic backgrounds.

And then, again, the wage disparity where the average statewide data, States that are the designated areas are financially in pretty good shape. But if you were to look at the overall where we have many people that are making a lot of money, and then some that are making very little, it skews the average. And to maybe look at that type of data and those types of figures as far as designation goes.

Senator ENZI. Thank you.

This is a question of you and Ms. Kuenning. What needs to be done to enhance and improve the coordination and collaboration between the Federal Government and the State government agencies to most effectively deploy the resources? How can we avoid duplication of efforts?

Ms. KUENNING. Thank you.

At least I can speak to Vermont and New Hampshire in terms of accepting, not the National Health Service Corps loan repayment to providers, but actually a loan repayment dollar. There are re-

strictions on how you use those resources. They have to be within health professional shortage areas rather than MUA's and MUP's.

If we could get a change from that in the Federal Government, then States like Vermont and New Hampshire who don't take any Federal funding for loan repayment—they have State loan repayment, but no Federal loan repayment—that actually would be very favorable.

Senator ENZI. Thank you. Were you going to comment on that, Miss Decklever?

Ms. DECKLEVER. Senator Enzi, I do not have enough information to be able to give you an intelligent answer, but I would be more than happy to do some research on that and get back to you.

Senator ENZI. OK. I do have some other questions for everybody on the panel that I hope they will answer in writing.

Dr. Mullan, what needs to be done to ensure that effective oversight and financial controls are in place to ensure that Federal funding is being used effectively, and helps ensure professional resources are being allocated more efficiently?

Dr. MULLAN. Thank you, Senator Enzi.

The array of Federal programs is quite different. I have spoken to the issue of Medicare GME, which I think—you would not issue a contract without a deliverable, without specificity. And I think oversight there is actually quite lax. I realize that is not the jurisdiction of this committee, but it inevitably speaks to this issue.

In regard to the title VII programs, these would be programs that support educational activities for primary care physicians, for physician assistants, and the title VIII programs for nurse practitioners, they are actually managed fairly tightly. They use an NIH-type grant award system, with Federal project officers, and I think there is good supervision. In fact, from the perspective of the schools, often, they feel it is too tight. It is very hard to move when things are highly stipulated.

The National Service Corps is a relationship, of course, with the individuals. And happily over the years, there used to be many individuals who bought out, simply didn't serve. That has been tightened with the help of Federal legislation. There is extra indemnity if you don't serve on the scholarship, and with loan repayment, that is managed quite tightly.

So I think in this area in general there is pretty good accountability across the programs, and no doubt, room for improvement, but in general, it is pretty good.

Senator ENZI. Thank you. My time has expired.

Senator SANDERS. Thank you, Senator Enzi.

Senator Warren.

Senator WARREN. Thank you.

Like Senator Enzi, I would like to followup with some questions about community health centers as a vehicle for delivering primary health care, and it is their impact on access, on costs, and on disparity.

I am very interested. I read through all of the testimony, and am very impressed by the work you have done, Ms. Kuenning. It is terrific work.

I was very glad to hear, Ms. Decklever, about the work that is done out in Wyoming and that you've got community health centers there.

But what I would really like to know is, what else do we know about them in any of those dimensions? As I said, it is about cost. It is about access. It is about reducing disparity. Can anyone speak to that?

Dr. Wilper, your head snapped up, so I am guessing it is you.

Dr. WILPER. Sorry for that.

Senator WARREN. No, no. I like it.

Dr. WILPER. In addition to my work at the VA, I also work at a community health center in Boise, ID called Terry Reilly Health Systems.

In my experience, the CHC's provide a critical safety net for the uninsured of our Valley. I live in the Treasure Valley. The uninsurance rate for this population is nearly 50 percent, which is actually second highest in the Nation.

My experience as a clinician working in that clinic is that despite the access that it provides, oftentimes what we end up providing is care that, at least in my other job at the VA, we would not find acceptable because we don't have other resources to offer to these patients seen in our community health center because they don't have insurance. So even though they have a foot in the door to the clinic at the community health center, oftentimes patients are unable to access additional services that would be standard of care in any other system in the United States.

Senator WARREN. Very helpful. Yes, ma'am.

Dr. FEGAN. Cook County also pairs with many other community health centers, and what we find is that when we provide access to primary care, we uncover specialty needs. One of the big problems that we have as a hospital, or one of our major challenges, is that these patients in between the health centers have nowhere to go to receive those services, and they refer them to us.

So I think that community health centers are invaluable because they offer care in the community where people live and they are likely to be more flexible in their hours and in their pay scale. People who don't normally have access to care will receive access. But then, they have nowhere to send them, and we are the safety net, and it is a continuous tension we have with capacity in meeting those needs.

Senator WARREN. Dr. Mullan, did you want to add?

Dr. MULLAN. Yes. Thanks, Senator Warren.

I had the privilege of working for 12 years at a community health center, the Upper Cardozo part of the Unity Network; it is about 2 or 3 miles from here. And what one saw there, what I saw there day to day was a population that, were it not for that health center, would be in the emergency room.

There were not private providers in the neighborhood and to the extent there were, they weren't really prepared to deal with the clinical needs, the language needs, the support needs of this population. Health centers, Unity here in DC and others around the country, have built-in, hardwired in social work, mental health, and a variety of services that typify the kinds of needs that our population had.

So it represents, at its best, a one-stop shop which is the spirit of primary care, but particularly attuned to the kind of neighborhood, the kind of population that you are working with. Without that, the emergency room would have been the recourse if care was to be delivered at all.

Senator WARREN. Thank you. Miss Kuenning.

Ms. KUENNING. Yes, thank you.

I would characterize that what we're doing in Vermont is, working toward a redesign of both the finance and the delivery system, and the community health centers are really part of that. There were acts that came out of the State house and all of them made primary care centric.

Part of that is the financing, which is you are going to do some kind of shared savings, or a global payment, or bundled payment. Then you are also going to change, with regard to the delivery system, in terms of ACO's, and that is your relationship with mental health and specialists so that you are not aligning in terms of your governance, but you are aligning with regard to the total medical expense. So you are responsible for that patient's expense, and it is changing the way that we do business. That we are not really doing it based on the volume of care, but doing it and being paid based on value. And that whole system is being done at many community health centers across the Nation.

Actually, Blackstone Valley is a great example. I am sorry the Senator left, but it is a great example of how they redesigned the visit to actually have the providers working at the top of their scope, bringing in more assistants to the nurses and to the health centers' physicians, and they saved over 1 year, $1 million just at one community health center looking at total medical expense. But that requires having electronic medical records and claims data so that you can actually see where your patients go. Because when you are at the health center, you have a medical record of where they have come to see you, but you don't have any experience of where they are going in terms of the hospital, or to the emergency room, or to mental health.

So this whole concept of ACO, as long as it is primary care centric, really aligns the thinking about both financing and delivery for our patients so that we are thinking about the total medical expense, and making interventions in the primary care that will matter both in terms of their outcomes and the finances.

Senator WARREN. Thank you. Enormously valuable. So it is an estimate. I am sorry, Mr. Chairman.

This estimate that we've got a $24 billion savings from the current community health centers, in part is coming from keeping people out of emergency rooms, in part is coming, I assume, from integrated care. As Dr. Reinhardt talks about different kinds of providers. But it is also coming from these innovative approaches to care.

Ms. KUENNING. Right, and a lot of the patients under medical home work—in Vermont we have a concept that is called the Blueprint, and it is really thinking about chronic care management. How do you really take somebody that has a higher prevalence of diabetes, or hypertension, or asthma and really manage their care to keep them out of the emergency room, keep them out of the hos-

pital and they are inpatient, as well as returning to the hospital? So it is about really focusing in on the patient rather than the delivery system.

Senator WARREN. Thank you very much.

Senator SANDERS. Thank you, Senator Warren.

Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman. Again, thank you for the focus of this hearing. The title sort of speaks volumes, "30 Million New Patients and 11 Months To Go."

Certainly our States have different experiences as we move forward in terms of the level of uninsuredness, the level of preparation with primary care providers, the distribution of those providers throughout the State.

I apologized earlier for having to step out to attend another organizational meeting of one of my other committees, and so, I missed some of your testimony. But I hinted in my opening statement that I would like to hear a little bit more about your opinions and the level of knowledge on the impact of the non-remunerative factors in increasing the supply of primary care practitioners.

I think about the anecdotal information I hear as medical students are going through their rotations and observing the specialties, as well as joining primary care settings. And they are observing mentors and teachers with different levels of autonomy, different levels of flexibility. I think about the difference in experience that one might have if they are in a setting where they are modeling a patient-centered medical home versus other settings that would be for service, more traditional payment systems. You know, how much is their mentor and teacher on-call? Every other night, is it more reasonable?

So I am wondering about the level of knowledge of how these non-compensatory factors play into the decisionmaking to specialize or to go into primary care as students have these observations and are looking to the future of the way we design medicine?

Dr. Mullan, I understand you did raise that briefly in your testimony. I wonder if you would start.

Dr. MULLAN. Thank you, Senator Baldwin. Could we spend the afternoon on it? It is an important topic.

Senator BALDWIN. I would love to.

Dr. MULLAN. I will be very quick.

The culture, as I have called it, of medical schools and teaching hospitals over the years, for good reasons, has developed a very reductionist, research-oriented, subspecialty-oriented culture. All of our medical schools have that element to them. Some do better in terms of local accountability, local focus.

I would like to see every medical school have a workforce plan. I travel often to medical schools and say, "What is your geography? What is your catchment area?" State schools do a little better. They say, "Our State," but even that is kind of vague. When a school has a fiduciary, a focus, they do much better and there are a number of schools who do that, Southern Illinois being an example.

A very new model of changing the culture is an osteopathic medical school in Phoenix, the A.T. Still College of Medicine. They now do 1 year on campus for the basic sciences. They take their class, then for the last 3 years and distribute them to 1 of 11 community

health centers, and they do all their teaching, all of their clinical medicine in a community health center working with local or regional hospitals. That is really breaking the mold; one school doing that.

There are other experiments underway, but we have 10 of our leading universities that don't even have family practice departments that are sort of saying, "That is somebody else's problem."

These issues are core to the economy of this country, the health of this country, and the nature of the physicians that we produce. And I think, in general, medical schools have not taken this as a challenge. There is a great deal that could be done and we could spend the afternoon on it, but that is just a sample of possibilities.

Senator BALDWIN. I don't know if any of our other witnesses would like to comment on this. I am particularly interested in knowing how much do we know about this rather than the anecdotal sharing that we hear?

Professor Reinhardt.

Dr. REINHARDT. The Macy Foundation in 2009, or even later, published a really comprehensive report on this issue, on the whole workforce issue and listed these nonfinancial factors.

One of them is the background of the student. That people from rural areas are more likely to go there from inner city, or people who sort of demonstrate that they are interested in this. And so through the admissions process, you could probably rearrange the classes; no guarantee, but nevertheless, you could go there.

Part of it is, of course, the culture. I have read about that also that one of the Senators mentioned, "You're too smart; you shouldn't go into primary care."

One way, perhaps, to do this is through the graduate medical education support. Most economists don't actually think it is warranted. That actually these residents are cheap labor to a hospital, but you could differentiate and give a teaching hospital more if they develop programs that specifically acculturize students into this. So that the residency is in community centers and that there are first rate faculties who do mentor them.

I think medical schools react very much like everyone else to the money, which is through the direct graduate medical education and indirect at them without really asking much in return.

Senator SANDERS. Thank you, Senator Baldwin.

Senator Murphy.

Senator MURPHY. Thank you very much, Mr. Chairman.

I worry a little bit about our ability to micromanage this problem, and I think a lot of the ideas we are talking about are incredibly important. But whether it is rate setting or loan forgiveness programs, I am sometimes more attracted to ideas that sort of reset the marketplace itself, to give the marketplace more reason to invest in primary care.

One of the themes we have talked about is that this new delivery system that is potentially based on bigger systems of care, accountable care organizations, more physicians working for salary rather than for fee-for-service, may help solve this prestige issue. Because if you are in charge of specialists instead of just referring out to specialists then you feel a little bit better about your work.

But there is probably also a theory that says that if you have more primary care doctors working for organizations rather than working on their own, and you have an ACO that is getting a big bundled payment to take care of a big group of patients, then the ACO is going to actually be incentivized to pay its primary care physicians more. Because that is going to help them manage their costs, and help them keep the delta of whatever they save, and you already see that happening. You see more primary care physicians now going to work for hospitals. At least in Connecticut, you are seeing hospitals starting to buy up primary care groups, and you are starting to see more of them working for salary.

I guess I pose that as the question here, is there a potential that as you shift a delivery system to have more integrated systems of care, more accountable care organizations, that there will be an incentive for the organizations to pay primary care doctors more, separate and aside from decisions that we may make on reimbursement?

Maybe I will put this to the economist first as to what, Dr. Reinhardt, what you think ultimately the shift in delivery system may mean for the kind of rates that primary care doctors get paid?

Dr. REINHARDT. Well, the great hope is that it will do exactly that, that a bundled payment, ideally there should be capitation for chronic or bundled payment for episodic care. That somebody is in charge of managing the money from that bundle, and will realize that having a heavy component of primary care is cost minimizing, and therefore profitable in that way.

I once talked to a group, North Texas Medical Group, and they were an integrated IPA, connected with a computer, who took risks. The hospital piece was done by Pacific Health Care and they did the medical piece; I think also the drugs. They told me, they had already tilted the fee schedule internally of primary care substantially and paid the specialists less because they were at-risk for a capitation that they got.

It might be worth it to talk to them. They are now, actually, an ACO. They were one of the first pioneer ACO's. It might be interesting to talk to them or invite them to tell you what they experienced.

Senator MURPHY. Dr. Wilper, you expressed skepticism based on the literature as to the cost savings medical home models may provide. ACO's are a little bit different.

What do we know about the ability for ACO's with perhaps primary care specialists, primary care doctors, elevated to get cost savings that maybe we have not seen in some of the early rollouts of medical home models?

Dr. WILPER. To my knowledge we know, actually, very little about how ACO's will reduce costs or what their effects on costs will be.

What we could look to is the model of care where I practice, which is in the VA, which is sort of the ultimate integrated care model, right. We have people for life after they return from service and do a very good job taking care of them. It is my understanding, although I do not know this literature in its entirety, that we provide care that is of similar or better quality to most private institutions in the United Stats at costs that are much lower.

Senator MURPHY. One final question to you, Dr. Wilper. You've got a provocative statement at the end of your testimony about the interests that the AMA may be serving here. Can you elaborate a little bit on that?

Dr. WILPER. Happy to, thank you.

My personal position on this is that this subcommittee of the AMA wields inordinate power over physician rate setting, and I know we are trying to get away from remuneration, but the Federal Government is sending a very clear price signal to students about what they want them, what the Federal Government would like them to practice in. And I think to minimize that is a little bit dangerous.

My personal view is that physician groups treat public payers as though they were their own entitlement programs rather than a source of coverage for the U.S. population.

Senator SANDERS. Thank you, Senator Murphy.

Senator Casey.

Senator CASEY. Thank you, Mr. Chairman.

I have two questions. One would be more specific, and the second is more broad-based for the whole panel. We appreciate your testimony here today.

The specific question—and I will direct it to Dr. Mullan and Dr. Fegan or anyone in between who wants to comment on this—relates to health care as it relates to children. Our child advocates always remind us that in the context of health care and otherwise, children are not small adults. They are different. We have to treat them differently and have strategies that recognize that reality.

When we were going through the debate about health care in this committee in the summer of 2009, Senator Dodd and I worked together, and he was really the lead on this, to design elements in the bill that would speak directly to that reality.

We had one, in particular, that spoke to the workforce. I am looking at section 5203, Health Care Workforce Loan Repayment Programs, "Establishing a loan repayment program for pediatric subspecialists and providers of mental and behavioral health services to children and adults who will be working in health professional shortage areas," and it goes on from there. But that was our intent. We were successful in that.

But I am wondering, now that we are beyond just the theoretical stage, and we have a piece of legislation which is in place and continuing to be implemented in this broader topic of primary care, are there steps we need to take to make sure that that primary care physician, and the services and treatments that come with it, are available for children?

Doctor, I don't know if you have a thought about that.

Dr. MULLAN. Thank you, Senator Casey.

Your observations about children are, of course, on point. Children are more vulnerable, they are poorer, and they are more underserved than the rest of the population as a matter of analysis of the benefits that come to children. We are definitely weighted toward the elderly in terms of benefits, public benefits, and that creates a challenge, particularly with the ACA principles of trying to be inclusive and bring kids in.

I think we are all optimistic that, particularly with the Medicaid expansion where it occurs, kids will get good benefits or better benefits than they have in the past.

The specific issues in pediatrics, generally the notion of primary care does not include subspecialties. I think probably the correct notion is underserved or under-populated disciplines, which primary care is the heart of it, but there are some others. General surgery, for instance, we have a growing trend of shortage.

Pediatric subspecialties, the argument is made and I do not know the arguments well, but they have been pretty well substantiated that there is not the tendency of pediatricians to subspecialize. There aren't as many training programs, and we probably do need more. So the spirit of the legislation that was encouraging that, makes sense in terms of workforce development.

I would not want to see the profile where well over two-thirds of adult internists are specializing and going into hospital medicine. Hospitalists, which is a good development, but it takes them out of the primary care field. So there is that challenge.

By and large, though, pediatrics has had a good market. Medical students like it. They tend to go into it in good numbers. So pediatrics overall is not short, but some of the subspecialties are.

Senator CASEY. Doctor, from the vantage point of Chicago and the pediatric workforce.

Dr. FEGAN. The issue of pediatric specialists, it is because pediatrics tends to be a loss leader for hospitals. So the number of specialists that are pediatric specialists that are available at general hospitals is very low.

In Chicago, we actually have, I would say, a glut of pediatric hospitals and so the specialists are generally available. But I know that in a more rural community, this is a tremendous challenge in terms of providing access for those children, complicated children who need multidiscipline support. Providing those services for them is increasingly difficult today and encouraging people not only to the specialties, not that they are underrepresented, but they are poorly distributed in terms of where the areas of need are for that.

Senator CASEY. I will hold my second question, but anyone in the 15 seconds we have want to comment on this question or not?

Senator SANDERS. Thank you, Senator Casey.

Let me conclude by thanking all of the Senators who participated in this hearing. I think the large turnout tells you how seriously many of us feel about this issue.

Most importantly, I want to thank all of our panelists for their wonderful testimony and to tell you that we are going to listen very seriously to what you had to tell us. And I especially want to thank those who came from such far distances, Ms. Decklever and Dr. Wilper, but thank you all very much for your help.

This hearing is adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP)

The American Academy of Family Physicians (AAFP), which represents 105,300 family physicians and medical students, is pleased to submit the following statement for the record of the Health, Education, Labor, and Pensions Committee's subcommittee hearing entitled, "30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care?"

According to the Institute of Medicine, primary care is defined as:

> The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

Unfortunately, our current health care system is not consistent with this definition. Instead, the system is fragmented, uncoordinated, wasteful and expensive.

Every day, family physicians and other primary care doctors see the results of our poorly functioning system of care. Duplicative and unnecessary tests are ordered. Diseases remain undiagnosed and untreated until they result in acute conditions. Patients with multiple chronic illnesses are shunted from one specialist to another, each one of whom treats only one of the diseases. And far too little attention is paid to prevention and wellness services.

That is why the AAFP consistently has supported efforts to increase the role of primary care physicians in the delivery of health care. Primary care provides high-quality, coordinated, cost-effective care to patients employing a whole-person approach.

As such, efficient and effective health systems result when primary care physicians are the usual source of care for people. Family physicians and other primary care physicians can help patients prevent disease by improving their healthy behavior. They can aid them in managing their chronic diseases, especially when the patient has more than one chronic illness, and refer to a subspecialist, when necessary. And family physicians and other primary care physicians can help patients navigate the complex world of hospitals and other health institutions.

Health delivery reform requires considering how our dysfunctional health care system can become one that serves the patient by coordinating care over time to prevent disease, managing chronic conditions and providing immediate and targeted care for an acute condition when it arises.

Consequently, the availability of an adequate primary-care physician workforce is essential to achieving these aims. Unfortunately, this workforce is stagnant, if not dwindling, which raises significant concerns about the viability of the Nation's health care system.

The Commission on Graduate Medical Education (COGME) in its 20th report (December 2010) offered specific recommendations and goals for building an adequate primary-care physician workforce.

COGME cited compelling evidence that health care outcomes and costs in the United States are strongly linked to the availability of primary care physicians. For each incremental primary care physician (PCP), there are 1.44 fewer deaths per 10,000 persons. Patients with a regular primary care physician have lower overall health care costs than those without one.

As a result of a number of factors including compensation, practice environments, and experience in medical school, there is a shortage in the number of primary care physicians, particularly those with the ability to care for adults and their associated chronic disease burden. This shortage is especially critical now in the context of health care reform objectives that will increase the need for primary care physicians. As a result of passage of the *Patient Protection and Affordable Care Act* (ACA), as many as 32 million previously uninsured Americans will be eligible for coverage. Such an influx of previously uninsured and likely underserved individuals will undoubtedly increase the demand for primary care services nationwide.

At the present time, 32 percent of physicians in the United States are primary care providers, of which 12.7 percent are family physicians, 10.9 percent general internists, 6.8 percent general pediatricians, and 1.6 percent in general practice. The current U.S. primary-care physician workforce is in jeopardy of accelerated decline because of decreased production and accelerated attrition. Decreased production from graduate medical education is a reflection of the choices made by young physicians and by teaching hospitals that are associated with a growing income disparity between primary care physicians and other specialties. Over the last several years, a variety of policies have been adopted to reduce this disparity and the new *Afford-*

able Care Act takes steps to reduce it even further. Decreased medical student interest in primary care is caused by multiple factors including heavy workload, insufficient reimbursement, the subtle persuasion in medical school away from primary care, and a lack of strong primary care role models.

Attrition also will be augmented as the primary-care physician workforce continues to age. At the present, there are 242,500 primary care physicians in the United States and almost one quarter (55,000) are age 56 or older. The likelihood is that many of these physicians will retire within the next decade.

The AAFP believes policies and programs should be implemented to support the practice of primary care, and to increase the supply of primary care physicians. Fee-for-service payment for physician services is biased in favor of hospital-based and procedural services and does not provide appropriate incentives for the practice of primary care, or to increase the supply of primary care physicians. Policy changes should be dramatic to remedy these legacy biases and have immediate effect.

Specifically, policies should be implemented that raise the percentage of primary care physicians (i.e., family physicians, general internists, and general pediatricians) among all physicians to *at least* 40 percent from the current level of 32 percent, a percentage that is actively declining at the present time. The achievement of this goal should be measured by assessing physician specialty once in practice, rather than at the start of postgraduate medical training.

In order to achieve the desired ratio of practicing primary care physicians, the average income of these physicians must achieve at least 70 percent of the median income of all other physicians. Currently this average is in the 50 percent range. If primary care physicians are paid differently and better, in the context of the physician-led Patient Centered Medical Home, costs should decline. Investment in primary care office practice infrastructure will also be needed to cope with the increasing burdens of chronic care and to provide comprehensive, coordinated care. Payment policies should be modified to support both of these goals.

Accordingly, Congress, CMS, and private insurers should embrace reimbursement mechanisms that enhance primary care physician income including:

1. Preferential increases in fee-for-service payments for primary care services.
2. Support for coordination in primary care practices through per-member, per-month care management fees.
3. Financial rewards for improvements in performance measures.
4. Reward the Patient-Centered Medical Home (PCMH) financially when its physicians meet the four essential functions (first contact access, patient-focused care over time, comprehensive care, and coordinated care) and the three corollary functions (family orientation, community orientation, and cultural competency) and when measures of process and quality are met and improved. The physician-led PCMH should be supported as the construct for the practice environment that achieves optimal care coordination and integration, for use of health information technology, for enhanced access, and for appropriate payment. Study levels of funding necessary to sustain the physician-led PCMH model and its impact on costs in settings other than physicians' offices.
5. Implement payment models that bundle payments for full-service accountable care organizations and incentivize the development of community health care organizations that provide the four essential functions of primary care through collaboration of primary care physicians, public health, care coordination organizations, and mental health organizations.

Medical schools and academic health centers should develop an accountable mission statement and measures of social responsibility to improve the health of all Americans. This includes strategically focusing and changing the processes of medical student and resident selection and altering the design of educational environments to foster a physician workforce of at least 40 percent primary care physicians and a health system that meets societal needs.

In order to accomplish the transformation of the educational environment, medical schools and academic health centers should:

1. Increase and sustain the involvement of primary care physicians through all levels of medical training;
2. Support student primary care interest groups;
3. Recruit, develop, and support community physician faculty members; and
4. Require student participation in rural, underserved, and global health experiences.
5. Expand medical school class size strategically to address the primary care physician deficit and maldistribution issues.

6. Reform admission processes to increase the number of qualified students more likely to choose a primary care specialty and to serve medically vulnerable populations.
7. Recruit and retain underrepresented minority students and faculty members.
8. Require block and longitudinal experiences of sufficient length that medical students clearly understand the essential functions of primary care and the medical home.
9. Collaborate with local communities and distribute resident training accordingly, support reductions in physician income disparities, and lead in the development of new models of practice like the physician-led PCMH.

The Federal and State Government contributions to this effort would include:

1. Providing increased incentives for physicians who practice primary care or other critical specialties in designated health workforce shortage areas.
2. Substantially enhancing funding for scholarships, loans, loan repayment, and tuition waiver programs to lower financial obligations for students who plan and pursue careers in primary care.

Graduate Medical Education (GME) payment and accreditation policies and a significantly expanded title VII program should also support the goal of producing a physician workforce that is at least 40 percent primary care.
To accomplish this objective, Congress, the Administration, Department of Health and Human Services, and accrediting agencies should:

1. Change regulations to support more training in outpatient settings and experimentation with practice models to prepare residents appropriately for an evolving contemporary health care environment;
2. Strategically increase the number of new primary care GME positions and programs to accommodate the increased production of medical school graduates and respond to the need for a workforce composed of at least 40 percent primary care physicians;
3. Increase training in ambulatory, community, and medically underserved sites by promoting collaboration between academic programs and Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), and the National Health Service Corps (NHSC);
4. Implement new methods of funding to include GME funding that is not calculated according to Medicare beneficiary bed-days, and substantial expansion of title VII funding specifically for community-based training;
5. Provide financial incentives for GME that directs funding to primary care residency programs, educational consortia, or non-hospital community agencies to provide the proper incentives for ambulatory and community-based training;
6. Explore augmenting payments for primary care residents, including differentially higher salaries and early loan repayments, to decrease the negative impact of educational debt on primary care specialty choice;
7. Fund all primary care residency programs at least at the 95th percentile level of funding for all programs (using total direct medical education (DME) and indirect medical education (IME) payments as a basis); and
8. Reward teaching hospitals, training programs, and community agencies financially on the basis of the number of primary care physicians produced, to be determined by specialty *in practice* and not at the initiation of training.

Last, to enable policy development predicated on data and to address geographic and socioeconomic maldistribution of physician supply, Congress and the Administration should:

1. Ensure funding for the Healthcare Workforce Commission included in ACA;
2. Ensure funding of the National Health Service Corps at the $1.15 billion amount authorized by the ACA so that the NHSC can recruit more primary care physicians, provide greater support of scholarship recipients, create special learning opportunities and networks for scholarship recipients and early loan repayers, and forge formal affiliations with academic institutions and training programs;
3. Increase substantially the funding for Title VII, section 747, in Primary Care Medicine and Dentistry cluster grants;
4. Implement programs to increase funding by the Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), and private research enterprises for projects that stimulate primary care and community-based research and emphasize methodologies such as population-based ecological and cluster studies, qualitative behavioral studies, and comparative effectiveness research; and
5. Increase funding for Community Health Centers (CHCs) that are committed to training students and residents; and increase funding for Area Health Education Centers (AHEC) programs to improve existing programs, support new programs,

and support innovative funding proposals that promote the practice of primary care in medically underserved areas.

The AAFP appreciates the opportunity to provide family medicine's views on the importance of an adequate primary-care physician workforce in the development of an efficient and effective U.S. health delivery system. In particular, we agree with the evidence that suggests that health system reform can be successful only if it is built on a base of primary care physicians. To this end, we recommend:

1. Elimination of the flawed sustainable growth formula in the Medicare physician fee schedule and support alternative delivery systems including the physician-led patient-centered medical home;
2. Full funding for the National Physician Workforce commission, title VII and the National Health Service Commission;
3. Increased availability of scholarships and loan repayment for medical students choosing to practice as primary care physicians; and
4. Support for innovation in graduate medical education funding, including allowing GME dollars to "follow the resident" and reimbursement for residency sponsoring entities other than hospitals.

Thank you for the opportunity to provide recommendations on this critical topic.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS (AAPA)

SUMMARY

Physician assistants (PAs) are one of three healthcare professions providing primary medical care in the United States today, and are an integral part of the solution to healthcare workforce shortages.

- In 2010, over 300 million patient visits were made to physician assistants.
- PAs practice in virtually every area of medicine. Approximately one-third of all PAs practice in primary care. PA education is based on the primary care model of care, providing greater flexibility for PA practice upon graduation.
- By design, PAs always work with physicians. Team-based, patient-centered medical care is a hallmark of the PA profession and a perfect fit for today's dynamically changing healthcare system.
- PAs serve as medical directors in rural health clinics, community health centers, and other federally qualified health centers. In rural and other medically underserved communities, a physician assistant may be the only health care professional available.
- PAs provide first contact, continuous, and comprehensive care for patients throughout the United States. PAs currently manage care for patients in primary care, chronic care, and other areas of medicine.
- Studies show that in a primary care setting, PAs can execute at least 80 percent of the responsibilities of a physician with no diminution of quality and equivalent patient-care satisfaction.
- By virtue of PA education in primary care and the ability of PAs to work in all medical and surgical specialties, PAs expand access to care in medically underserved rural and urban communities.

In addition to the need to produce more primary care physicians and nurses, it is critical that Congress support PA educational programs as they develop strategies for addressing healthcare workforce challenges.

- The Title VII, Public Health Service Act's, Health Professions Program is successful in training health care professionals for practice in medically underserved communities. Funding for PA educational programs through title VII should be a priority.
- The single largest barrier to PA educational programs educating more PAs is a lack of clinical training sites. Attention must be directed to investing in the number of these sites, including loan repayment for preceptors in primary care medical practices and/or the increased use of VA facilities as clinical training sites for PA educational programs.
- Funds must be made available to increase the number of faculty at PA educational programs. Eligible PA students are being turned away because of the lack of faculty and clinical sites.
- Federally supported student loans and increased opportunities through the National Health Service Corps are key to attracting PA students and clinicians to primary care.

• Graduate medical education funding should be used to support the educational preparation of physician assistants in hospitals and outpatient, community-based settings.
• The President's initiative to create a pathway for veterans to PA education is particularly well-suited to support the increased presence of PAs in rural areas. Veterans are disproportionately from rural areas and are well-equipped to return to rural communities and provide quality medical care as PAs. The initiative is a good healthcare workforce development model that warrants ongoing support.

Physician assistants are key to healthcare workforce shortages. However, to be fully utilized and add maximum efficiency of team-based medical care, technical changes must be made to Federal programs to provide full transparency of the medical care (and cost of medical care) provided by PAs. Additionally, current barriers to care that exist in Federal law must be addressed.

• Medicare and Medicaid must be updated to fully enroll PAs.
• The Medicare statute must be amended to allow PAs to order home health and hospice care, as well as to provide hospice care for Medicare beneficiaries.
• The Federal Employee Compensation Act needs to be updated to allow PAs to diagnose and treat Federal employees who are injured on the job.

On behalf of the nearly 90,000 certified physician assistants (PAs) represented by the American Academy of Physician Assistants (AAPA), thank you for the opportunity to submit written testimony for the hearing record of the Senate Subcommittee on Primary Health and Aging, Committee on Health, Education, Labor, and Pensions.

As one of three professions (medicine, nursing, and physician assistants) with a primary role in healthcare delivery, the growth of the physician assistant workforce is an integral part of addressing our Nation's future needs.

The Affordable Care Act has brought unprecedented attention to ensuring the supply of primary healthcare professionals is adequate to address the future needs of patient care. When ACA is fully implemented, up to 32 million currently uninsured patients will have healthcare coverage, requiring an accompanying growth in the healthcare workforce. The Bureau of Labor Statistics projects 39 percent increase in demand for physician assistants from 2008 to 2018.

The PA profession with its generalist education, commitment to team-based practice, and relatively short training is ideally positioned to address both the short-term and long-term needs of the Nation. However, those needs can be met by PAs only if the profession is able to substantially increase the number of graduates over the next 10 years.

PHYSICIAN ASSISTANTS

Physician assistants are licensed health professionals, or in the case of those employed by the Federal Government, credentialed health professionals, who:

• practice medicine in teams with physicians,
• exercise autonomy in medical decisionmaking,
• provide a comprehensive range of diagnostic and therapeutic services, including performing physical exams, taking patient histories, ordering and interpreting laboratory tests, diagnosing and treating illnesses, assisting in surgery, writing prescriptions, and providing patient education and counseling, and
• may also work in educational, research, and administrative settings.

PAs are located in almost all health care settings and in every medical and surgical specialty. PAs are covered providers within Medicare, Medicaid, Tri-Care, and most private insurance plans. Additionally, PAs are employed by the Federal Government to provide medical care, including the Department of Defense, the Department of Veterans Affairs, the Public and Indian Health Services, the State Department, and the Peace Corps.

AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

The AAPA represents PAs throughout the United States, and is the only national organization representing PAs in all medical specialties. The mission of the Academy is to promote quality, cost-effective, accessible health care, and to promote the professional and personal development of physician assistants. The Academy assures competency of PAs through active involvement in the development of educational curricula and accreditation of PA programs, provides continuing medical

education, conducts PA-related research, and educates the general public about the PA profession.

OVERVIEW OF PHYSICIAN ASSISTANT EDUCATION

The PA educational program is modeled on the medical school curriculum, a combination of classroom and clinical instruction. The PA course is rigorous and intense. The average length of a PA education program is 27 months.

Admission to PA school is highly competitive. Applicants to PA programs must have completed at least 2 years of college courses in basic science and behavioral science as prerequisites, analogous to premedical studies required of medical students.

PA programs are located at schools of medicine or health sciences, universities, teaching hospitals, and the Armed Services. All PA educational programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant, an organization composed of representatives from national physician groups and PAs.

The first phase of the program consists of intensive classroom and laboratory study, providing students with an in-depth understanding of the medical sciences. More than 400 hours in classroom and laboratory instruction are devoted to the basic sciences, with over 70 hours in pharmacology, more than 149 hours in behavioral sciences, and more than 535 hours of clinical medicine.

The second year of PA education consists of clinical rotations. On average, students devote more than 2,000 hours or 50–55 weeks to clinical education, divided between primary care medicine and various specialties, including family medicine, internal medicine, pediatrics, obstetrics and gynecology, surgery and surgical specialties, internal medicine subspecialties, emergency medicine, and psychiatry. During clinical rotations, PA students work directly under the supervision of physician preceptors, participating in the full range of patient care activities, including patient assessment and diagnosis, development of treatment plans, patient education, and counseling.

After graduation from an accredited PA program, the physician assistant must pass a national certifying examination jointly developed by the National Board of Medical Examiners and the independent National Commission on Certification of Physician Assistants. To maintain certification, PAs must log 100 continuing medical education credits over a 2-year cycle and reregister every 2 years. Also to maintain certification, PAs must take a recertification exam every 6 years.

The majority of PA educational programs offer master's degrees, and the overwhelming majority of recent graduates hold a master's degree.

TITLE VII SUPPORT OF PA EDUCATION PROGRAMS

The title VII support for PA educational programs is the only Federal funding available, on a competitive application basis, to PA programs.

Targeted Federal support for PA educational programs is authorized through section 747 of the Public Health Service Act. The funds are used to encourage PA students, upon graduation, to practice in underserved communities. These goals are accomplished by funding PA education programs that have a demonstrated track record of: placing PA students in health professional shortage areas; exposing PA students to medically underserved communities during the clinical rotation portion of their training; and recruiting and retaining students who are indigenous to communities with unmet health care needs.

The Title VII program works.

• A review of PA graduates from 1990–2009 demonstrates that PAs who have graduated from PA educational programs supported by title VII are 67 percent more likely to be from underrepresented minority populations and 47 percent more likely to work in a rural health clinic than graduates of programs that were not supported by title VII.

• A study by the UCSF Center for California Health Workforce Studies found a strong association between physician assistants exposed to title VII during their PA educational preparation and those who ever reported working in a federally qualified health center or other community health center.

The PA programs' success in recruiting underrepresented minority and disadvantaged students is linked to their ability to creatively use title VII funds to enhance existing educational programs. Without title VII funding, many special PA training initiatives would be eliminated. Institutional budgets and student tuition fees are not sufficient to meet the special, unmet needs of medically underserved areas or disadvantaged students. The need is very real, and title VII is critical in leveraging innovations in PA training.

NEED FOR INCREASED TARGETED SUPPORT FOR PA EDUCATION

Federal support must be directed to PA educational programs to stimulate growth in the PA profession to meet the needs of universal health care coverage. Targeted funding should be directed to:

- The use of title VII funds for recruitment and loan repayment for faculty in PA educational programs.
- Incentives to increase clinical training sites for PA education.
- Federally backed loans and loan repayment programs for PA students.
- Graduate Medical Education support for the education of PAs in hospitals and community-based settings.
- Expansion of the President's initiative to create a pathway for veterans to PA educational programs.

ELIMINATING BARRIERS TO CARE IN FEDERAL LAW

Eliminating current barriers to medical care provided by PAs that exist in the Medicare, Medicaid, and the Federal Employees Compensation Act (FECA) laws would do much to expand access to needed medical care, particularly for patients living in rural and other medically underserved areas.

- AAPA believes that the intent of the 1997 Balanced Budget Act was to cover all physician services provided by PAs at a uniform rate. However, PAs are still not allowed to order home health, or hospice care, or provide the hospice benefit for Medicare beneficiaries. At best, this creates a misuse of the patient's physician's, and PA's time to find a physician signature for an order or form. At worst, it causes delayed access to care and inappropriate more costly utilization of care, such as longer stays in hospitals. For patients at end-of-life, it creates an unconscionable disruption of care. (*A 2009 report by the Lewin Group estimates an overall cost savings through implementation of the PA Medicare provisions*.)
- Most States recognize services provided by PAs in their Medicaid Programs, but it is not required by law. Consequently, some State Medicaid Directors pick and choose which services provided by PAs they will cover. Others impose coverage limitations not required by State law, such as direct supervision by a physician.
- Although nearly all State workers' compensation programs recognize the ability of PAs to diagnose and treat State employees who are injured on the job, the Federal program does not. As a result, Federal workers who are injured on the job may be rerouted to emergency rooms for workers' compensation-related care, rather than to go to a practice where the PA is the only available health care professional.

The Medicare, Medicaid, and FECA statutes create Federal barriers to care that do not exist in State law. The barriers need to be eliminated to promote increased access to the quality, affordable medical care provided by PAs and to add efficiency to team-based care.

NEED FOR TRANSPARENCY IN THE MEDICARE CARE AND REIMBURSEMENT FOR CARE PROVIDED BY PAS

PAs contribute a unique role as part of medical teams in virtually all medical specialties and health care systems. However, the contribution of PAs and the physician-PA team are rarely captured in reporting systems. The AAPA strongly encourages Congress to encourage the development of patient-centered comparative effectiveness research to require that all public and private health care reporting systems identify medical services and payment for medical services provided by PAs. The Academy believes that a requirement of data systems to track medical care provided by PAs is essential to track the clinical and economic performance of PAs for issues related to cost-effectiveness, quality, and outcomes research; practice patterns; and to determine the volume of patient care services delivered for workforce projections.

To encourage transparency, as well as increased accountability for medical care provided by PAs, AAPA recommends that:

- PAs be fully enrolled in Medicare by amending the Medicare statute to update payment services provided by PAs to allow for payment to the PA, just as payment is allowed for virtually every other healthcare professional recognized by Medicare;
- All State Medicaid programs enroll PAs, as opposed to reimbursing medical care provided by PAs through the physician; and
- The Medicare claims system be modified to require the identification of PA delivered services.

A baseline for medical care provided by PAs will be increasingly important as the healthcare delivery system moves toward a model that relies more on team-based delivery of care in order to better evaluate the cost-effectiveness of team-based care.

Thank you for the opportunity to submit a statement for the hearing record of *30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care*?

AMERICAN ASSOCIATION COLLEGES OF OSTEOPATHIC MEDICINE (AACOM®)

The American Association of Colleges of Osteopathic Medicine (AACOM®) is pleased to submit this statement for the record to the U.S. Senate Health, Education, Labor, and Pensions (HELP) Subcommittee on Primary Health and Aging for the January 29, 2013 hearing, "30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care?" AACOM® commends subcommittee Chairman Bernard Sanders for convening this hearing on this extremely important issue.

AACOM® represents the Nation's 29 colleges of osteopathic medicine at 37 locations in 28 States. Today, more than 21,000 students are enrolled in osteopathic medical schools. One in five U.S. medical students is training to become an osteopathic physician. AACOM® was founded in 1898 to support and assist the Nation's osteopathic medical schools, and to serve as a unifying voice for osteopathic medical education.

OSTEOPATHIC MEDICAL EDUCATION AND PRIMARY CARE

Osteopathic medical education (OME) has a long history of establishing educational programs for medical students and residents that target the health care needs of rural and underserved populations. Colleges of osteopathic medicine (COMs) have a standing commitment and focus on training primary care physicians, and osteopathic physicians have a special commitment to providing primary care, particularly to the Nation's rural and underserved communities. All osteopathic medical schools provide training in community-based settings, where students spend time in community hospitals, physician offices, and health care facilities such as Area Health Education Centers (AHECs) and Community Health Centers (CHCs) in which they are integrated into those communities. The majority of osteopathic medical schools are located outside of urban areas and have particular missions related to the underserved areas in which they are located.

OME plays an extremely strong role in training future primary care physicians—many of whom will serve in workforce shortage areas. In each of the last three cohorts of osteopathic medical school graduates (2010–12), 32 percent of graduates indicated the intention to specialize in the primary care specialties of family practice, general internal medicine, and general pediatrics. For each year, an additional 11 to 12 percent planned to specialize in emergency medicine, and 5 percent in obstetrics and gynecology. From these same three classes, one-third of graduates indicated plans to practice in areas that are designated health care underserved/physician shortage areas.

AACOM® strongly believes that primary care should be an essential part of any foundation of a modern health care system. Any proposal that would displace physicians from this role would disrupt the health care delivery system and create obstacles to the development of the integrated, team-based system needed to maximize value, access, and quality. A medical education system that produces the kind of primary care physicians that are needed to work in a value-driven health care system should be a strong goal of medical education.

PHYSICIAN WORKFORCE

There are nearly 70,000 active osteopathic physicians (DOs) practicing in the United States today, including those currently in graduate medical education (GME) (or internships, residencies, and fellowships). Of osteopathic physicians who have completed GME, 56 percent are practicing in the primary care specialties of family and general practice, pediatrics and adolescent medicine, and general internal medicine (*http://www.osteopathic.org/inside-aoa/about/aoa-annual-statistics/Documents/2012-OMP-report.pdf*).

Currently, more than 20 percent of new U.S. medical students are training to be osteopathic physicians. By 2019, that number is expected to grow to 25 percent. Many current osteopathic medical students will pursue careers in primary care and many will practice in rural and underserved areas; these are areas that already face shortages of primary care providers.

AACOM® believes that GME funding should be more closely associated with specific workforce needs. With rising projections of physician shortages to meet the

health care needs of a growing and aging population, AACOM® supports the sustainable expansion of GME positions in areas of specialty need (e.g., primary care, geriatrics, general surgery) in which there are substantial current demand and anticipated growing shortages—especially in rural and underserved areas. AACOM® believes that GME funding is critical to ensuring the stability and continuity of both the Nation's medical residency training programs that produce future physicians and the hospitals that provide care to the Nation's citizens.

GRADUATE MEDICAL EDUCATION SUPPORTS PHYSICIAN WORKFORCE SHORTAGES

The current number of GME positions funded by the Centers for Medicare & Medicaid Services (CMS) will not be sufficient to accommodate the number of medical school graduates seeking positions or the number of positions needed to offset projected physician workforce shortages; there is growing evidence of the need for community-based medical education to produce an outcome that will address the need for a primary care-based health care system that provides access and value to populations in rural and underserved areas, as well as to those areas traditionally well-served. Since osteopathic medical students who train in community-based institutions are more likely to practice in these areas, AACOM® continues to support GME programs that expand the participation of community-based institutions. This is particularly important at a time when the number of osteopathic medical school graduates is growing and is expected to continue to grow in response to physician workforce shortages that exist and are projected over the next 5 to 15 years.

AACOM® understands the necessity of evaluating the process of and funding mechanism for future physician training, but we also firmly believe Congress must take into consideration the full spectrum of medical education in order to thoroughly understand the complexities of GME as appropriate avenues of reform are explored.

THE ROLE OF INNOVATION IN TRAINING FUTURE PHYSICIANS

AACOM® believes that there are many potential innovative solutions that could address the challenges in the current GME system and recognizes that training needs to support developments leading to a patient-centered, team-based and value-driven system. It is important to note the strong connection between osteopathic medical colleges' training of students, which is patient-centered and geared toward primary care in community-based and non-hospital settings, and osteopathic GME programs, which are tied together through the oversight of an Osteopathic Postdoctoral Training Institution (OPTI). OPTIs are built upon partnerships between one or more teaching hospitals, a medical school, and other medical training facilities. Additionally, osteopathic medical schools are actively pursuing innovative approaches to education with many students participating in interprofessional education for team-based care, as well as utilizing problem- and case-based curricular models.

AACOM® supports the evaluation of Medicare GME funding as it relates to need and supports expanded flexibility of current funding to create an environment in which innovation can occur. Innovation, partnership, and targeting of resources should help address need. The current OME model links the osteopathic medical schools training to the community where their student's learn. For instance, the number and distribution of GME positions should be tied directly to the number and type of positions needed, with an eye to geographic, demographic, and specialty need; the development of more programs should be developed at hospitals that do not fall under the GME cap; osteopathic medical colleges should be enabled to work with their OPTIs on creative development of more GME programs, in association with a variety of institutions and funding mechanisms.

In addition, programs such as the Health Resources and Services Administration's (HRSA) Teaching Health Center GME Program, which provides funds to establish or enlarge primary care residency training programs in community health centers, should continue to expand with stable funding sources beyond those originally provided in the Patient Protection and Affordable Care Act (P.L. 111–148). The HRSA Teaching Health Center GME Program, currently in its third year, has provided a model of innovation that produces primary care physicians in the communities in which they are most needed. While approximately 10 percent of all U.S. GME programs are osteopathic programs, 21 of the 32 Teaching Health Center residencies are osteopathic consortia programs accredited by the American Osteopathic Association (AOA), and three of those programs are dually accredited by both the AOA and the Accreditation Council for Graduate Medical Education (ACGME). Sustainability for programs such as these is critical in addressing physician workforce needs and has the potential to increase the number of primary care physicians that serve the communities most in need.

Thank you again for the opportunity to submit this statement for the record. AACOM® looks forward to working with the subcommittee on supporting quality patient care and a robust physician workforce that will meet the demands of our Nation's complex and evolving health care system.

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES (AAMC)

The Association of American Medical Colleges (AAMC) is pleased to submit this statement to the record for the January 29, 2013, hearing, "30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care?" of the Health, Education, Labor, and Pensions (HELP) Subcommittee on Primary Health and Aging.

AAMC is a not-for-profit association representing all 141 accredited United States and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians.

The AAMC applauds subcommittee Chairman Bernard Sanders, and Senators Mike Enzi and Rand Paul for convening this hearing on a timely and important topic. Five years ago—nearly to the day—the AAMC testified before the committee on this matter at a hearing chaired by Senator Sanders, "Addressing Healthcare Workforce Issues for the Future."

Much has changed in the 5 years that have passed. Enactment of the Affordable Care Act (ACA, P.L. 111–148 and P.L. 111–152) ushered historic reforms that will provide affordable health care coverage to as many as 32 million more Americans; many of these people finally will be able to access regular care for previously untreated health conditions. The first Baby Boomers entered the Medicare program in 2011, and for the next two decades, another 10,000 Americans will turn 65 daily. The Nation's medical schools already have taken the first critical step to address increased demand for physician services expected as the number of Medicare beneficiaries soars and coverage expands under the ACA: 15 new medical schools and 9 new osteopathic medical schools have opened since 2008, with several more planned. In combination with existing medical schools that have expanded enrollment, the number of medical graduates is currently on track to meet by 2016 the goal of a 30 percent increase in enrollment over 2002 levels.

Yet, despite this growing shift in demographics and the response of the medical education community, the central challenge discussed at the 2008 HELP Committee hearing remains a challenge today: the Nation faces a critical shortage of physicians. By 2020, the shortfall will reach 91,500 physicians, and grow to more than 130,000 by 2025. While medical schools have taken action by graduating 30 percent more students, we have not seen a proportionate increase in the number of residency training or graduate medical education (GME) positions. The limited availability of residency positions—the direct result of a cap Congress imposed in 1997, freezing Medicare support for GME at 1996 levels—soon will preclude medical graduates from completing the supervised training required for independent practice. In other words, the best efforts of medical schools to increase the number of matriculates will not curtail the physician shortages unless Congress releases the bottleneck and lifts the Federal cap on residency training support.

Underserved populations in both urban and rural areas will continue to bear the greatest burden of workforce deficits, but extensive shortages across a number of specialties are likely to impede access to care for many Americans. The AAMC projects there will be 45,000 too few primary care physicians by the end of the decade, hindering access to preventive care for millions.

Accordingly, in a 2010 survey of medical school deans, 75 percent (94 of 125 respondents) reported instituting or considering initiatives to encourage primary care.

Less commonly reported, but equally troubling, is the parallel shortage of more than 46,000 specialists, leaving patients with cancer, Alzheimer's disease and dementia, hip fractures, and other ailments without immediate access to necessary care. These trends are of particular concern as the Nation ages and requires specialty care for many age-related illnesses and disabilities.

Some have argued that policymakers should limit the number of specialists, based on a study suggesting that places with more generalists report lower Medicare spending and higher quality. These findings repeatedly have been challenged and invalidated—most recently in a January 2013 Working Paper for the Federal Reserve Board of Governors' Finance and Economics Discussion Series—for neglecting to adjust appropriately for socioeconomic factors. The recent analysis clearly dem-

onstrates that including the rate of uninsured and black in the regression negates the original conclusion correlating workforce composition with health care spending.

Indeed, prioritizing only one component of the workforce will be a futile strategy, as the broad scope of the problem necessitates an equally multi-faceted response. As the subcommittee discusses potential solutions, the AAMC provides the following background principles about graduate medical education and teaching hospitals, and offers policy recommendations to consider in the interest of improving access to care for all patients.

BACKGROUND PRINCIPLES

Medicare Supports GME to Ensure Access to Physicians and to Highly Specialized Services for Medicare Beneficiaries

Physician training is inextricable from patient care, and Medicare historically has paid for its share of the costs of training and the highly sophisticated health services provided by teaching hospitals. Medicare reimburses teaching hospitals for a portion of these costs through two types of payments: Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments.

DGME payments are intended to offset the direct costs of GME, such as resident stipends and benefits; supervising faculty salaries and benefits; and allocated institutional overhead costs. These payments are tied directly to a program's "Medicare share," an institution-specific amount that reflects Medicare volume as a percent of patient care days at the institution. According to fiscal year 2009 Medicare cost reports (*www.HealthData.gov*), Medicare DGME payments reimbursed *less than one quarter of the total direct costs* teaching hospitals incurred in fiscal year 2009. The training costs above Medicare's share are borne primarily by the program itself.

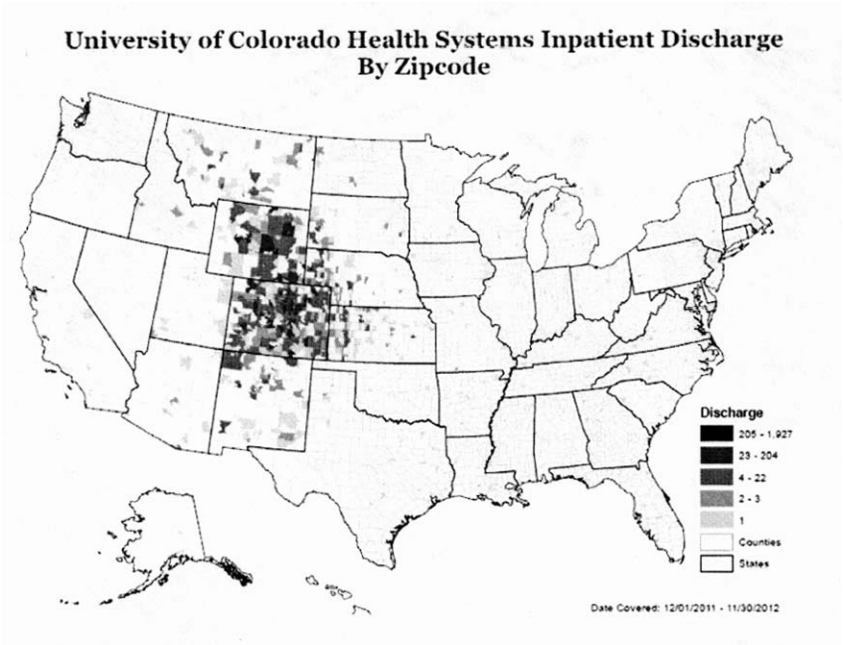
Medicare DGME payments are not limited to teaching hospitals; currently, community health centers and other teaching settings are eligible for DGME payments that, like teaching hospitals, are calculated based on the facility's Medicare share. Congress repeatedly has clarified that Medicare GME support should remain tied to the level of Medicare services provided, rather than diverting limited Medicare funds to providers that do not treat a substantial number of Medicare beneficiaries.

Medicare IME payments, on the other hand, are *patient care payments* that recognize the additional costs incurred by teaching hospitals because they maintain specialized services and treat the most complex, acutely ill patients. As stated in House and Senate report language when Congress created the IME adjustment as part of Medicare's Prospective Payment System (PPS) in 1983:

> This adjustment is provided in light of doubts . . . about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . . The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (House Ways & Means Committee Rept. No. 98–25, March 4, 1983, and Senate Finance Committee Rept. No. 98–23, March 11, 1983)

For example, AAMC-member teaching hospitals operate 80 percent of Level 1 Trauma centers and provide a range of highly sophisticated services not offered elsewhere in communities. IME payments are meant to partially offset these costs. Providers that do not incur the unique patient care costs associated with caring for highly complex, severely ill inpatients (i.e., ambulatory sites that largely provide primary, non-acute care) do not qualify for these payments.

The specialized services supported in part by IME payments extend far beyond the locale of the recipient institution. Rather, in many cases, major teaching hospitals provide life-saving care to the entire region. Consider, for example, inpatient discharges for the University of Colorado Health Systems. As depicted in the map below, patients across the State of Wyoming, regions of Montana, New Mexico, and several other States beyond Colorado rely on services offered by the University of Colorado Health Systems.



Major Teaching Hospitals Offer A Comprehensive Range of Unique Services to All Patients

As described above, AAMC-member teaching hospitals maintain the vast majority of the country's critical standby units. In addition to the trauma centers, AAMC members operate: 79 percent of all burn care units; 40 percent of neonatal- and 61 percent of pediatric-ICUs; nearly half of the surgical transplant services; over one-fifth of all cardiac surgery services; and 44 percent of Alzheimer centers. These institutions provide over one-third of all hospital charity care. Compared with physician offices and other hospitals, major teaching hospitals care for patients that are sicker, poorer, and more likely to be disabled or non-white.

At nearly half of academic medical centers, the majority of Medicare visits are provided in hospital-based clinics. Hospital Outpatient Departments (HOPDs) serve as a safety net for vulnerable populations, offering both primary care, and comprehensive and coordinated care settings for patients with chronic or complex conditions. Examples include access to pain centers, cancer clinics, or psychiatric care, as well as wrap-around services, such as translation and community-based services.

Academic medical centers also serve as vital partners to community-based facilities. A 2010 study described the barriers that community health centers (CHCs), which primarily provide primary care services, face in securing specialty care for patients; 91 percent reported difficulties in finding offsite specialists for uninsured patients, 71 percent for Medicaid patients, and 49 percent for Medicare patients, though hospital affiliations eased the difficulty in some cases. These findings suggest a major obstacle in ensuring timely treatment, as an October 2007 study in *Health Affairs* reported that 25 percent of visits to CHCs result in "medically necessary referrals for services not provided by the center." The *Health Affairs* study describes that those CHCs affiliated with medical schools or hospitals report better access to specialty services, and notes:

> "If policymakers plan to extend access to primary care for the uninsured by increasing the number of CHCs, they must also address the problem of access to secondary and tertiary levels of care."

With major teaching hospitals treating a substantial and growing percentage of Medicaid and/or financially disadvantaged patients, the studies reinforce the importance of a comprehensive approach to resolving access issues, rather than growing the capabilities of one type of facility or specialty at the expense of others.

Teaching Hospitals Are Leading Innovative Efforts to Improve Care Quality and Efficiency

The current caps on physician training were imposed at a time when most researchers predicted that the delivery system would change rapidly and drastically under the influence of tightly managed care. Today, the health care delivery system is in a time of significant transformation with numerous Federal, State, and private efforts under way to improve coordination and quality of care, increase access, and reduce cost—which may have a significant impact on demand for physician services.

Major teaching hospitals are at the forefront of many of these innovations in care delivery. AAMC member institutions account for less than 6 percent of all hospitals but constitute a much larger percentage of participants in reforms sponsored by the Centers for Medicare and Medicaid Services (CMS). For example, AAMC members make up 44 percent of Health Care Innovation Award grantees; 34 percent of the Innovation Advisors Program; 18 percent of all CMS Accountable Care Organizations (ACOs); 38 percent of Pioneer ACOs; and 17 percent of Medicare Shared Savings Program participants.

Similarly, AAMC medical schools and teaching hospitals are innovating to prepare the next generation of health professionals for practice in a new delivery system. For example, AAMC has partnered with other health education associations through the Interprofessional Education Collaborative (IPEC) to focus on better integrating and coordinating the education of physicians, nurses, pharmacists, dentists, public health professionals, and other members of the patient health care team to provide more collaborative and team-based care.

It is too early to know the short-or long-term effect these nascent efforts will have on our future workforce needs, but these changes will take years to come to fruition. In the interim, it would be irresponsible to ignore the Nation's expanding health care needs. As demonstrated in Massachusetts, expanding insurance coverage leads to an initial increase in utilization of both primary and subspecialty care.

Influencing Specialty Choice: Studies Indicate Debt Plays a Minor Role

Many claim prohibitive debt levels lead medical students to choose careers other than primary care, but surprisingly little evidence supports this assertion. In fact, a thorough review of the academic literature shows little to no connection between debt and specialty choice. Rather, studies show specialty choice is a complex and personal decision involving many factors. According to AAMC's annual survey of graduating medical students, the most important factors are a student's personal interest in a specialty's content and/or level of patient care; desire for the "controllable lifestyle" offered by some specialties; and the influence of a role model in a specialty. Student debt consistently ranks toward the bottom of the list for this question every year.

Further, Federal programs, such as the National Health Service Corps (NHSC), offer incentives to help physicians manage their debt. A January 2013 study in *Academic Medicine* found that,

> "physicians in all specialties, including primary care, can repay the current median level of education debt. At the most extreme borrowing levels . . . options exist to mitigate the economic impact of education debt repayment. These options include an extended repayment term or Federal loan forgiveness/repayment program, such as IBR, PSLF, and the NHSC."

In addition to the NHSC, other programs at the Health Resources and Services Administration (HRSA) have proven successful in guiding students toward a career in primary care and underserved communities. The title VII health professions programs offer support for educational opportunities in these settings. Marking their 50th anniversary in 2013, these programs serve as a catalyst for innovations in education and training, helping the workforce over the years adapt to the Nation's changing workforce needs. Similarly, the Children's Hospitals Graduate Medical Education program provides critical support to strengthen the future primary and specialty care workforce for the Nation's children.

The Teaching Health Center (THC) program is a new HRSA initiative, established in the Affordable Care Act and funded with a mandatory appropriation. The THC program provides payments of $150,000 per resident, per year, to community-based, ambulatory patient care centers that operate primary care residency programs. These payments are being made at a far higher level than Medicare supports teaching hospitals. AAMC continues to support HRSA funding for this new program, given that the agency oversees the Federal health center program, health professions workforce development programs, and other community-based entities. We look forward to studying the outcomes of the initial cohort of THCs, and how continued HRSA funding can sustain the higher payments made to these facilities.

It should also be noted that past attempts to influence specialty selection through Medicare GME payments have failed, leading the Medicare Payment Advisory Commission (MedPAC) to promote other mechanisms, such as clinical reimbursement, NHSC, and title VII programs, instead. Since the mid-1990s, hospitals have received twice the DGME payment for primary care and geriatrics residents as compared to subspecialty fellowships, yet shortages persist. As observed by MedPAC in its November 2003 report on the Impact of Resident Caps on the Supply of Geriatricians, "[f]actors other than Medicare's resident caps may better explain the slow growth in the number of geriatric physicians." The report further notes that:

> "federal policies intended to affect the number, mix, and distribution of the health care workforce should be implemented through specific targeted programs rather than through Medicare."

POLICY RECOMMENDATIONS

Despite the best-implemented health care delivery reforms, the growing and aging Nation will need a larger physician workforce. The United States cannot afford to wait until the physician shortage takes full effect, as the education and training of each physician takes more than a decade. These recommendations are intended to clarify that an adequate supply of physicians must be achieved both through more efficient health care delivery models and by increasing physician training positions. No single approach is sufficient; all of the following are necessary to ensure an adequate supply of physicians:

1. The number of federally supported GME training positions should be increased by at least 4,000 new positions a year to meet the needs of a growing, aging population and to accommodate the additional graduates from accredited medical schools. The medical education community will be accountable and transparent throughout the expansion.

Training an additional 4,000 physicians a year would allow the Nation to increase its expected supply of doctors by approximately 30,000 by the end of the decade—meeting approximately one-third of the expected shortage. This represents an expansion of approximately 15 percent over current training levels, which would provide a sufficient number of positions to accommodate U.S.-educated doctors while allowing for international medical graduates (IMGs) to occupy about 10 percent of training positions. Absent the necessary increases in residency positions, per capita numbers of physicians will continue to fall as the population grows and ages with rising per capita needs.

The AAMC believes that primary care is the foundation of a high-performing health system, but it is equally important to increase the supply of subspecialists in many areas. As patients age, incidence of both chronic and acute conditions rises dramatically; U.S. health care has made great advances in the care of these conditions. Cancer, arthritis, diabetes, and other illnesses of adults will continue to be treatable disorders that require the care of oncologists, surgeons, endocrinologists, and other specialties. Children who previously would have succumbed to their illnesses will survive into adulthood but require decades of followup by primary care, pediatric subspecialists, and adult subspecialists. Meeting these needs cannot be accomplished without increasing the number of residency positions.

2. Current and future targeting of funding for new residency positions should be planned with clear attention to population growth, regional and State-specific needs, and evolving changes in delivery systems. Today, approximately half (2,000) of these additional positions should be targeted to primary care and generalist disciplines; the remainder should be distributed across the dozens of the approximately 140 other specialties that an aging nation relies upon. Attempts to increase physicians in targeted specialties by reducing training of other specialists will impede access to care.

Approximately half (or 13,000) of first-year residency training positions are in family medicine, internal medicine, and pediatrics; while many of these residents will go on to subspecialize, the number of fellowship (or subspecialty) training positions accounts for approximately 20 percent of all available GME slots. Even the largest internal medicine subspecialty, cardiology, trains fewer than 1,000 physicians a year; fewer than 500 oncologists are trained annually. Attempting to force physicians to forgo subspecialty training by limiting fellowship opportunities would have limited effect and, even if successful, would jeopardize timely access to care for patients who require a subspecialist.

Wait times for access to subspecialists continue to grow, necessitating that, in some cases, training capacity must be increased, combined with efforts to more efficiently use subspecialty care. The AAMC believes that the ideal team-based health care delivery and utilization model should efficiently use human resources to im-

prove patient access to appropriate services. For example, some patients managed by specialists can be directed back to primary care providers with management plans for chronic conditions. Other providers in a variety of settings could care for lower acuity patients now treated by physicians. Optimizing utilization will help relieve both the burden on patients seeking to access appropriate health care services and on overwhelmed providers, but will not obviate the need to train more doctors.

Physician shortages will persist even if the Medicare funding caps are lifted today, given the severity of the problem and a likely modest rate of change in the delivery and payment systems. Increasingly, patient access to both primary and specialty care will be a challenge. As health care is better integrated—team care expands and unnecessary variations are reduced—newly insured patients will present in the offices of primary care providers. For many of those patients, primary care providers will need to coordinate the care of subspecialists for complex illnesses. These needs will outstrip the supply of many subspecialties at current levels, even if utilization rates are significantly reduced.

It is unclear how extensive this increase in utilization will be over the course of subsequent years. Therefore, it is imperative to target the current and future increase in federally funded residency positions through ongoing analysis of health care utilization and estimates of future demand, rather than by prescribing a static specialty composition that does not actively respond to a dynamic health care environment.

3. In addition to expanding support for GME, policymakers should leverage clinical reimbursement and other mechanisms to affect geographic distribution of physicians and influence specialty composition.

While the ACA took steps to increase reimbursement to primary care providers, policymakers will need to reimburse cognitive and patient management services in a way that makes these specialties more attractive to new physicians. Similarly, programs like NHSC and title VII have successfully improved distribution of primary care providers to underserved areas, but policymakers must find ways to reward physicians economically who serve geographically or economically underserved communities. Education and training cannot overcome the intense market incentives that influence physician choices.

Recent studies show 31 percent of physicians are not accepting new Medicaid patients. Teaching hospitals and physician faculty are more likely to serve poor and vulnerable populations and will be asked to see more patients for whom reimbursement is less than the cost of providing care. Physicians and other providers must be paid adequately to ensure that patients have access to care.

4. The Federal Government should continue to invest in delivery system research and evidence-based innovations in health care delivery.

Lifting the 15-year freeze in Federal support for physician training by 15 percent only would meet one-third of the expected shortage of physicians by the end of this decade, and is insufficient to ensure access to care. Delivery system innovations that improve efficiency, integrate care, and leverage other health professionals also will be necessary.

The ACA created new opportunities for health care delivery reform at the Federal level and for the States, which are now in the beginning stages of implementation. AAMC institutions and faculty are working with the Federal Government to improve delivery and payment by participating in numerous initiatives. AAMC members are focused on the transformation of health care delivery, including through the Patient-Centered Outcomes Research Institute (PCORI).

AAMC teaching hospital members receive significant public funding for their missions and are willing to be meaningfully accountable for that support. The training of physicians and other health professionals has changed significantly in the last 15 years and is increasingly focused on teaching doctors to improve systems of care. As measures are created, tested, and evaluated, these data will demonstrate the increasing ability of new physicians to work in teams; facilitate system changes to improve population health; and foster continuous quality improvement.

Continued research will inform how providers, systems, and payers can ensure access to care as well as optimal outcomes. Along with the AAMC, the Federal Government should continually assess how these delivery changes affect workforce needs and make the necessary additional investments in training to provide an adequate physician workforce.

Communities in all regions of the country rely on academic medical centers for high-quality medical care, advanced research, job creation, new business development, and education of medical professionals. As the Nation faces an unprecedented demand for health care services, continued support for medical schools and teaching hospitals will be essential.

Thank you again for the opportunity to submit this statement for the record and for your leadership in addressing this important subject. The AAMC looks forward to working with the subcommittee in strengthening access to health care for patients across the country.

PREPARED STATEMENT OF THE SOCIETY OF GENERAL INTERNAL MEDICINE (SGIM)

Mr. Chairman and members of the subcommittee, the Society of General Internal Medicine is pleased to submit this statement for the record associated with the subcommittee's January 29, 2013 hearing, "Primary Care Access—30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care?"

SGIM is comprised of approximately 3,000 general internists who provide patient care and conduct research and educational activities to improve the health of individuals, many of whom suffer from complex, multiple chronic illnesses. Our mission is rooted in the fact that patients who have access to a robust primary care system experience better health care quality and better outcomes at lower costs. For the poor, the uninsured and the elderly, in particular, primary care functions as a safety net by serving as the first, and often their *only* source for medical care and treatment.

Primary care is the backbone of our health care system, but it is under severe strain. Recent studies show that half of adults reported problems obtaining access to care and nearly two-thirds experienced problems with the coordination of their care by providers. Patients often encounter extended waits for primary care services, with one in five adults reporting a delay of 6 days or more to see a physician. Lacking ready access to care, one in five chronically ill adults end up visiting the emergency room for care they could have received from a primary care physician.

With an estimated 30 million newly insured people set to enter the health care market over the next 6 years, the demand for primary care services will skyrocket. The current physician shortage and maldistribution will be aggravated, and quality of care will be threatened.

And unless our national leaders act soon, the situation will only get worse. Within the next 10 years the demand for primary care services in the United States will increase dramatically as 80 million baby boomers age into the Medicare system, as the obesity epidemic continues to grow and as the Affordable Care Act is fully implemented across the United States.

Just as demand is growing dramatically, the supply of primary care clinicians is dwindling, with projections of a shortage of *52,000* primary care physicians by 2025. At the same time, one-third of generalist physicians will retire from medical practice. As a result, by 2016 the number of adult primary care physicians leaving practice will exceed the number who are entering.

What can be done to ensure greater access to primary care? Multiple steps must be taken to right-size primary care.

ALIGN TAXPAYER SUBSIDIES WITH SOCIETAL NEEDS

Medicare is the Nation's single largest funder of graduate medical education (GME), the training that medical school graduates receive as residents in approximately 1,100 of the Nation's teaching hospitals. To help overcome the current shortage of primary care practitioners, Congress should consider policy changes that better align the Medicare GME program with physician workforce needs. These would include:

- Increasing the direct GME per resident payment for trainees in primary care programs;
- Providing bonus payments to hospitals for graduating residents who practice primary care after their training is completed;
- Expanding loan repayment programs for residents who practice primary care;
- Increasing salaries of primary care residents;
- Raising the cap for funded GME positions by 3,000 positions annually for 5 years and allocating at least 80 percent of the new slots for primary care training programs; and
- Teaching hospitals should be encouraged to pursue funding through the CMS's Center for Medicare and Medicaid Innovations to develop innovative models to enhance the training of primary care residents.

Equitable pay during residency could help reduce the financial strain on many residents and enable them to make career and specialty decisions that are not dictated by financial constraints.

REDUCE FINANCIAL BARRIERS

Low reimbursement rates have long threatened patient access to primary care providers and services. While the ACA put in place a modest 10 percent Medicare bonus for primary care services from 2010 through 2015, this is insufficient to appreciably address the workforce shortage as the demand for primary care services increases. A much larger increase that is not time limited is needed to change behavior and increase the supply of primary care physicians. A primary care physician's annual practice income would need to increase by 63 percent, for example, to generate the same lifetime earnings as that of a cardiologist.

In 2008, median income for generalist physicians was 54 percent of that for specialty physicians. This compares to almost 65 percent in the early 1990s, when the compensation gap between generalists and specialists narrowed, and we saw a 12 percent rise in the number of students choosing primary care residencies.

So long as physician reimbursement rates for both existing and new services are so severely skewed toward procedural services, primary care will be undervalued and underinvested. Aligning incentives, especially monetary ones, for current and future physicians with the society's need for more primary care physicians would bring about the desired change more quickly and dependably than will continue to support the existing infrastructure that has contributed to the maldistribution of physicians and shortages in primary care specialties.

Since 1991, the Centers for Medicare and Medicaid Services (CMS) has relied upon the recommendations of the American Medical Association's Relative Value Scale Update Committee (RUC) to determine the relative value units for physician services, including the evaluation and management services billed by primary care providers. Historically, CMS accepts over 90 percent of the RUC's recommendations. While the RUC has recently added primary care members, the vast majority of the 31 person panel is composed as specialists. Given the influence of this committee over payment policy, more must be done to increase primary care membership and the transparency of its proceedings. The Affordable Care Act took the first step at scrutinizing the RUC's work by including a provision to review mis-valued codes, and CMS has awarded a contract to do this work. In 2011, Representative Jim McDermott introduced legislation aimed at the RUC. These were important first steps, but policymakers must further scrutinize the work and composition of the RUC and change current incentives in a fiscally prudent manner.

STRENGTHEN SUPPORT FOR TITLE VII PRIMARY CARE TRAINING AND ENHANCEMENT

Title VII of the Public Health Service Act authorizes the only source of Federal funds for primary care training. In order to meet the growing demands for primary care services, particularly in underserved rural and urban communities, SGIM strongly urges Congress to support the following HRSA programs with a proven track record of increasing the supply of primary care physicians, including:

- $150 million for Training in Primary Care Medicine to support training and improved general competencies of primary care professionals through grants to hospitals, medical schools and other entities;
- $30 million for Centers of Excellence designed to increase the number of minority youth who pursue careers in the health professions;
- $30 million for the Health Careers Opportunity Program (HCOP) to provide students from disadvantaged backgrounds an opportunity to develop the skills needed to successfully compete, enter and graduate from health professions schools; and
- $3 million for the National Health Care Workforce Commission to provide Congress and the executive branch with comprehensive, unbiased recommendations on workforce goals, priorities and policies.

SGIM stands ready to work with the subcommittee as it grapples with these challenges.

Thank you for the opportunity to submit this statement.

THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.,
BETHESDA, MD 20814–1220,
February 11, 2013.

Hon. BERNARD SANDERS, *Chairman*,
Committee on Health, Eduation, Labor, and Pensions,
Subcommittee on Primary Health and Aging,
U.S. Senate,
Washington, DC 20510.

Hon. MICHAEL B. ENZI, *Ranking Member*,
Committee on Health, Eduation, Labor, and Pensions,
Subcommittee on Primary Health and Aging,
U.S. Senate,
Washington, DC 20510.

DEAR CHAIRMAN SANDERS AND RANKING MEMBER ENZI: The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 140,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. We greatly appreciate the recent subcommittee hearing, "30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care?" As the subommittee proceeds in forming recommendations to improve the current healthcare system and promote timely, cohesive, quality healthcare services, AOTA would like to provide a brief explanation of the critical role occupational therapy practitioners can play in primary care settings through promoting wellness, coordinating care, and providing rehabilitative services to individuals throughout the lifespan, thus reducing healthcare costs and promoting a healthier nation.[1]

Occupational Therapy (OT) is a profession dedicated to the improvement and maximization of function and performance—how, when and how well people do the activities or "occupations" important to them—so that people can live healthier, more productive and satisfying lives. People define health in many ways but it is beyond being disease-free. When people describe "healthy" it usually involves being able to DO things: to work and care for oneself despite conditions or age, being interested in the world, having energy and vitality. All of this involves performance of activities of daily life which ultimately contribute to quality of life.[2] Including Occupational Therapy as part of the team providing services and interventions in a coordinated manner, is the way for people to live life to its fullest.

Primary care can be defined very narrowly, simply identifying practitioners—physicians, nurse practitioners, and physician's assistants, or it can be defined from the much broader view of *primary health care*—comprehensive care that addresses the majority of a patients needs over time including both preventative and curative services. This latter, more broad view of primary care is essential to improving health outcomes and reducing healthcare costs. We believe that Occupational Therapy can be central to many aspects of a cohesive, quality healthcare system.

PRIMARY CARE TEAMS

Primary care addresses basic health needs but must also include the ability to effectively link to rehabilitative services that enable individuals to become or stay healthy. Because of the holistic nature of occupational therapy and expertise related to performance and function across the lifespan, occupational therapy practitioners should be utilized in primary care teams.

Occupational therapy's collaborative approach to the provision of healthcare and focus on increasing client capacity and independence make practitioners a valuable part of beneficiaries' primary care team particularly in critical areas such as preventing falls for elderly patients, working with individuals with diabetes on assuring their lifestyles support health, monitoring child development to increase early and appropriate intervention. Other areas where occupational therapy can be useful in a coordinated model are in premature infants/NICU, mental health (e.g., schizo-

[1] Journal of the American Medical Association, Vol. 278 (1997). Occupational therapy for independent-living older adults: A randomized controlled trial.

[2] British Medical Journal, Vol. 319 (1999) Population-based study of social and productive activities as predictors of survival among elderly Americans.

phrenia), and hand, wrist or shoulder injuries to begin the rehabilitation process immediately or even avoid more expensive treatments.[3] [4]

MEDICAL HOMES

Similar to the arguments for primary care participation, AOTA supports the medical home concept and sees a unique role for occupational therapy as part of the medical home team to help clients get the right services to maximize their functional independence. Additionally, occupational therapy interventions help clients with compliance with their medical regimen delivering improved outcomes and thus cost savings.

PREVENTION

Occupational therapy practitioners have the education, perspective and knowledge base to be recognized as qualified providers of preventative services. Occupational therapy practitioners have expertise in falls risk assessment, smoking cessation, obesity interventions and a variety of other lifestyle management techniques important to the formulation and implementation of comprehensive, successful personalized prevention plans. Research indicates that preventative occupational therapy cost effectively slowed down the declines associated with aging and improved health in the elderly or simply prevented injuries (e.g., through preventable falls) and improved lives.[5] [6] [7]

CARE COORDINATION

Occupational therapy practitioners bring a unique skill set and expertise that can and should be a vital component of any new or existing care coordination models to achieve optimal client outcomes and deliver more targeted, effective care. Occupational therapy addresses issues of daily living that are often ignored but are critical to care coordination, particularly for individuals with chronic conditions. Occupational therapy is particularly effective in addressing children with disabilities like autism in school or in other settings [8] or families addressing Alzheimer's disease.[9]

CHRONIC CARE MANAGEMENT

Occupational therapy focuses on enabling individuals to participate in productive and meaningful activities of daily life using approaches that help individuals self-manage—vital to such things as appropriate medication management skills, fall prevention, energy conservation, self-care, and maintaining participation in key activities such as work, family management or leisure. Savings can be achieved as people maintain their health and independence through their own actions. Practitioners achieve improved outcomes through active collaboration with clients and their caregivers during the evaluation and intervention process. Occupational therapy should be a part of chronic care management teams for persons with traumatic brain injury, multiple sclerosis, spinal cord injury, diabetes, autism, stroke among other conditions.[10] [11]

As stated throughout the subcommittee hearing, allied health professionals have the potential to be a key component to reducing healthcare spending costs if utilized properly. **While considering new and innovative ways to provide primary health care and improve outcomes within our healthcare system, we**

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[3] The British Journal of Occupational Therapy, Vol. 132 (2008). Audit of a therapist-led clinic for carpal tunnel syndrome in primary care.

[4] Occupational Therapy International, Vol. 15 (2008). Effectiveness of a peer-support community in addiction recovery: participation as intervention.

[5] Journal of Gerontology: Psychological Sciences, Vol. 56 (2001). Embedding health promoting changes into the daily lives of independent-living older adults: Long-term followup of occupational therapy intervention.

[6] Journal of the American Geriatrics Society, Vol. 54 (2006). A randomized trial of a multicomponent home intervention to reduce functional difficulties in older adults.

[7] Journal of Rehabilitation Medicine, Vol. 40 (2008). A single home visit by an occupational therapist reduces the risk of falling after hip fracture in elderly women: a quasi-randomized controlled trial.

[8] American Journal of Occupational Therapy, Vol. 62 (2008). Evidence-based review of interventions for autism used in or of relevance to occupational therapy.

[9] The Gerontologist, Vol. 41 (2000). A randomized controlled trial of home environmental intervention to enhance self-efficacy and reduce upset in family caregivers of persons with dementia.

[10] American Journal of Occupational Therapy, Vol. 63 (2009). Changing face of stroke: Implications for occupational therapy practice.

[11] Multiple Sclerosis, Vol. 14 (2008). A longitudinal study on effects of a 6-week course for energy conservation for multiple sclerosis clients.

strongly encourage you to consider the important role that occupational therapy can play as part of the healthcare solution.

Thank you for the opportunity to express our views to the subcommittee. Should you have any questions or need additional information about the role of occupational therapy practitioners in primary care, please contact Heather Parsons at *hparsons@aota.org* or (301) 652–6611 Ext. 2112.

Sincerely,

CHRISTINA METZLER,
AOTA Chief Public Affairs Officer,
American Occupational Therapy Association, Inc.

[Whereupon, at 11:58 a.m., the hearing was adjourned.]

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