Documents for the Record

Health Subcommittee Hearing on "Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care"

04/19/2023

Republican

- Testimony of Traci Couture Richmond, Executive Director, Spokane Teaching Health Center
- April 19, 2023, Health Leadership Council Letter to Reps. Guthrie and Eshoo
- Testimony of the National Indian Health Board
- American College of Emergency Physicians Letter to Reps. Guthrie and Eshoo
- Statement from the Association for Clinical Oncology
- American College of Obstetricians Gynecologists statement

Democrat

- Statement from Rep. Young Kim on H.R. 2411
- Letter from HealthImpact on H.R. 2411
- Letter from Center on American Progress on H.R. 2411
- Letter from American Dental Association on H.R. 2569
- Letter from American Academy of Family Physicians
- Statement by the Association of American Medical Colleges
- Letter from American Health Care Association on H.R. 2411
- Letter from National Forum of State Nursing Workforce Centers on H.R. 2411
- Statement from PA Education Association (PAEA)
- Statement from American Hospital Association
- Letter from West Coast University on H.R. 2411

TESTIMONY OF TRACI COUTURE RICHMOND

EXECUTIVE DIRECTOR
SPOKANE TEACHING HEALTH CENTER

Hearing on "Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care"

Before the Health Subcommittee of the Committee on Energy and Commerce
April 19, 2023

Chair McMorris Rodgers, Chairman Guthrie, Ranking Member Pallone, and Ranking Member Eshoo, I am grateful for the opportunity to submit this testimony for the hearing record on the Teaching Health Centers Graduate Medical Education program and pending proposals to reauthorize it. The four of you have helped maintain and expand the THCGME program over the years and we're fortunate to you have you leading this process this year.

I am the Executive Director of the Teaching Health Center in Spokane, Washington, where we have been blessed for many years to have Chair McMorris Rodgers as a stalwart champion of our program and those around the nation. In our community, Cathy, as she is known, often speaks of the need to expand health care access in both urban and rural settings. With her help, our residency program is known for its ability to train and retain new physicians who will see hundreds of thousands of patients during their careers in Eastern Washington and similarly challenged communities.

Before I provide some background on our program and how it helps respond to the challenges we face in primary health care in our region, I would like to say at the outset that we are mindful of the budget complexities that the Committee and Congress face. I am a former Congressional staffer myself and understand that some on the Committee might challenge the need to increase funding or make permanent the THCGME program. When I'm done, I hope

you will consider my testimony as making a strong case for increased funding and a lengthy reauthorization. This medical residency program has proven results and is an extremely efficient way to solve the problem of physician shortages in rural American and our cities. From a fiscal perspective, while I understand that CBO won't give us sufficient credit for this, it is proven that better access to primary care physicians means that more Americans can address their longer term health issues better and rely less on more expensive trips to the Emergency Department and expensive prescription medications. I'll bet that each dollar you allocate to THCGME will save many dollars in the future on health care system costs and warrants a substantial investment now in our reauthorization legislation.

Primary care physicians are the key to a healthy community In Spokane, our residents provide care for some of the most medically complex patients in our communities. We treat patients across the age spectrum, providing a team-based care model to make sure the patients have access to all the resources they need. One story I recently heard from a resident was about a patient who had been home bound for several years and receiving care via telemedicine only. He got approval from his supervising physician to go to the patient's home with a team. At the end of the visit, they got this patient connected to the appropriate resources and service agencies to assist her in being able to leave her home for the first time in years.

Our Internal Medicine Residents provided coverage in the ICU at the hospital during the height of the COVID-19 surge and were an integral part to keeping the ICU fully staffed.

The federal THCGME program is successful at the national level in doing what we in Spokane have accomplished and it is essential that we maintain this important momentum and that Congress fully funds and extends this program for years to come.

For the benefit of Members of the Subcommittee who are not as familiar with the THCGME program, I would note that it started about 10 years ago and is the only federal program that invests

in the residency training of future physicians in a community setting as opposed to hospitals. As a result, it has been reauthorized several times with strong bipartisan support.

Currently, there are 72 Teaching Health Center programs in 24 states and the District of Columbia with 969 medical residents handling more than an estimated one million patient visits annually in rural and urban communities.

THCs are responding to the crisis-level shortage of primary care physicians by delivering doctors to communities where they are needed most.

Reflecting a growth in interest in primary care in underserved communities like ours, the THC program is a highly sought after program for medical school graduates, as many THCs have over 100 applicants for every residency slot. This past interview season, our Family Medicine Residency program received more than 600 applications for 112 interview slots with a total of 12 slots to fill. The numbers for Internal Medicine Residency are even greater, with 831 applicants for 112 interview slots with a total of 10 slots to fill.

We are optimistic, based on the experience that we and other THCs have had, that many of our residents will stay with us or at least in our region after they graduate. Our rural training program, based 72 miles north of Spokane, boasts a retention rate of 85% of our graduates.

Our association, the American Association of Teaching Health Centers, has calculated based on a recent survey that:

- 82% percent of THC graduates remain in primary care practice, compared to 23 percent of traditional GME graduates.
- 55% percent of THC graduates practice in underserved communities, compared to 26 percent of traditional GME graduates.
- 20% percent of THC graduates practice in rural America, compared to 8 percent of traditional GME graduates.

In short, this is a program that is working and has the metrics to prove it.

This hearing is very timely because the THCGME program expires on Sept. 30, 2023 and, after multiple piecemeal short-term authorizations over the past seven years, we need a permanent extension such as the one envisioned by Ranking Member Pallone's reintroduced bill, the DOC Act. THCs are grateful to him and Congressman Raul Ruiz, an original cosponsor along with Congressman Gabe Vasquez, for recognizing that the best approach to avoid unnecessary disruption for our residency programs is to put it on par with the Medicare-funded traditional GME program. The DOC Act would create a glide path for existing THCs and as many as 48 new THCs to recruit, enroll, and retain over 1,000 new residents above the 969 currently training. With the extra funding and the permanence, so many more states and communities would have their own new residency programs and millions more patient visits would occur in red, blue, and purple regions. It would eliminate the inefficiencies that come from running medical residencies on Congressional authorizations that have run from one day to three years.

If a permanent solution like the DOC Act is not in the cards for any reason, AATHC strongly urges Congress to provide a lengthy, multi-year reauthorization that permits the per resident allocation to increase from the current $160,000 annually to $210,000. We need the certainty that a lengthy reauthorization would provide. Further, the increased per resident allocation is justified by the recent HRSA-commissioned survey that found the national median training costs are around $210,000 annually. When the program started around 10 years ago, HRSA provided $150,000 per resident and we have seen only one $10,000 increase and that only occurred in the past two years. I can assure you that the costs associated with training have gone up for legitimate reasons well before the higher inflation of the past year. The per resident allocation covers reasonable salaries and benefits for the residents, faculty time, curriculum development, and physical infrastructure needs at the medical facility, just to name a few cost centers. Failure to provide an adequate increase will undoubtedly lead to some THCs leaving the program or severely curtailing their recruiting, which would leave slots unfilled and create the opportunity costs for each unfilled slot in terms of hundreds

of thousands of patients that resident would see over a career in an underserved community like Spokane.

I want to close by describing the stark world we will be in if Congress fails to reauthorize THCGME by September 30 or if it provides two or three years of flat funding at the $126 million level. Some THCs will stop taking residents entirely. Others will severely curtail their recruiting. And, many organizations that received Planning and Development grants and aspired to be designated as THCs by HRSA in the next year or two will most likely put their projects on hold and will not be able to start matriculating residents at all.

For Spokane, this will mean a reduction in resident numbers for the class starting on July 1, 2024 and will take our programs back to resident numbers from 1996. This will mean access issues for those who are on Medicare and Medicaid as their primary payer. This will also mean our Emergency rooms will be taking care of medical problems best addressed with a primary care physician. I urge you all to not let that happen and to reauthorize this program with sufficient resources and for a long time so we can continue to train the next generation of primary care residents.

April 19, 2023

The Honorable Brett Guthrie
Chairman
Energy and Commerce Committee
Subcommittee on Health
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
Energy and Commerce Committee
Subcommittee on Health
Washington, D.C. 20515

Dear Chairman Guthrie and Ranking Member Eshoo:

The Healthcare Leadership Council (HLC) appreciates the opportunity to provide comments in advance of your hearing, "Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care."

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, homecare providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach. We are uniquely positioned to address disaster preparedness comprehensively from all perspectives in the healthcare industry.

The healthcare workforce continues to face an extreme shortage of workers throughout America. In fact, the United States faces a shortage of up to nearly 124,000 physicians by 2034, including shortfalls in both primary and specialty care.[1] This shortfall could disproportionately affect rural and underserved communities. The 46 million Americans who live in rural areas often have trouble accessing care due to a shortage of healthcare workers and long distances to healthcare services that can be made more challenging by difficult terrain and severe weather. As a result, rural residents overall suffer poorer health outcomes and are at greater risk of dying from heart disease, cancer, unintentional injuries, chronic lower respiratory disease, and stroke than their urban counterparts.[2] Without Congressional action, workforce shortages are likely to worsen and, consequently, the state of health for people across America may worsen as well.

As Congress examines current federal government programs to support the healthcare workforce and improve primary care, we believe Congress should support the National Health Service Corps (NHSC), which provides scholarships and loan repayment funds for medical providers who agree to practice in

[1] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034, Association of American Medical Colleges (June 2021) https://www.aamc.org/media/54681/download?attachment

[2] Medicaid and Rural Health, MACPAC (April 2021) https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf

medically underserved areas, and Teaching Health Centers, that train medical residents to work as primary care physicians in those same areas. This support is important as many of the NHSC providers and graduates from teaching health centers serve in community health centers. In addition, we urge Congress to pass H.R. 2559, the "Strengthening Community Care Act," which would fund community health centers through 2028 and provide continued access to care for millions of Americans. HLC also supports efforts to improve medical education and training programs for future primary care workers. There is an ongoing need to enhance funding for graduate medical education, along with teaching health center graduate medical education programs. To support this need, we urge Congress to enact H.R. 2569, the "Doctors of Community Act," which would permanently authorize and expand the teaching health center graduate medical education program to assist the training of primary care medical and dental residents in high-need communities.

To better address the national shortage of registered nurses, HLC believes Congress should pass H.R. 2411, the "National Nursing Workforce Center Act." One of the major barriers to understanding this shortage is the lack of standardized information about the landscape of nursing in each state, making it difficult to develop informed interventions to recruit and retain nurses. Nursing workforce centers advance the profession through a data driven approach throughout 39 states in America. These centers conduct local research, publish reports on nursing supply, demand, and education, and share best practices. However, not every state has a center and those centers that exist do not always have the funding essential for their work. That is why we believe this legislation is an important step forward to support our nursing workforce.

HLC continues to work on multiple fronts in support of workforce expansion and flexibility in the short term. This includes support for immigration policies that enable the entry of qualified medical professionals into the United States. Currently, there is a dire need to expand immigration rules that allow recruitment of nurses and other workers critical to the healthcare industry. We also continue to support the need for more flexibility in state licensure. The pandemic highlighted the importance of having a mobile healthcare workforce that can address needs when and where they occur. However, current state licensure restrictions create barriers to workforce mobility. HLC believes Congress should enact legislation that would provide licensing reciprocity for healthcare professionals for any type of services provided to a patient located in another state in communities where shortages exist.

We also urge Congress to pass H.R. 1770, the "Equitable Community Access to Pharmacist Services Act," to secure patient access to healthcare services and permanently provide pharmacists the ability to care for those in need during any future public health emergencies. Pharmacists play a critical role in ensuring people in medically underserved communities have access to healthcare resources. Pharmacists are among the most accessible healthcare professionals and provide regular access to healthcare services and treatments for patients. In fact, nine in ten Americans live within five miles of a pharmacy, allowing pharmacists to serve their local communities and be a trusted healthcare resource where others may not exist. By advancing this legislation, Congress can ensure pharmacist services are covered, alleviating gaps in care, preserving vital healthcare access in the future, while also improving health inequities.

Lastly, HLC believes Congress should further explore value-based care as a long-term way to better align the healthcare workforce and address shortages. A value-based care system will improve healthcare quality and outcomes for patients. The shift to value-based care will require numerous changes in the way our healthcare system is structured and operates. This shift will enable consistent and efficient data collection, and communication among healthcare providers which will allow for better utilization of the healthcare workforce. Additionally, value-based care will encourage greater use of appropriate telehealth and remote patient monitoring services, leading to improved patient access to healthcare for millions of Americans in rural and underserved communities.

Thank you again for considering our request to build a stronger healthcare workforce and improve primary care in America. HLC looks forward to continuing to collaborate with you on this important issue. If you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435 or dwitchey@hlc.org.

Sincerely,

Mary R. Grealy
President

Testimony for the Record of the National Indian Health Board
Health Subcommittee Hearing on the "Special Diabetes Program for Indians Reauthorization Act of 2023"
April 19, 2023

Members of the Health Subcommittee, on behalf of the National Indian Health Board (NIHB) and the 574 sovereign federally recognized American Indian and Alaska Native (AI/AN) Tribal nations we serve, thank you for the opportunity to provide testimony on the Special Diabetes Program for Indians Reauthorization Act of 2023 (H.R. 2547).

NIHB requests that Special Diabetes Program for Indians (SDPI) be permanently reauthorized this year and funded at a level of $250 million with annual increases tied to the rate of medical inflation. Additionally, we request that Tribes be permitted to receive SDPI funding through Self-Governance contracts and compacts.[1]

SDPI Overview:

We would like to highlight the need for Congress to renew SDPI as it is set to expire on September 30, 2023. SDPI serves 780,000 American Indians and Alaska Natives across 302 programs in 35 states. [2] SDPI focuses on community-directed approaches to treat and prevent Type 2 diabetes in Tribal communities that are culturally informed. American Indians and Alaska Natives suffer disproportionately from Type 2 diabetes, but thanks to the success of SDPI, that statistic is improving.

Congress established the Special Diabetes Program for Indians (SDPI) in 1997 as a mandatory funding program as part of the Balanced Budget Act to address the growing epidemic of diabetes in American Indian and Alaska Native (AI/AN) communities. The Special Diabetes Program for Type 1 Diabetes (SDP) was established at the same time to address the opportunities in type 1 diabetes research. Together, these programs have become the nation's most strategic, comprehensive, and effective efforts to combat diabetes and its complications.

At a rate approximately 2 times the national average, AI/ANs have the highest prevalence of diabetes. In some AI/AN communities, over 50% of adults have been diagnosed with type 2 diabetes and AI/ANs are 1.8 times more likely to die from diabetes.

SDPI has become the nation's most effective federal initiative to combat diabetes. Thanks to SDPI, for the first time, from 2013 to 2017 diabetes incidence in AI/ANs decreased each year. AI/ANs are the only racial/ethnic group that have seen a decrease in prevalence. Fewer cases

[1] See: https://www.nihb.org/docs/03012021/21-04_NIHB%20Resolution%20on%20SDPI.pdf
[2] See: https://www.ihs.gov/sites/sdpi/themes/responsive2017/display_objects/documents/factsheets/2023SDPIGrants.pdf

have coincided with a decrease in diabetes related mortality by 37 percent between 1999 and 2017. SDPI has also resulted in significant savings from Medicare due to reduction in End Stage Renal Disease (ESRD). Between 1996 and 2013, incidence rates of ESRD in AI/AN individuals with diabetes declined by 54 percent. This reduction alone is estimated to have already saved $520 million between 2006-2015. [3] Hospitalizations for uncontrolled diabetes among AI/AN people has also dropped by 84 percent, which significantly lowers health care costs.

This success is due to the nature of this grant program which is administered at the federal level but is implemented locally. This design has allowed Tribal communities to design and implement diabetes interventions that address locally identified community priorities. Tribal leaders have identified community adaptability to be a strong element of SDPI's success. They have shared that the ability of the community to make local level decisions, choose best practices, and adapt the program to be culturally appropriate has been vital to its success. Communities with SDPI-funded programs have seen substantial growth in diabetes prevention resources, including more than doubling the number of on-site nutrition services, and physical activity and weight management specialists for adults, and an exponential increase of sites with physical activity services for youth.

Programs are able to address the most urgent needs in their communities, and this has led to incredible results both locally and nationally. Programs have reported improvements in A1Cs, blood pressure, diabetes-related eye disease outcomes, and foot health of their patients. Because programs are locally led, staff are often able to incorporate both traditional practices and evidence-based prevention. This combined approach has led to significant community buy-in. Kevin Fortuin, the SDPI Program Manager for Tohono O'odham Nation shared "O'odham people have always been traditional runners. The connection between traditional foods, activity, and exercise is tied not only to health, wellness, diabetes prevention, and management, but also in terms of who the O'odham people are. It's part of the O'odham culture."

SDPI has been so successful that it has been recognized as one of the most successful public health interventions in our nation's history, after childhood vaccination. SDPI models have been applied to other populations as well. One state Medicaid agency actually contracts with SDPI programs to treat the non-native population in the state because the methods are so effective.

Unfortunately, SDPI has faced significant uncertainty with stagnant funding and short-term reauthorizations. A 2020 NIHB survey found that 43 percent of SDPI programs faced challenges related to cutbacks in services due to funding uncertainty, and 39 percent of programs faced potential delays in purchasing medical equipment.[4] "The uncertainty of funding has resulted in the need to prioritize personnel expenses over other program-

[3] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation. "The Special Diabetes Program for Indians: Estimates of Medicare Savings." May 2019.

[4] https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/SDPI2020Report_to_Congress.pdf

related expenses... As such, the participation of SDPI staff in events such as the annual Village Health Fairs was placed in potential jeopardy," one respondent shared. Another respondent stated their program faced challenges, including, "not being able to hire staff for program activities in a timely manner [and] not being able to maintain staff due to uncertainties."

H.R. 2547 - the Special Diabetes Program for Indians Reauthorization Act of 2023:
NIHB would like to express our appreciation to Congressman Cole and Ruiz for their leadership in introducing H.R. 2547 to reauthorize SDPI at $150 million per year for 5 years. As noted above, we request that SDPI be funded at $250 million with annual increases tied to medical inflation. Under P.L. 93-638, NIHB requests that Tribes be permitted to receive SDPI funding through Self-Governance contracts and compacts.

Unfortunately, SDPI has been flat funded since FY 2004 at $150 million. In recent years, SDPI has been subject to mandatory sequestration, leaving the funding total to be only $147 million. Adjusting for inflation alone, SDPI should be funded at $246 million per year. In 2022, HHS determined that all eligible entities can apply for SDPI, not just current grantees, which resulted in 11 new grantees being added. Overall, this means SDPI grantees are being asked to do more with less. This program is highly successful despite stagnant funding. However, if appropriately funded, more lives would be saved and health care costs reduced. Due to the lack of increased funding, SDPI programs have had to cut staff positions and delay the purchase of necessary equipment. Michelle Moran-Walking Elk, Cheyenne River Sioux Tribe Youth Diabetes Prevention Program, shared, "Our funding hasn't increased with inflation- we end up topping out and not being able to extend or enhance. The funding delays and stagnant funding effects programs where you have to decrease staff- when I very first came, I had five outreach staff, now I'm down to three. You don't want to always be focused on money and programs- but it makes or breaks the program. We have to have funding come in on regular basis to be able to do the work."

We understand and appreciate the 118th Congress' commitment to fiscal austerity and prudent use of taxpayer dollars. SDPI is one of the best federal health investments Congress has made and can continue to make. Not only is SDPI proven to decrease disease incidence and complications from type 2 diabetes, but it saves the health system money. As previously stated, HHS found the reduction of ESRD prevalence resulted in $520 million savings between 2006-2015.

The President's FY 2024 Budget Request to Congress supports funding the SDPI program at $250 million for FY 2024. Additionally, the budget request includes increasing the program funding to $260 million in FY 2025 and $270 million in FY 2026.

Expansion of Tribal Self Governance for SDPI:
Tribes and Tribal organizations have repeatedly called for a change to the SDPI program structure to allow recipients the option to receive funding through 638 contracts and compacts which would allow for self-determination and self-governance. This would establish SDPI as an essential health service, remove the culturally inappropriate competitive grant structure, prevent the unnecessary federal administrative burden, and

support Tribal sovereignty by transferring control of the program directly to Tribal governments.

Conclusion:
NIHB appreciates the work that the members of the 118th Congress have done to support SDPI reauthorization over the years. Your leadership in supporting this critical program has been essential in ensuring that we can sustain the major accomplishments of this life-saving program. Thank you again for your strong support of this program, NIHB looks forward to working with you to renew SDPI at a funding level that will enable the program to serve more AI/ANs and continue providing remarkable results.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

April 19, 2023

The Honorable Brett Guthrie
House Energy and Commerce
Subcommittee on Health
2434 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eshoo
House Energy and Commerce
Subcommittee on Health
272 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Guthrie and Ranking Member Eshoo,

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 members, I would like to thank you for holding this hearing, entitled, "Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care." As emergency physicians who strive to provide high-quality, objective and evidence-based care, we share your concerns about the state of the health care workforce, especially as we continue to experience high levels of burnout, workplace violence, mental health challenges, and emergency department boarding. Regardless of these many challenges, emergency physicians are on the frontlines for all types of emergencies, and they are ready to do whatever is necessary, every day of the year, to care for patients during all manner of medical emergencies in the hospital and the event of public health crises, natural disasters, terrorist attacks, and many other scenarios. We appreciate the opportunity to share some of our experiences and suggestions on how to bolster federal programs and support for the health care workforce, and we look forward to continuing to work with you to improve patient access to care throughout our country.

The emergency department (ED) serves as the "front door" to the health care system, receiving more than 131 million visits in 2020, with more and more of our patients older in age and arriving via emergency medical services (EMS) transport. Of these visits, 16 to 18 percent of patients are admitted to the hospital, accounting for more than half of all inpatient admissions nationwide. And for many Americans, the ED may be the first – and only – interaction they have with the health care system, especially for safety-net and otherwise underserved populations.

Historically, emergency medicine has been one of the most-desired and fastest-growing physician specialties. Over the past five years, the number of positions offered for residency training in emergency medicine grew by 21 percent, compared to 16.5 percent for all specialties. Previous to this growth, emergency medicine residency programs routinely filled 99 percent of their available positions in the annual Match. However, over the last two residency application cycles, the number of unfilled residency spots has grown at an unprecedented rate, with 219 emergency residency positions unfilled in the 2022 match, and another even sharper increase to 555 unfilled in the 2023 initial match. While emergency medicine remains a vibrant and appealing specialty, our community is working to identify and better understand the factors contributing to the imbalance between growth and interest and develop strategies to mitigate them. Informed speculation about many of the factors leading applicants to opt for other specialties includes: burnout from violence and boarding in our nations emergency departments; concerns about projections of potential workforce oversupply; a shift to more programs being developed by non-academic hospitals that are less constrained by traditional GME funding caps; ongoing impact of the COVID-19 pandemic; economic challenges and the corporatization of medicine; growing use of physician assistants (PAs) and nurse practitioners (NPs) as lower-cost substitutes unable to provide high quality care; and many others. To better identify, understand, and respond to these various factors, a broad group of emergency medicine organizations have convened to establish a Match Task Force to develop strategies to mitigate these issues and establish an

WASHINGTON, DC OFFICE
901 New York Ave, NW
Suite 515E
Washington DC 20001-4432

202-728-0610
800-320-0610
www.acep.org

appropriate path forward. While this is a challenging time for emergency medicine, it is also one of opportunity, and the specialty remains one of the most popular for next generations of physicians.

But even despite the growth of the specialty and the overall supply of emergency physicians, we face challenges similar to those of our primary care and behavioral health colleagues in terms of maldistribution in rural and underserved communities. Workforce shortages are especially pronounced in rural and underserved areas throughout the country, and numerous barriers to providing equitable care in these communities persist. Among these are the inability to recruit qualified and sufficiently experienced, educated, and trained physicians, nurses, ancillary support staff, and other health care providers. Despite a 28 percent increase in emergency medicine residency positions over the past 10 years, there has been no corresponding increase in emergency medicine residency trained or emergency medicine board certified physicians working in rural EDs. Like the other issues noted here, this too is a complex problem due to a variety of factors, including limited opportunities for exposure to these communities during residency training, fewer full time employment opportunities overall due to ED staffing requirements and continued rural facility closures, a lack of recruitment tools and incentives such as those provided for primary care professions, among many others. Additionally, rural EDs, compared to their urban counterparts, are resource limited, financially stressed, and experience higher interfacility transfer rates. And while the COVID-19 pandemic increased the use of telehealth, rural areas still suffer from inconsistent availability of telehealth access and structural challenges like limited or functionally nonexistent broadband access. Transportation issues also limit many individuals' ability to reach hospitals, and emergency medical services (EMS) in rural areas also experience significant transportation delays due to issues with crew availability.

In order to attract more emergency physicians to rural and underserved communities, Congress can build off of existing designations and programs aimed at bolstering the rural health care workforce. Congress should consider establishing an Emergency Medicine Health Professional Shortage Area (HPSA), based on the existing criteria for HPSAs for mental health and primary care professionals (42 CFR Part 5), as well as ensuring that emergency physicians are eligible for student loan repayment assistance through the National Health Service Corps (NHSC) Loan Repayment Program for qualifying service in an approved site within such an emergency medicine HPSA. Another challenge in recruiting qualified health professionals to rural areas is that while an individual physician may seek or be afforded such an opportunity, their spouse or partner may not have the same employment opportunities, ability to move, or may face other barriers like occupational licensing and credentialing. Congress could help facilitate such transitions by implementing employment assistance programs similar to those that already exist for members of the Armed Services and their spouses. This could include federal hiring preferences and priority placement programs, licensure and recertification reimbursement, employment fellowship opportunities, and additional relocation and placement support for qualified spouses and partners.

The recently-established Rural Emergency Hospital (REH) designation for facilities in rural areas, a concept for which ACEP has long advocated, also has the potential to improve access to quality emergency care in certain rural areas, especially those affected by recent hospital closures. ACEP believes that all services delivered in REHs should be overseen by board-certified emergency physicians, though we acknowledge that this is not always possible due to existing workforce shortages in rural areas. We have urged CMS to require that in cases where a board-certified emergency physician is not available, a physician with training and/or experience in emergency medicine (such as a family physician) provide the care or oversee the care delivered by non-physician practitioners.

Under the REH designation, covered outpatient department services provided by an REH will receive an additional five percent payment for each service. Beneficiaries will not be charged a copayment on the additional five percent payment. CMS is proposing to consider all covered outpatient department services that would otherwise be paid under the Outpatient Prospective Payment System (OPPS) as REH services in these facilities. REHs would be paid for furnishing REH services at a rate that is equal to the OPPS payment rate for the equivalent covered outpatient department service, increased by five percent. CMS is also proposing that REHs may provide outpatient services that are not otherwise paid under the OPPS as well as post-hospital extended care services furnished in a unit of the facility that is a distinct part of the facility licensed as a skilled nursing facility; however, these services would not be considered REH services and therefore would be paid under the applicable fee schedule and would not receive the additional five percent payment increase that CMS proposes to apply to REH services. Finally, CMS is proposing that REHs would also receive a monthly facility payment. After the initial payment is established in calendar year (CY) 2023, the payment amount will increase in subsequent years by the hospital market basket percentage increase.

ACEP supports this payment approach as it aligns with the methodology outlined in the Consolidated Appropriations Act of 2020. However, we also note that the statute only addresses additional facility payments to REHs under the OPPS—not added reimbursement for physicians and other clinicians under the Physician Fee Schedule (PFS) who actually deliver the services in REHs. **In order to incentivize physicians and other clinicians to work in rural areas and appropriately staff REHs, ACEP strongly recommends that CMS consider creating an add-on code or modifier that clinicians could append to**

claims for services delivered in REHs. CMS could consider setting the value of this add-on code or modifier at five percent of the PFS rate for each Current Procedural Terminology (CPT) code that is billed—consistent with the additional OPPS payment that the statute provides. We urge the Congress to consider this approach as well.

Some have proposed expanding the scope of practice of nonphysician professionals in order to increase access to care, especially in rural and underserved communities. However, in reviewing the actual practice locations of nurse practitioners and primary care physicians, it is clear nurse practitioners and primary care physicians tend to work in the same large urban areas. There remain significant shortages of nurse practitioners in rural areas— the very problem with physician access that scope expansion has sought to address. This occurs regardless of the level of autonomy granted to nurse practitioners at the state level.

We also hope the Committee's examination of current health care workforce shortages will include a focus on the ongoing nursing shortages and the perverse incentives created by a growing over-reliance on over-priced nurse staffing agencies that have resulted in exorbitant increases in costs to already-strained health care systems. The extreme physical and mental toll of the COVID-19 pandemic response has inflicted enormous trauma and stress on physicians and nurses, resulting in increased burnout and dissatisfaction for those on the front lines and greater attrition in the health care workforce. This has left many health systems, who even before the pandemic often had to rely on mandatory overtime and other stopgap measures to ensure an adequate nurse workforce, desperate to fill workforce gaps by relying on nurse staffing agencies, some of whom have imposed extreme rate hikes to supply travel nurses to hospitals. This in turn draws off even more nurses previously employed in hospitals, given the higher pay and greater autonomy over their own working conditions. In many cases, facilities have been left with no other choice than to pay substantially inflated rates in their attempts to maintain staffing levels capable of meeting their community's needs. We appreciate Congress' recent attention to this issue and encourage continued investigation and oversight of potentially anticompetitive practices occurring in the health care workplace.

We believe that the ongoing challenges in recruiting and retaining all levels of health care professionals in rural and underserved areas are more complex, and that this persistent issue requires more innovative solutions to incentivize physicians and other health care professionals to work in these communities. We would welcome the opportunity to work with you and your colleagues to find more effective and durable solutions to these longstanding workforce challenges to ensure that Americans in rural and underserved areas have access to high-quality emergency care, recognizing the level of expertise and training required for independent practice of emergency medicine and supporting the provision of physician-led team-based care.

Once again, thank you for the opportunity to provide our perspective on the issues facing the health care workforce, especially for the communities that are most in need of expanded access to care. We look forward to working with you during the 118th Congress to help ensure that our emergency medicine workforce is strong enough to support our patients, their families, and our communities. Should you have any questions or require any further information, please do not hesitate to contact Ryan McBride, ACEP's Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,

Christopher S. Kang, MD, FACEP
ACEP President

Lori J. Pierce, MD, FASCO
President
Association for Clinical Oncology

Statement prepared for:
U.S. House Committee on Energy and Commerce
Subcommittee on Health

Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care

April 19, 2023

The Association for Clinical Oncology (ASCO)[1] is pleased to submit this statement for the record of the hearing entitled, "Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care." ASCO is grateful that the U.S. House Committee on Energy and Commerce, Subcommittee on Health has provided stakeholders the opportunity to weigh in on the critical issue of health care workforce shortages. We also appreciate the Subcommittee's efforts to address workforce shortages to protect the integrity and stability of the U.S. health care system.

ASCO is the national organization representing more than 45,000 physicians and other professionals who care for people with cancer. ASCO members are dedicated to conducting research that leads to improved patient outcomes, and we are also committed to ensuring that evidence-based practices for the prevention, diagnosis and treatment of cancer are available to all Americans, including Medicare beneficiaries.

Protecting the vitality of the health care workforce is critical to the U.S. health care system. For years, data from our affiliate organization, the American Society of Clinical Oncology (the Society), the American Association of Medical Colleges (AAMC), the American Cancer Society (ACS) and other stakeholders have shown a steady decline in supply of practicing health care providers to meet the demand of the evolving needs of U.S. patients. Like the broader health care workforce, oncology is also facing shortages across care teams. These shortages are driven by several factors, including an aging population, increased demand for cancer care, and a limited number of physicians choosing to specialize in oncology. The shortage of oncology providers has significant implications for patients, as delays in diagnosis and treatment can have a substantial impact on outcomes. To address this issue, organizations like ASCO

[1] The Association for Clinical Oncology, referred to as the "Association" is an affiliate organization of the American Society of Clinical Oncology, referred to as the "Society".

are advocating for policies that support and encourage more physicians to specialize in oncology, as well as for increased funding for graduate medical education slots and workforce programs that aim to train and retain the next wave of the oncology workforce. The Society currently offers several award and mentorship opportunities to aid new physicians into the oncology workforce.

A Glance at the Oncology Workforce

Currently, the U.S. population is aging, with people age 65 and older expected to grow from 19% of the population in 2019 to 21.6% by 2040.[2] Not only is the population aging, but cancer cases are also on the rise. In 2023, 1,958,310 new cancer cases are projected to occur in the U.S. – up from 1.9 million in 2022.[3] The oncology workforce treating this population is also aging and retiring at a faster rate than the workforce pipeline can maintain. Currently, 22% of practicing oncologists are nearing retirement age.[4] In contrast, 13.9% of the oncology workforce is age 40 and under. Workforce shortage concerns extend beyond physicians to include the broader group of cancer care delivery professionals. From nurses to physician assistants and technicians, the consequences of workforce shortages are being felt throughout the community. The consequences of shortages—less time with patients, increased workload, stress, and access challenges—may lower quality of care. It could even discourage clinicians from entering or remaining in the field.

In the research field, early career investigators are also struggling to enter the workforce due to a lack of resources. The National Cancer Institute (NCI) is the largest funder of cancer research in the world, but its funding has not kept pace with opportunities for innovative research. Between FY2013 – FY2022, R01 and R37 grant applications rose by 45%, but today only 14% percent of life-saving research can be funded. Apart from these missed opportunities, we lose early career investigators who choose other careers when grant submissions are not funded, disrupting the workforce pipeline.

Physician Burnout

Oncology care teams face significant clinician burnout, leading to early retirement or individuals leaving the field. Burnout in oncology has been linked to provider shortages and the increased demand for health care services from an aging population. Providers of all types report stress and burnout directly stemming from increased administrative and financial burdens from payer policies, such as prior authorization, step therapy, and copay accumulator/maximizer programs.

ASCO recently published the results of a member survey[5] that assessed the impact of prior authorization on cancer care. The survey results show prior authorization is delaying patient care, impacting cancer care outcomes, and diverting providers from patient care. Nearly all survey participants reported that a patient has experienced harm because of prior authorization processes, including significant impacts on patient health such as disease progression (80%) and loss of life (36%). The most widely cited harms to patients reported were delays in treatment (96%) and diagnostic imaging (94%); patients being forced

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[2] Administration for Community Living. 2020 PROFILE OF OLDER AMERICANS. https://acl.gov/sites/default/files/aging%20and%20Disability%20In%20America/2020Profileolderamericans.final_.pdf

[3] Siegel RL, Miller KD, Wagle NS, Jemal A. Cancer statistics, 2023. CA Cancer J Clin. 2023 Jan;73(1):17-48. doi: 10.3322/caac.21763. PMID: 36633525.

[4] 2022 Snapshot: State of the Oncology Workforce in America. JCO Oncol Pract. 2022 May;18(5):396. doi: 10.1200/OP.22.00168. PMID: 35544658.

[5] ASCO Prior Authorization Survey Summary. 2022 Nov; https://old-prod.asco.org/sites/new-www.asco.org/files/ASCO-Prior-Auth-Survey-Summary-November-2022.pdf

onto a second-choice therapy (93%) or denied therapy (87%); and increased patient out-of-pocket costs (88%).

The survey responses also reflected the unnecessary complexity of the prior authorization requirements. Nearly all respondents reported onerous administrative requirements, delayed payer responses, and a lack of clinical validity in the process. The survey also found that, on average:

- It takes a payer five business days to respond to a prior authorization request from a physician.
- A prior authorization request is escalated beyond the staff member who initiates it 34% of the time.
- Prior authorizations are perceived as leading to a serious adverse event for a patient with cancer 14% of the time.
- Prior authorizations are "significantly" delayed (by more than one business day) 42% of the time.

Pharmacy Benefit Manager (PBM) policies are also contributing to workforce burnout. Data collected during the 2018 ASCO Practice Survey[6] showed PBMs may reduce access and quality of care while increasing burdens on providers. For example, three-quarters of practices surveyed said PBMs interfered with patient care and/or made it difficult to deliver care, and 56% say that PBMs disrupted practice workflow. The significant erosion of time spent delivering care stands in direct opposition to the most common reason clinicians cite as their motivation for entering practice: helping patients.

To address burnout, the Association recommends continued federal investments for programs authorized under the *Dr. Lorna Breen Health Care Provider Protection Act* that aid physicians in combatting and coping with burnout in the workplace. The Association also recommends enactment of policy solutions to address administrative burdens, which impede the delivery of quality patient care and lead to burnout. Legislative solutions include the *Safe Step Act* (S. 652), the *Help Ensure Lower Patient (HELP) Copays Act* (H.R. 830), and the *Pharmacy Benefit Manager Transparency Act* (S. 127). Advancement of pending regulatory solutions under the Centers for Medicare and Medicaid Services on prior authorization[7][8][9] could also reduce burdens for providers. The Society has developed several oncology-specific resources to assist physicians with burnout and the organization recently launched access to an 18-month pilot program, Safe Haven, which offers wellbeing resources, such as counseling and mental health access.

Workforce Diversity

The physician workforce continues to struggle with adequate representation of racial and ethnic minorities, as well as females, with hematology and oncology not keeping pace with medicine in general. Increased oncology workforce diversity and representation is correlated with increased equity in cancer prevention, screening, care, and patient outcomes. In a recent analysis, only 4.7% of

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[6] Royce TJ, Schenkel C, Kirkwood K, Levit L, Levit K, Kircher S. Impact of Pharmacy Benefit Managers on Oncology Practices and Patients. JCO Oncol Pract. 2020 May;16(5):276-284. doi: 10.1200/JOP.19.00606. Epub 2020 Apr 20. PMID: 32310720; PMCID: PMC7351331.

[7] https://www.federalregister.gov/documents/2022/12/27/2022-26956/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

[8] https://www.federalregister.gov/documents/2022/12/21/2022-27437/administrative-simplification-adoption-of-standards-for-health-care-attachments-transactions-and

[9] https://www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

oncologists identify as Hispanic or Latinx; 3% identify as Black or African American; and 0.1% identify as American Indian or Alaskan Native. Regarding Black representation in the oncology workforce, at each step to becoming an oncologist, the percent of Black participation decreases. Of the U.S. population, 13.4% of people identify as Black. Eleven percent of recent college graduates; 8.4% of recent medical school applicants; 6.2% of recent medical school graduates; 3.9% of oncology fellows; and 3% of oncologists identify as Black.[10] Looking closer at Hispanic or Latinx oncologists and patients, the provider to cancer care needs ratio further emphasizes the underrepresentation in oncology.[11] As mentioned, only 4.7% of U.S. oncologists identify as Hispanic or Latinx, while 9.3% of new cancer cases are among patients that identify as Hispanic or Latinx. A similar trend can be observed with gender representation, as women comprise roughly one-third of the oncology workforce. According to an AAMC analysis, women represent only 35% of hematology and oncology specialists; and only 27.7% of radiation oncologists.[12] When considering race and gender, the underrepresentation gap widens as only 4.2% of oncologist/hematologists in 2018 identity as Black females, down from 5.3% in 2008.[13]

Minority physicians have a greater tendency than non-minority physicians to practice in communities designated as physician shortage areas, according to a 2008 report from the U.S. Health Resources and Services Administration.[14] In an AAMC report, Hispanic or Latinx medical students and Black medical students showed growing willingness to practice medicine in underserved communities, increasing from 39% in 2015 to 41.9% in 2019 for Latinx students and increasing from 51.1% in 2015 to 60.5% in 2019 for Black students.[15][16] A diverse physician workforce also strengthens cultural competency and engenders trust and comfort in patients. Therefore, recruiting oncologists from diverse backgrounds can provide increased and improved clinical oncology care to underserved communities.

ASCO recognizes additional work is needed to achieve greater workforce diversity and representation in oncology across race, ethnicity, gender/gender identity and sexual orientation. To that end, the Society has implemented several programs and initiatives to improve the current status. Of note, the Society's Equity, Diversity and Inclusion (EDI) strategic plan outlines specific objectives, such as improving and expanding mentoring opportunities and career development for oncologists and trainees from populations that are underrepresented in medicine (UIM); assessing policy solutions that could increase the proportion of oncologists who are UIM; and increasing racial/ethnic diversity among the organization's leadership. The strategic plan will guide overall workforce diversity efforts and build on existing programs, including the Society's Diversity in Oncology Initiative, which offers award, internship and mentorship opportunities for medical students and residents who are underrepresented in

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[10] 2021 Snapshot: State of the Oncology Workforce in America. JCO Oncol Pract. 2021 May;17(5):249. doi: 10.1200/OP.21.00166. PMID: 33974817.

[11] 2022 Snapshot: State of the Oncology Workforce in America. JCO Oncol Pract. 2022 May;18(5):396. doi: 10.1200/OP.22.00168. PMID: 35544658.

[12] Association of American Medical Colleges 2022 Physician Specialty Data Report; https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-sex-specialty-2021

[13] 2021 Snapshot: State of the Oncology Workforce in America. JCO Oncol Pract. 2021 May;17(5):249. doi: 10.1200/OP.21.00166. PMID: 33974817.

[14] U.S. Department of Health and Human Services. The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand. 2008. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/physiciansupplyissues.pdf

[15] Association of American Medical Colleges. Report on diversity and medicine: Facts and Figures 2019. https://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019.

[16] Association of American Medical Colleges. Report on diversity and medicine: Facts and Figures 2016. https://www.aamcdiversityfactsandfigures2016.org/report-section/section-3/#figure-29.

oncology. The Association recommends increasing federal investments in health care workforce programs to train and retain UIM providers as a policy solution to improve workforce diversity.

Oncology Workforce Distribution

Oncology workforce shortages are more significant in rural and underserved areas, as many facilities have difficulty attracting and retaining health care providers. According to workforce data from the U.S. Health Resources and Services Administration, non-metro oncology supply will only meet 37% of demand by 2035.[17] Additionally, only 10.5% of oncology practices are located in rural geographic areas. A 2021 study shows that 64% of counties in the U.S. had no oncologists with a primary practice location in that county. Twelve percent had no oncologists, either within the county or in adjacent counties. When cross referenced by the corresponding cancer rates, the study found a negative association between the availability of oncology workforce and cancer rates.[18]

Building on its longstanding commitment to health equity, the Society launched a multi-year pilot program to increase access to high-quality, equitable cancer care in rural Montana. The pilot program, referred to as the Increasing Access to Cancer Care in Rural Montana pilot program, will enable patients to receive cancer care in their own community through a hub-and-spoke care delivery model, a proven method of extending access to cancer care in rural and remote areas. This initiative aims to reduce patients' commute to treatment locations, enable rural sites to be primary points of contact, improve care delivery through education and training, and encourage patient engagement throughout the cancer care continuum. The hub and spoke model leverages community resources, clinician experts in "hub" centers, and all members of the care team to provide care in "spoke" areas where workforce shortages have created access barriers.

The Increasing Access to Cancer Care in Rural Montana pilot program includes Bozeman Health Cancer Center, located at Bozeman Health Deaconess Hospital, a regional facility that serves as the initiative's "hub," and Barrett Hospital & HealthCare, a community-based non-profit Critical Access Hospital and medical clinic provider in Dillon that serves as the "spoke." It will enlist the assistance of the Mark and Robyn Jones College of Nursing at Montana State University, the only nursing graduate program in Montana, offering a potential pipeline to build a trained nursing workforce to increase capacity and care delivery at participating community-based, or spoke, clinics.

Due to the diverse and community-dependent challenges in delivering oncology care to rural areas, multiple strategies are necessary to address workforce shortages and ultimately decrease nationwide rural disparities in cancer care. The experiences of the Montana pilot program suggest that increasing patient access to care requires creating partnerships between providers and community leaders to address local workforce shortages.

Moreover, a team-based approach to delivering care has been an effective solution for oncology teams struggling with workforce shortages. The integration of advanced practice providers (APPs) into oncology practice offers a reliable means to address increased demand for oncology services without adding physicians. According to a 2011 Society study on Collaborative Practice Arrangements[19],

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[17] https://data.hrsa.gov/topics/health-workforce/workforce-projections

[18] Shih YT, Kim B, Halpern MT. State of Physician and Pharmacist Oncology Workforce in the United States in 2019. JCO Oncol Pract. 2021 Jan;17(1):e1-e10. doi: 10.1200/OP.20.00600. Epub 2020 Dec 3. PMID: 33270520; PMCID: PMC8189614.

[19] Towle EL, Barr TR, Hanley A, Kosty M, Williams S, Goldstein MA. Results of the ASCO Study of Collaborative Practice Arrangements. J Oncol Pract. 2011 Sep;7(5):278-82. doi: 10.1200/JOP.2011.000385. PMID: 22211119; PMCID: PMC3170055.

practices in which the APP worked with all practice physicians showed significantly higher productivity than those practices in which the APP worked exclusively with a specific physician or group of physicians.

In addition to strategies outlined above, telemedicine has also helped, not only to bridge the gap in care for rural patients but also enhancing access to care in general. This was especially important during the recent public health emergency, when face to face interactions were limited. The Association appreciates Congress' extension of telehealth flexibilities for services through 2024 and would encourage policymakers to make these flexibilities permanent.

ASCO is pleased to serve as a resource to you and your colleagues as you develop and advance innovative legislative solutions to ensure we have the health care workforce needed to serve our patients. Should you have any follow-up questions or concerns, please do not hesitate to contact Kristine Rufener at Kristine.Rufener@asco.org.

Statement for the Record

Of

The American College of Obstetricians and Gynecologists

Before the

House Committee on Energy & Commerce

Subcommittee on Health

Regarding the legislative hearing entitled “Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care.”

April 19, 2023

Chair Guthrie, Ranking Member Eshoo, Chair Rodgers, Ranking Member Pallone, and distinguished members of the House Energy & Commerce Subcommittee on Health, thank you for your commitment to supporting a robust physician and health care workforce. The American College of Obstetricians and Gynecologists (ACOG), representing more than 60,000 physicians and partners dedicated to advancing the health of individuals seeking obstetric and gynecologic care, is pleased to submit this statement for the record in support of your efforts to address the health care workforce needs. ACOG members include physicians who are devoted to providing quality obstetric and gynecologic medical and surgical care to their patients as their primary care practitioners as well as subspecialty care, including oncology care and high-risk obstetric care. Unfortunately, our nation is facing a shortage and maldistribution of obstetrician-gynecologists, highlighted by an increase in maternity care deserts throughout the country.

In light of this, ACOG appreciates the Subcommittee's commitment to programs that support clinicians, and for recognizing the positive impact a robust physician workforce has on women's health. As part of the Subcommittee's efforts, we urge consideration of policies that support a well-trained and diverse physician workforce, including an examination of ways in which existing programs at the Department of Health and Human Services (HHS) can be leveraged and expanded to support the training, recruitment, and retention of clinicians practicing in the United States, including racial and ethnic groups who are traditionally underrepresented in medicine. To achieve these goals, we encourage the Subcommittee to consider the following recommendations:

<u>Support the Increased Provision of Women's Health Care in Rural Areas.</u>

Addressing the shortage of clinicians providing obstetric and gynecologic care to individuals in rural areas is critical. Women living in rural areas have less access to health care and experience poorer health

outcomes than women living in urban areas—a trend exacerbated by physician shortages, the rapid rate of rural hospital closures, and shuttering of obstetric units.[i] Although national data on women's health and outcomes according to residence are limited, inequities experienced by women living in rural areas are apparent. General health conditions and behavior that women living in rural areas experience at higher rates than their urban counterparts include self-reported fair or poor health status, unintentional injury and motor vehicle-related deaths, cerebrovascular disease deaths, suicide, cigarette smoking, obesity, and incidence of cervical cancer.[ii] In addition, studies have confirmed the urban-rural disparity in maternal mortality, finding that the pregnancy-related mortality ratio increased with rurality.[iii]

According to the most recent available data, 49 percent of U.S. counties, home to 10.2 million women in the U.S., lacked an obstetrician-gynecologist.[iv] This has resulted in increased numbers of out-of-hospital births, births in hospitals without an obstetric unit, and preterm births as well as higher rates of delayed prenatal care, pregnancy-related hospitalizations, low birthweight infants, and infant mortality.[v] In some rural areas, family physicians provide all available obstetric care, yet data show that even this type of access is declining, with only 19.2 percent of family physicians providing routine deliveries.[vi] In 2011, the Health Resources and Services Administration's (HRSA) National Advisory Subcommittee on Rural Health and Human Services found that the successful retention of primary care practitioners in rural communities is contingent on the ability to expand rural training opportunities and use new recruitment strategies, while also strengthening existing programs.[vii] ACOG encourages the Subcommittee to consider pathways that incentivize obstetrician-gynecologists, including residents and young physicians, to train and practice in rural communities, increasing the likelihood that they will remain in those areas.

<u>Support for HRSA's Rural Training Tracks.</u>

ACOG supports efforts that have been made to expand the physician workforce in rural areas through HRSA's Office of Rural Health Policy. Women in rural communities are more likely to begin prenatal

care late and are more likely to experience maternal mortality and severe maternal morbidity.[viii] As such, ACOG encourages the Subcommittee to support the continuation and expansion of the Office of Rural Health Policy's Rural Residency Planning and Development (RRPD) Program, which supports the development of rural residency programs, known as Rural Training Tracks (RTTs).

Specific to obstetrics and gynecology, there is a growing demand for rural training opportunities, and limited options. One example is a rural residency obstetrics and gynecology program at the University of Wisconsin-Madison, which was the first in the nation and supports one resident per residency class. Increased federal support for the RRPD program at HRSA would allow for the expansion of this program, as well as the establishment of additional programs across the country. ACOG urges the Subcommittee to invest in and expand the RRPD program at HRSA and explore additional ways to invest in programs that seek to expand the physician workforce in rural areas.

<u>Continue Investment in Physician Loan Repayment Programs.</u>

The National Health Service Corps (NHSC) plays a critical role in providing health care services in underserved areas while offering tuition assistance and loan repayment for physicians, including obstetrician-gynecologists. As such, ACOG urges the Subcommittee to continue its support of robust authorization for the NHSC.

In addition, the Improving Access to Maternity Care Act (Public Law 115-320), enacted in 2018, responded to our nation's growing maternity care shortage by requiring HRSA to create a maternity care health professional target area designation for use by the NHSC. Since its enactment, HRSA has regularly solicited public feedback on implementation of the law, and in August of 2022, finalized the scoring criteria for the designations, also known as Maternity Care Target Areas (MCTAs). ACOG encourages the Subcommittee to engage with HRSA to support full and continued implementation of the law, and

ensure the agency has everything it needs to determine the maternity care areas of greatest need and publish data on the availability of and need for maternity care health services in these MCTAs. Full implementation of this law will create a pathway for obstetric clinicians to practice in rural communities with the greatest need.

Furthermore, ACOG welcomes the opportunity to work with the Subcommittee to develop new, innovative programs to provide loan repayment for clinicians, particularly for obstetrician-gynecologists of racially and ethnically diverse backgrounds, providing care to women in rural and underserved areas across the country. Additionally, we urge the Subcommittee to consider increased investments in programs authorized under Title VII of the Public Health Service Act (PHSA), including programs crucial to increasing diverse representation in the health professions.

Permanently Authorize the Teaching Health Center Graduate Medical Education (THCGME) Program.

According to data from the American Association of Medical Colleges, the United States faces a projected physician shortage of between 37,800 and 124,000 physicians by 2034.[ix] Teaching Health Centers play a critical role in addressing these shortages through the provision of quality health care services and the simultaneous training of the next generation of physicians. Physicians who train in these programs are far more likely to stay in those communities and continue providing primary care. Data show that when compared to traditional postgraduate trainees, residents who train at Teaching Health Centers are more likely to practice primary care (82 percent vs. 23 percent) and remain in underserved (55 percent vs. 26 percent) or rural (20 percent vs. 5 percent) communities.[x] THCGME programs play a vital role in training our next generation of primary care physicians and help to bridge our nation's physician shortfall. The program helps to address the need to attract and retain physicians in rural areas and medically underserved communities, while also addressing the issue of physician maldistribution.

ACOG appreciates the reauthorization of the THCGME program at the end of 2020 and the supplemental funding included in the American Rescue Plan Act, both of which are critical to supporting the existing programs and assisting with meeting the demand for growth. However, the THCGME program's authorization expires in FY 2024. ACOG encourages the Subcommittee to build on its prior commitment to the THCGME program by advancing legislation such as H.R. 2569, the Doctors of Community (DOC) Act introduced by Ranking Member Pallone, and moving beyond the uncertainty caused by short-term reauthorizations of the program and toward permanent authorization and robust funding.

Thank you again for the opportunity to provide input as the Subcommittee develops solutions to bolster our nation's health care workforce. We appreciate your continued commitment to improving health outcomes for all those in need of obstetric and gynecologic care by investing in a robust workforce of clinicians and look forward to serving as a resource to the Subcommittee as you advance legislation in this space.

[i] Health disparities in rural women. Committee Opinion No. 586. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:384–8.
[ii] Ibid.
[iii] Merkt PT, Kramer MR, Goodman DA, Brantley MD, Barrera CM, Eckhaus L, Petersen EE. Urban-rural differences in pregnancy-related deaths, United States, 2011-2016. Am J Obstet Gynecol. 2021 Feb 25:S0002-9378(21)00144-7. doi: 10.1016/j.ajog.2021.02.028. Epub ahead of print. PMID: 33640361.
[iv] Health disparities in rural women. Committee Opinion No. 586. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:384–8.
[v] Kozhimannil, Katy B. PhD, MPA; Hung PhD, PSPH; Hening-Smith, PhD, MPH, MSW; et al. "Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States," Jama Network, 27 March 2018.
[vi] ACOG CO 586. Health disparities in rural women.

[vii] The Rural Implications of Key Primary Care Provisions in the Affordable Care Act. National Advisory Committee on Rural Health and Human Services. 2011. Retrieved from https://www.hrsa.gov/advisorycommittees/rural/publications/wpacaprimarycareprovisions092011.pdf.

[viii] Centers for Medicare and Medicaid Services. Improving Access to Maternal Health Care in Rural Communities: Issue Brief. 2019. Retrieved from https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf.

[ix] Association of American Medical Colleges. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. June 2021. Retrieved from https://www.aamc.org/media/54681/download .

[x] American Association of Teaching Health Centers. Teaching Health Centers: The Facts. Retrieved from http://aathc.org/know-the-facts/.

House Committee on Energy and Commerce
Subcommittee on Health
"Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care"
April 19, 2023

Statement from Representative Young Kim (CA-40) in support of H.R. 2411, the National Nursing Workforce Center Act of 2023

Dear Chairman Guthrie, Ranking Member Eshoo, and Members of the Subcommittee:

I thank you for convening this important hearing today, and for including H.R. 2411, the National Nursing Workforce Center Act of 2023, in today's discussion. I am proud to have worked with Representative Lisa Blunt Rochester and Yorba Linda Councilwoman Beth Haney, a nurse practitioner and constituent of mine, on this legislation that will help us address the critical nursing workforce shortages we are facing in America today.

This issue is particularly felt in my home state of California. The Golden State has an estimated current shortage of about 40,567 full-time equivalent registered nurses that is projected to last through 2026[1]. A key concern is that many older registered nurses intend to leave the bedside within the next couple of years, citing significant burnout during the COVID-19 pandemic. While the pandemic clearly played a role in causing this increased burnout, it is clear that this shortage was not caused by it; rather, the pandemic merely exacerbated existing issues we have had within the nursing workforce. Left unchecked, this gap could threaten access to quality care for millions of Californians.

[1] Spetz, J, Chu, L, Blash, L. Forecasts of the Registered Nurse Workforce in California. San Francisco, CA: Philip R. Lee Institute for Health Policy Studies, August 2022.

The National Nursing Workforce Act would establish a fully-offset, two-year pilot grant program through the Health Resources and Services Administration (HRSA) to support nursing workforce centers, who help collect and analyze data and recommend changes necessary to bolster the nursing workforce. With support from federal grants and a newly established, nursing-focused technical assistance center, state entities and/or nonprofits would be empowered to either establish a nursing workforce center in their state or provide more support to existing centers so that they can continue to support their nursing workforces through data collection, curriculum development and training programs.

My state's nursing workforce center, HealthImpact, has been dedicated to finding innovative ways to help strengthen and plan the future of California's nursing workforce. They have used simulation-based training to prepare students to be ready for practice when they graduate and enter the workforce. They also have worked with a variety of California stakeholders on initiatives such as the Nurse Role Exploration Project, in which they identified and recommended new roles registered nurses could transition into to help address gaps in care delivery. These efforts are critical in informing us regarding the best path forward for protecting the long-term health of the nursing workforce.

Patients, nurses, and students alike deserve solutions to ensure that our nursing workforce remains strong and access to care is not impeded. Nursing workforce centers play an integral part in helping us understand the existing challenges the current workforce faces and recommending effective solutions to address them. Once again, I thank the Committee for holding this hearing, and I stand ready to work with all of you on this important legislation.

HealthImpact
Optimizing health through nursing

April 17, 2023

Honorable Cathy McMorris Rogers (R-WA), Chair, House Energy and Commerce Committee
Honorable Brett Guthrie (R-KY), Chair, Health Subcommittee

Re: H.R. 2411 -- SUPPORT

Dear Representatives Mc Morris Rogers and Guthrie,

On behalf of *Health**Impact***, the California nursing workforce and policy center, we would like to thank you for including H.R. 2411, the *National Nursing Workforce Act*, as part of your April 19, 2023 hearing on "Examining Existing Federal Programs to Build a Stronger Health Workforce and Primary Care." We are asking the House Energy and Commerce Committee to support H.R. 2411 that would provide critical funding for state-level nursing workforce centers such as HealthImpact and improve the delivery of nursing care throughout the United States.

*Health**Impact*** was founded in 2001 as a 501(c)(3) non-profit organization dedicated to building, sustaining, and upskilling the nursing workforce. Our vision is to have a highly skilled health care workforce optimizing health through innovation, interprofessional leadership, and nursing excellence. Our mission is to shape health care through workforce strategy, stakeholder convening, and policy advocacy. Our workforce strategy can be summarized in the infographic at the end of this letter in Appendix A.

H.R. 2411, the *National Nursing Workforce Center Act*, will support nursing workforce centers to serve as hubs to advance nursing education, practice, leadership, and workforce development at state and local levels using data-driven approaches. With more Americans growing older and the demand for health care increasing, the impact of a nursing shortage could be catastrophic. As the public health challenges of the past several years has shown, our country needs nurses to ensure access to critical health care services. All states are reporting difficulties in recruiting nurses to every setting where nurses practice – hospitals, long-term care facilities, clinics, and more.

Federally-supported institutions, such as the National Advisory Council on Nurse Education and Practice, National Center for Health Workforce Analysis, and Health Workforce Research Centers, research and advise on policies related to the national healthcare workforce. While these entities inform health workforce planning and policy at a national level, the needs of communities differ significantly across the country. Policies developed based on national data may not always make sense for individual regions, states, or local jurisdictions.

State nursing workforce centers fill this gap. Nursing workforce centers are hubs that advance nursing education, practice, leadership, and workforce development at the state and local levels using data-driven approaches. Services of a nursing workforce center typically include conducting localized research; publishing reports related to supply, demand, and educational capacity of the

MAIN ADDRESS Alta Bates Summit Medical Center, 3012 Summit Street, C-Wing, G677-G678, Oakland, CA 94609
SATELLITE ADDRESS HASC, 515 S. Figueroa Street, #1300, Los Angeles, CA 90071 • **MAILING ADDRESS** PO Box 70007, Oakland, CA 94612
TEL 510.832.8400 • **WEB ADDRESS** HealthImpact.org

nursing workforce; and implementing new programs to improve the nursing workforce in their states.

Since every state needs an individual approach to influence the nursing shortage, state nursing workforce centers implement evidence informed strategies to make the biggest impact. For instance, individual state nursing workforce have addressed the nursing shortage by:

Studying the unique characteristics state nursing workforce

- Gather data on supply, demand and educational pipeline of nurses (24 states).
- Explore regional and workplace setting differences to inform solutions (Oregon).

Increasing the number of new nurses

- Collect data and testing solutions to nurse faculty shortages (California, Connecticut, Hawaii, Idaho, Indiana, Louisiana, New Jersey, New York, Washington, and Wisconsin).
- Address inefficiencies in clinical experience scheduling and advocate for new clinical sites (California, Colorado, Connecticut, Hawaii, Idaho, Indiana, Maryland, Mississippi, New Jersey, Washington).
- Predict the need to increase nurse production which resulted in funding to more than double the students enrolled in nursing schools (North Dakota, New Jersey and Oregon).
- Coordinate scholarship programs (Colorado, Illinois, Indiana, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, and Vermont).

Recruiting nurses to the profession

- Create programs to increase interest and awareness of nursing to K-12 students (Arkansas, Colorado, Hawaii, Indiana, Mississippi, North Dakota, Washington).
- Build programs to diversify their nursing workforce including mentoring programs (Arkansas, California, Colorado, Connecticut, Illinois, Indiana, Louisiana, Michigan, Mississippi, New York, Pennsylvania, Washington, and Wisconsin).

Retaining nurses in the workplace

- Ensure the well-being of the nursing workforce and improve workplace environment (California, Colorado, Hawaii, Idaho, Indiana, Maryland, Mississippi, New Jersey, North Dakota, Pennsylvania, South Dakota, Washington, and Wisconsin).
- Create training opportunities for nurses at all levels and in all settings to advance leadership and professional practice (Arkansas, California, Colorado, Connecticut, Hawaii, Illinois, Indiana, Louisiana, Maryland, Mississippi, Montana, New Mexico, North Dakota, Pennsylvania, Washington, and Wisconsin).
- Promote continual learning and academic progression for nurses (Arkansas, California, Colorado, Connecticut, Hawaii, Indiana, Maryland, Pennsylvania, and Washington).

Advocate for changes to improve the stability of our state's nursing workforce

- Provide critical employer- education connections through statewide planning and implementation of programs (Colorado, Connecticut, Indiana, North Dakota)

- Leverage connections through state nursing stakeholders to pass critical legislation such as Nurse Licensure Compacts and respond to the future needs of the nursing workforce needs following the COVID pandemic (Louisiana, North Dakota, Oregon, Louisiana, West Virginia).

We, at *Health**Impact***, ask the House Energy and Commerce Committee and the Health Subcommittee to continue the discussion at the federal level to ensure that all people in America have access to high quality and safe patient care by nurses.

Please do not hesitate to contact me if you have any questions.

Sincerely,

Garrett Chan, PhD, RN, NP, FAAN
President & CEO
*Health**Impact***

MAIN ADDRESS Alta Bates Summit Medical Center, 3012 Summit Street, C-Wing, G677-G678, Oakland, CA 94609
SATELLITE ADDRESS HASC, 515 S. Figueroa Street, #1300, Los Angeles, CA 90071 • MAILING ADDRESS PO Box 70007, Oakland, CA 94612
TEL 510.832.8400 • WEB ADDRESS HealthImpact.org

Appendix A: *HealthImpact*'s Workforce Strategy for California

Center for American Progress
1333 H Street NW, Suite 100E
Washington, DC 20005
202.682.1611
americanprogress.org

April 19, 2023

The Honorable Cathy McMorris Rodgers, Chair
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Frank Pallone, Ranking Member
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

RE: H.R. 2411, the "National Nursing Workforce Center Act of 2023"

Dear Chairwoman Rodgers and Ranking Member Pallone:

The Center for American Progress (CAP) submits this letter in support of H.R. 2411, the "National Nursing Workforce Center Act of 2023". As a nonprofit policy institute dedicated to improving the lives of all Americans, CAP has been a leader in advocating for labor and workforce policies that advance opportunities for workforce development, promote access to job growth and economic mobility, and protect workers. CAP also leads in promoting policies to improve the nation's health care and public health infrastructure, ensuring better health for all communities.

Nursing is a bedrock profession that provides economic security to millions of workers across the country, and nurses deliver essential services to patients every day. Over the past several years, CAP has documented and analyzed the significant workforce challenges facing the nursing workforce, and has put forth several recommendations to address the nursing shortage.[i]

The nursing profession faces longstanding pipeline and retention challenges. On the pipeline side, lack of sufficient faculty, clinical placements, and adequate training facilities cause nursing programs at colleges and universities to turn away tens of thousands of applicants every year. However, nurses are also leaving the profession in droves, due to concerns including pay, staffing ratios, workplace safety, and burnout.[ii]

Yet, COVID-19 has exacerbated long standing challenges in the nursing profession. An April 2023 study published in the Journal on Nursing Regulation found that approximately half of nurses in a representative sample felt 'emotionally drained', 'used up', 'fatigued', or 'burned out', while approximately thirty percent were at the 'end of their rope' a few times a week or every day. These experiences occur as a remarkable 97,312 Registered Nurses left the workforce last year – and nurses with less than ten years of experience comprise 41% of that number.[iii]

The United States cannot sustain this volume of nursing drop off. Historically, interventions in nursing shortages have been reactive rather than strategic. And while recent investments[iv] – largely in nursing education – are welcome, it is crucial to ensure that states have the necessary tools and structure to develop and implement holistic strategies that use data and research to address both pipeline and retention issues.

The introduction and standardization of state-level nursing workforce centers, such as those authorized by H.R. 2411, would be a critical step towards preventing and mitigating future nursing shortages. Specifically, this legislation would enable state-level nursing organizations to be at the forefront of nursing workforce strategy and convene partners, conduct analysis and research, conduct workforce planning, and implement programs that tactically address both pipeline and retention challenges in the nursing workforce. Nurse recruitment and retention cannot be left to chance, and state-level nursing workforce centers can drive nursing analysis and strategy in a region.

Notably, this legislation is designed as a two-year pilot program. This will allow the Secretary of Health and Human Services to evaluate the efficacy of this model and develop best practices, if appropriate, for expansion.

CAP is committed to identifying the causes and solutions to workforce shortages across the nursing workforce, and we are grateful for the opportunity to provide this support to the Committee including our analysis and recommendations.

If you have any questions or would like to speak further about any proposals included above, please reach out to Madeline Shepherd, Director of Government Affairs, at mshepherd@americanprogress.org.

Thank you for your work on behalf of the American people.

Sincerely,
Marina Zhavoronkova, Senior Fellow, Workforce Development
Center for American Progress
mzhavoronkova@americanprogress.org

Bradley Custer, Senior Policy Analyst, Higher Education
Center for American Progress
bcuster@americanprogress.org

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[i] Marina Zhavoronkova, Bradley Custer, Anona Neal, Justin Schweitzer, and Marcella Bombardieri, "How To Ease the Nursing Shortage in America, Center for American Progress, May 23, 2022, available at https://www.americanprogress.org/article/how-to-ease-the-nursing-shortage-in-america/.

[ii] Marina Zhavoronkova, Nicole Rapfogel, and Emily Gee, "Address the nursing shortage with realistic staffing and fair contracts", The Hill, March 2, 2023, available at https://thehill.com/opinion/healthcare/3880961-address-the-nursing-shortage-with-realistic-staffing-and-fair-contracts/.

[iii] Brendan Martin, PhD, Nicole Kaminski-Ozturk, PhD, Charlie O'Hara, PhD, and Richard Smiley, MS, "Examining the Impact of the COVID-19 Pandemic on Burnout and Stress Among U.S. Nurses", Journal of Nursing Regulation, April 2023, available at https://doi.org/10.1016/S2155-8256(23)00063-7.

[iv] Marcia Frellick, "Government Funding Helps Train More Nurses Amid Faculty Shortage", MedScape, January 19, 2023, available at https://www.medscape.com/viewarticle/987190.

ADA American Dental Association®

1111 14th Street, N.W.
Suite 1200
Washington, DC 20005

T 202.898.2400
F 202.898.2437
www.ada.org

April 18, 2023

The Honorable Frank Pallone, Jr.
U.S. House of Representatives
2107 Rayburn House Office Building
Washington, DC 20515

Dear Representative Pallone:

On behalf of our 159,000 dentist members, the American Dental Association (ADA) would like to thank you for sponsoring H.R. 2569, the Doctors of Community Act (DOC Act). The ADA strongly supports efforts to increase the dental workforce, especially in underserved communities and populations, through support for new and expanded dental residency programs. We would also like to thank you, as Ranking Member of the House Energy and Commerce Committee, for including this bill in the Health Subcommittee's hearing on "Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care."

As you know, the DOC Act would permanently extend and expand the Teaching Health Center Graduate Medical Education (THCGME) program, which trains residents to serve some of our nation's most vulnerable populations in community-based settings such as Federally Qualified Health Centers (FQHCs), Rural Health Clinics, and tribal health centers. Permanent, dedicated funding would provide stability to teaching health centers and strengthen continuity of care in underserved communities.

The DOC Act would also direct critical funding to a program that has needed increased resources for years, allowing for the expansion of existing THCGME programs and the creation of many new THCGME programs and residency slots. The expansion would address general health workforce shortages and would also increase equity by addressing persistent disparities. Because 60 percent of THCGME training sites are in Medically Underserved Communities (MUCs), and research suggests that dentists and physicians are more likely to practice near the location of their training, this bill would likely increase access to care in MUCs and lead to better health outcomes among populations experiencing oral health disparities.

The ADA greatly appreciates your introduction of H.R. 2569 and your leadership on this issue. If you have any questions, please contact Ms. Jennifer Fisher at (202)789-5160 or fisherj@ada.org.

Sincerely,

George R. Shepley, D.D.S.
President

Raymond A. Cohlmia, D.D.S.
Executive Director

GRS:RAC:jf

AMERICAN ACADEMY OF FAMILY PHYSICIANS

April 19, 2023

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

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

Dear Chairman Guthrie and Ranking Member Eshoo:

On behalf of the American Academy of Family Physicians (AAFP) and the 129,600 family physicians and medical students we represent, I applaud the committee for its focus on the health care workforce. I write in response to the hearing: "Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care" to share the family physician perspective and the AAFP's policy recommendations for ensuring that we have a robust primary care workforce to address our nation's current and future health care needs.

The AAFP has long been concerned about the shortage of primary care physicians in the U.S., particularly the supply of family physicians, who provide comprehensive, longitudinal primary care services for patients across the lifespan, including chronic disease management, treatment of acute illnesses, and preventive care. It is projected that we will face a shortage of up to 48,000 primary care physicians by 2034.[1] Additionally, the lack of transparency in how federal graduate medical education (GME) funds are spent undermines efforts to address physician shortages. For example, Medicare spends about $16 billion annually on GME – but CMS does not assess whether they address physician shortages.[2]

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

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

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

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

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

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

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

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

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

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

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

Strengthen and Target Federal Graduation Medical Education Programs

We know most physicians are trained at large academic medical centers in urban areas, and evidence indicates physicians typically practice within 100 miles of their residency program.[6] As a result, the current distribution of trainees leads to physician shortages in medically underserved and rural areas.

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

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

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

One barrier to creating a more equitable and effective Medicare GME program is the lack of transparency in how funds are used. Medicare is the largest single payer – spending about $16 billion annually on GME – but it does not assess how those funds are ultimately used or whether they actually address physician shortages.[7] CMS has indicated their authority is limited to making

payments to hospitals for the costs of running approved GME residency programs. **Congress should pass legislation granting the Secretary of HHS and the CMS Administrator the authority to collect and analyze data on how Medicare GME positions are aligned with national workforce needs and publish an annual report.**

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

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

Address the Burden of Medical Student Debt

The average student loan debt for four years of medical school, undergraduate studies and higher education is on average between $200,000 and $250,000.[10] Research has shown that loan forgiveness or repayment programs directly influence physician practice choice. The rising level of educational debt disproportionately affects underrepresented and low-income students and limits their representation in the health workforce but reducing student debt will diversify the physician pipeline and help reduce physician shortages. **Congress should expand funding for federal programs, including the National Health Service Corps Program, that incentivize physicians to go into primary care practice by providing loan forgiveness.**

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

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

Invest in Primary Care

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

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

Congress must also act to bolster the primary care physician pipeline by enacting Medicaid payment parity. On average, Medicaid pays just 66 percent of the Medicare rate for primary care services and can be as low as 33 percent in some states.[12] This severely reduces the number of physicians who participate in Medicaid and limits access to health care for children and families. Increasing Medicaid payment rates will improve access to care for Medicaid patients, lead to better health outcomes, and reduce longstanding health disparities. **The AAFP urges Congress to pass the Kids' Access to Primary Care Act of 2023 (H.R. 952) to permanently raise Medicaid payment rates for primary care services to at least Medicare levels.**

Support Physician-Led Team Based Care

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

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

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

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

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

Diversify the Physician Workforce

The lack of a diverse physician workforce has significant implications for public health. Physicians who understand their patients' languages and understand the larger context of culture, gender, religious beliefs, sexual orientation and socioeconomic conditions are better equipped to address the needs of specific populations and the health disparities among them. Several studies show that racial, ethnic and gender diversity among physicians promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.[15,16] Improving quality of care for the most vulnerable groups can improve a patient's health outcomes, which in turn can reduce health care costs over the long run. Studies also show that students from backgrounds currently underrepresented in medicine are more likely to care for underserved populations in their careers and are more likely to choose primary care careers.[17]

While primary care specialties fare better than other specialties in representation of racial and ethnic minorities in the workforce, the entire physician workforce lags significantly behind the racial and ethnic diversity of the U.S. population. Today, Black and Hispanic Americans account for nearly one-third of the U.S. population, but just 11 percent of physicians.[18,19]

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

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

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

Strengthen and Sustain our Health Care Safety Net

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

Support Integration of Behavioral Health and Primary Care

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

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

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

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

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

Stop Anti-Competitive Contracting Practices that Harm Clinicians and Patients

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

Increase Investment in Primary Care Research

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

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

Thank you in advance for consideration of our recommendations. The AAFP looks forward to working with the committee to develop and implement policies to strengthen and sustain our nation's health care workforce. Should you have any questions, please contact David Tully, Vice President of Government Relations at dtully@aafp.org and Natalie Williams, Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

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Statement by the Association of American Medical Colleges (AAMC) on Federal Health Submitted for the Record to the House Committee on Energy and Commerce Subcommittee on Health hearing, titled, "Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care"
April 19, 2023

Thank you for the opportunity to submit a document for the record regarding the important role of federal health care workforce programs. We greatly appreciate the subcommittee's bipartisan leadership in this area, and we look forward to collaborating on policies to foster a robust and diverse health care workforce that is prepared to meet the needs of patients everywhere.

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 157 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers.

The AAMC's recommendations for strengthening the health workforce and improving access to care can be summarized as follows:

1. Expanding federal support for graduate medical education (GME)
2. Investing in proven Health Resources and Services Administration (HRSA) Title VII workforce programs
3. Supporting programs that provide new pathways into medicine
4. Advancing immigration policies that bolster healthcare workforce and retain health professionals, including Conrad 30 and reduction of Green Card backlogs
5. Expanding medical schools at Minority Servicing Institutions, Historically Black Colleges and Universities, and in underserved communities
6. Retaining Public Service Loan Forgiveness (PSLF)
7. Expanding the National Health Services Corps (NHSC)
8. Ensuring the preservation of the health care safety net

AAMC Recommends Expanding Federal Support for GME

The AAMC continues to project that physician demand will grow faster than supply (primarily driven by a growing, aging U.S. population), leading to a projected shortage of up to 124,000 physicians by 2034. This includes shortages of both primary care and non-primary care specialty physicians (e.g., psychiatry, infectious disease, and general surgery). These shortages in the physician supply will have a real impact on patients, particularly those living in rural, frontier, island or non-contiguous settings, as well as other already underserved communities. The AAMC's "Health Care Utilization Equity" scenario finds that if underserved populations were to experience the same health care use patterns as populations with fewer barriers to access, the U.S. would need an additional 102,400 to 180,400 physicians just to meet *current* demand.[1] These estimates, which are separate from the 2034 shortage projection ranges, illustrate the magnitude of current barriers to care and provide an additional reference point when gauging the inadequacy of physician workforce supply.

Addressing the nation's physician workforce shortages in both primary care and other needed specialties requires a multipronged, innovative, public-private approach beyond just increasing the overall number of physicians, including implementing team-based care models and furthering the use of technology. We are open to and in fact, ask for, innovative solutions to address health workforce shortages. Since academic year 2002-2003, total medical school enrollment has grown by more than 38 percent, as medical schools have expanded class sizes and more than 32 new medical schools have opened. Indeed, our institutions have risen to the challenge, taking serious steps to enroll, educate, and produce more physicians. This expansion has been thoughtful, deliberate, and with significant cost – our institutions should be acknowledged and applauded. While this increase is encouraging, additional action is still needed to address the physician shortage.

We appreciate that Congress has taken bipartisan steps to expand Medicare support for graduate medical education (GME) to help address current and projected physician shortages. Although it is not within the purview of this subcommittee hearing, the AAMC urges Congress to build upon these efforts and to enhance investment in Medicare-supported GME, which helps offset a portion of the costs associated with operating residency training programs. While we are extremely grateful that Congress has provided 1,200 new Medicare-supported GME positions over the last three years, more must be done to address this looming crisis. As the nation's population ages and requires more medical care, it is imperative that the physician workforce is equipped to meet the needs of patients and communities. For this reason, the AAMC supports the bipartisan Resident Physician Shortage Reduction Act of 2023 (H.R. 2389), which would gradually increase the number of Medicare-supported GME positions by 2,000 per year over seven years.

The AAMC also supports GME programs administered by HRSA, including Children's Hospitals GME (CHGME) and Teaching Health Center GME (THCGME), which help to increase the number of residents training in children's hospitals and community health centers, respectively. The $330 million in supplemental funding for THCGME in FY 22 enabled HRSA

[1] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034, Prepared for the AAMC by IHS Markit Ltd., June 2021.

to support new community-based primary care residency programs. The AAMC continues to urge Congress to increase annual appropriations for these GME programs in FY 2024, including $738 million for CHGME.

AAMC Urges Congress to Invest in Proven HRSA Title VII Workforce Programs

To help shape the physician workforce, the AAMC recommends significantly increasing funding for the HRSA workforce development programs under Title VII and Title VIII of the Public Health Service Act. For FY 2024, the AAMC joins an alliance of national organizations, the Health Professions and Nursing Education Coalition (HPNEC), in recommending at least $1.51 billion combined for Title VII and Title VIII programs.

We recognize the value of diversity in health care and the health workforce and agree that diversity may manifest in different forms. The HRSA Title VII health professions and Title VIII nursing programs play an important role in connecting students to health careers by enhancing recruitment, education, training, and mentorship opportunities. Inclusive education and training experiences expose students and providers to backgrounds and perspectives that heighten cultural awareness in health care, resulting in benefits for all patients and providers. Studies also show that underrepresented students are more likely to serve patients from rural and under-resourced communities.[2] Despite their success and widespread interest, currently only 21 schools have HRSA Health Careers Opportunity Program (HCOP) grants and only 18 have HRSA Center of Excellence (COE) grants — down from 80 HCOP programs and 34 COE programs in 2005 before the programs' federal funding was cut substantially.

Part of fortifying the physician workforce is taking care of existing, practicing physicians. We know that physicians and other health professionals dedicate their careers to keeping people healthy, but too often they do not receive the care they need to address their own well-being. In these past years during the pandemic, we have seen an increase in stress and burnout among physicians, sometimes with a tragic, fatal end. The HRSA Title VII Preventing Burnout in the Health Workforce program authorized by the Dr. Lorna Breen Health Care Provider Protection Act (P.L. 117-105), which received no funding in the FY 23 omnibus, must receive funding to support existing physicians. We cannot afford to lose any of our physicians to the stress of the profession that they have dedicated so much time and energy to master.

Bipartisan members of Congress will attest that there is a shortage of health providers in rural, frontier, and island or non-contiguous communities. Important to addressing shortages across the spectrum of health providers in these rural areas is conducting education and training in these communities and drawing on members of these areas to enter health professions. Medical students who grow up in rural and under-resourced communities are much more likely to return to these areas to practice medicine, including primary care. Many medical schools aim to identify

[2] Stewart, K., Brown, S. L., Wrensford, G., & Hurley, M. M. (2020). Creating a Comprehensive Approach to Exposing Underrepresented Pre-health Professions Students to Clinical Medicine and Health Research. Journal of the National Medical Association, 112(1), 36-43. doi:10.1016/j.jnma.2019.12.003.
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potential candidates from rural and under-resourced communities and encourage them to pursue a career in medicine.[3] The HRSA Title VII Area Health Education Centers (AHECs) specifically focus on recruiting and training future physicians in rural areas, as well as providing interdisciplinary health care delivery sites. Additionally, the HRSA Title VII Primary Care Training and Enhancement (PCTE) and Medical Student Education programs support education and training programs for future primary care physicians. Though we have seen progress towards diversifying the future physician workforce across the spectrum of our AAMC-member institutions, there is more work to be done. As these programs undergo reauthorization, we look forward to working with House Energy and Commerce Committee and the full Congress to ensure these programs are authorized before they expire at the end of fiscal year 2025.

AAMC Endorses New Pathways into Medicine

Medical education costs can also be a significant deterrent and burden for individuals interested in medicine, and the AAMC is deeply concerned about the impact these costs may have on the physician pathway.[4] Medical school leaders across the country are committed to serving the interests of medical students and reducing this burden. Some institutions have increased institutional aid, while a few have committed to eliminating debt or tuition altogether in the hopes of attracting diverse candidates and increasing interest in primary care.[5] In the 117th Congress, the AAMC endorsed both the Ways and Means Committees' "Rural and Underserved Pathway to Practice Program and "National Medical Corps Act" (H.R. 9105, as introduced in the 117th Congress) scholarship programs to help address the financial debt burden for students who are underrepresented in medicine. Importantly, the Pathway to Practice program would prioritize applicants who attended HBCUs or MSIs, as well as those who participated in certain HRSA pathway programs.

AAMC Encourages Congress to Reauthorize the Conrad 30 Program

Immigration must be mentioned as we consider health workforce shortages, as the US health workforce has been bolstered by individuals who have come from other countries to our nation and worked in the health sector. Over the last 15 years, the Conrad 30 J-1 visa waiver program has brought more than 15,000 physicians to underserved areas — comparable to (if not more than) the National Health Service Corps (NHSC), at no cost to the federal government. As the 118th Congress considers immigration reform, the AAMC reiterates that the bipartisan Conrad State 30 and Physician Access Reauthorization Act would allow Conrad 30 to expand beyond 30 waivers per state if certain nationwide thresholds are met. We applaud this bipartisan reauthorization proposal for recognizing immigrating physicians as a critical element of our nation's health care infrastructure, and we support the expansion of Conrad 30 to help overcome hurdles that have stymied growth of the physician workforce.

[3] Attracting the next generation of physicians to rural medicine, Peter Jaret, Special to AAMCNews, Feb. 2020.
[4] Physician Education Debt and the Cost to Attend Medical School: 2020 Update.
[5] Will free medical school lead to more primary care physicians? Ken Budd, Special to AAMCNews, Dec. 2019.

AAMC Supports Retaining Health Professionals by Reducing Green Card Backlogs

To bolster the workforce, the U.S. should address the backlog of applications for green cards by lifting per country caps that are impeding physicians and other healthcare professionals entering the U.S. from certain countries. At the same time, we are concerned that limiting the aggregate number of green cards each year only shifts the problem from one country to another. This is particularly problematic for nurses who, depending on state licensure requirements, may not be eligible for H-1B specialty occupation visas and instead apply directly for immigrant visas and green cards, potentially facing decade-long wait times while overseas. To break these backlogs, the bipartisan Healthcare Workforce Resilience Act (H.R. 2255, S. 1024 as introduced in the 117th Congress) would authorize the recapture of unused immigrant visas and redirect them to 25,000 immigrant visas for professional nurses and unused 15,000 immigrant visas for physicians. Importantly, these visas would be issued in order of priority date, not subject to the per country caps, and premium processing would be applied to qualifying petitions and applications.

AAMC Supports Expanding Medical Schools at Minority Servicing Institutions, Historically Black Colleges and Universities, and in Underserved Communities

According to the AAMC report, Altering the Course: Black Men in Medicine, only 3% of all physicians are Black men.[6] The projections related to the future physician workforce as measured through a diverse lens emphasize that interventions to increase the number of black men in medicine requires collective, current efforts. The pathway for students to be exposed to STEM and health professions must begin sooner and should include options to attend institutions committed to diverse communities. The AAMC encourages increasing federal investment in minority serving institutions (MSIs), including Historically Black Colleges and Universities (HBCUs), Predominantly Black Institutions (PBIs), Hispanic Serving Institutions, and Tribal Colleges and Universities. AAMC also supports the Expanding Medical Education Act (H.R. 801, S. 3422 as introduced in the 117th Congress), which would authorize HRSA grants to establish or expand medical schools, including regional branch campuses, and would prioritize HBCUs, MSIs, or those institutions that propose to establish or expand schools in medically underserved communities or areas with shortages of health professionals where no such schools exist. An increase of diverse physicians will help more diverse patients establish trusted, coveted physician-patient relationship and will hopefully lead to better clinical outcomes.

AAMC Encourages Congress to Retain Public Service Loan Forgiveness

Public service loan repayment programs offered by HRSA, NIH, VA, the Department of Defense, and the Indian Health Service are effective, targeted incentives for recruiting physicians and other health professionals to serve specific vulnerable populations. Increasing federal investment in these programs is a proven way to increase the supply of health professionals serving health professional shortage areas (HPSAs), nonprofit facilities, and other under-resourced communities. For example, the Public Service Loan Forgiveness (PSLF) program administered by the Department of Education encourages physicians to pursue careers that

[6] Association of American Medical Colleges. Altering the Course: Black Males in Medicine. https://store.aamc.org/altering-the-course-black-males-in-medicine.html. Accessed April 13, 2023.

benefit communities in need. The AAMC supports preserving physician eligibility for PSLF to help vulnerable patients and nonprofit medical facilities that use the program as a provider recruitment incentive.

AAMC Supports Expanding NHSC to Address Shortage Areas

The National Health Service Corps plays a significant role in recruiting primary care physicians to federally-designated HPSAs through scholarships and loan repayment options. Congress provided a historic $800 million supplemental NHSC funding in FY 22, enabling NHSC to recruit the largest primary care workforce for the program in its 50-year history.[7] With a field strength of 20,215 in 2022, including 2,587 physicians, more than 21 million patients relied on NHSC providers for health care.[8] Despite the NHSC's success, it still falls far short of fulfilling the wide-ranging health care needs of all HPSAs due to growing demand for health professionals across the country. The AAMC supports continued growth for the NHSC in FY 2024 appropriations, and we urge Congress to provide a level of funding for the NHSC that would fulfill the needs of all current HPSAs.

AAMC Supports the Preservation of the Health Care Safety Net

The AAMC recognizes the critical role that community-based organizations, including community health centers, play in expanding access to care in rural, under-resourced, and historically marginalized communities, thereby advancing health equity. As anchor institutions in their communities, our member teaching hospitals and health systems and physician faculty partner with these organizations to redress historic inequities, build trust, and secure a healthier future for all.

AAMC-member institutions rely on key federal programs to help support and enhance collaborations with their community partners. One such program, the 340B Drug Pricing Program, allows certain types of "covered entities" to purchase outpatient drugs at a discount, thereby enabling them to "stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." These covered entities, which include community health centers, certain types of hospitals, and specialized clinics, constitute the foundation of our nation's health care safety net, caring for a disproportionate number of historically marginalized and under-resourced patients.

Safety-net hospitals, many of which are teaching hospitals, play an important role in the 340B program: they provide access to a wide range of high-quality, specialized health care services, which patients may be unable to receive elsewhere. Academic medical centers will frequently partner with local community health centers by providing medical professional staffing, as well as financial, administrative, and IT support. Thanks to these partnerships, community health centers can provide their patients with coordinated care, referring them to the academic medical center should they require a more intensive or complex interventions. Community health centers

[7] Health Resources and Services Administration. Department of Health and Human Services Fiscal Year 2024 Justification of Estimates for Appropriations Committees. hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf. Accessed April 10, 2023.
[8] *Ibid.*

also provide an opportunity for medical students and residents to work, learn, and collaborate in a community-based setting, thereby strengthening the medical education experience.

Our member institutions put their 340B savings to good and proper use. Without 340B, many AAMC-member teaching hospitals could struggle to maintain their community partnerships, which would significantly reduce patients' access to the continuum of care. AAMC-member institutions also utilize their 340B savings to ensure that uninsured and underinsured patients have access to cutting-edge treatment regimens for complex conditions like cancer, hemophilia, sickle cell disease, HIV/AIDs, and hepatitis C. In addition, they use their savings to invest in preventive, community-based care, which help to keep patients healthy and reduces the need for hospital-based care.

Again, the AAMC thanks the committee for its bipartisan work to address health care challenges related to access to care and workforce shortages. We urge you to continue bipartisan efforts to increase the federal government's investments in federal programs that have demonstrated results and impact. The cost of inaction today will lead to higher costs, reduced access, and ultimately an underserved, less healthy population tomorrow. We at the AAMC are committed to working with the entire House Energy and Commerce Health Subcommittee, and the full Congress to achieve this goal. If you have any further questions, please contact AAMC Chief Public Policy Officer Danielle Turnipseed, at dturnipseed@aamc.org, or Len Marquez, Senior Director, AAMC Government Relations and Legislative Advocacy, at lmarquez@aamc.org.

1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.ahca.org

April 18, 2023

The Honorable Cathy McMorris Rodgers
Chairwoman
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman McMorris Rodgers and Ranking Member Pallone:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) is the nation's largest association of long-term and post-acute care providers. AHCA/NCAL advocates for quality care and services for frail, elderly, and disabled Americans. Our members provide essential care to millions of individuals in more than 14,500 nursing homes, assisted living and centers for individuals with intellectual and developmental disabilities.

Our organization is proud to endorse H.R. 2411, National Nursing Workforce Act, introduced by Representative Lisa Blunt Rochester.

According to data available via the BLS (Bureau of Labor Statistics), the long-term care industry has faced the worst job loss among all healthcare providers throughout the pandemic, especially nurses.

H.R. 2411 The National Nursing Workforce Center Act would do four things: Establish a fully-offset, sustainable pilot grant program through the Health Resources and Services Administration (HRSA) to support state-based nursing workforce centers; Broaden HRSA's authority to establish Health Workforce Research Centers on any program under the Public Health Service Act, rather than just Title VII programs authorized under current

statute: Give HRSA clear authority and a mandate to focus on nursing issues by requiring the agency to establish a nursing focused research and technical assistance center under the Health Workforce Research Center Program. Require reports assessing this public-private partnership and if and how it should be expanded nationwide.

This bipartisan legislation will help in resolving existing nursing workforce challenges, in conjunction with the increased demand for health care and our rapidly aging population.

AHCA/NCAL looks forward to working with you to see this legislation become law as quickly as possible.

Sincerely,

Clifton Porter, II
Senior Vice President, Government Relations

NATIONAL FORUM OF STATE NURSING WORKFORCE CENTERS

April 19, 2023

Chair Cathy McMorris Rodgers
Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives
Washington, DC 20510

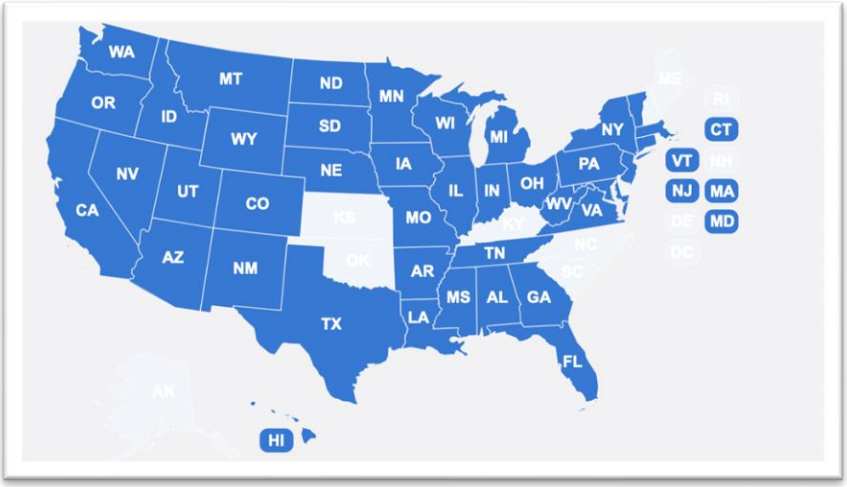
Rep. Frank Pallone
Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives
Washington DC 20510

Chair McMorris Rodgers and Representative Pallone:

On behalf of the National Forum of State Nursing Workforce Centers (National Forum), we would like to thank you for including the National Nursing Workforce Act HR 2411 as a part of your April 19th hearing on "Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care."

This act would provide critical funding for state-level nursing workforce centers and improve the delivery of nursing care throughout the United States.

The National Forum is a group of 40 state nursing workforce centers that focus on addressing the nursing shortage within their states and contribute to the national effort to meet the health needs of the US population with an adequate supply of qualified nurses.



The Forum supports the advancement of new and existing nurse workforce initiatives by sharing best practices in nursing workforce research, workforce planning, workforce development, and the formulation of workforce policy.

Federally-supported institutions, such as the National Advisory Council on Nurse Education and Practice, National Center for Health Workforce Analysis, and Health Workforce Research Centers, research and advise on policies related to the national healthcare workforce. While these entities inform health workforce planning and policy at a national level, the needs of communities differ significantly across the country. Policies developed based on national data may not always make sense for individual regions, states, or local jurisdictions.

State nursing workforce centers fill this gap. Nursing workforce centers are hubs that advance nursing education, practice, leadership, and workforce development at the state and local levels using data-driven approaches. Services of a nursing workforce center typically include: conducting localized research; publishing reports related to supply, demand, and educational capacity of the nursing workforce; and implementing new programs to improve the nursing workforce in their states.

Since every state needs an individual approach to influence the nursing shortage, state nursing workforce centers implement evidence informed strategies to make the biggest impact. For instance, individual state nursing workforce have addressed the nursing shortage by:

Studying the unique characteristics state nursing workforce

- Gather data on supply, demand and educational pipeline of nurses (24 states).
- Explore regional and workplace setting differences to inform solutions (Oregon).

Increasing the number of new nurses

- Collect data and testing solutions to nurse faculty shortages (California, Connecticut, Hawaii, Idaho, Indiana, Louisiana, New Jersey, New York, Washington, and Wisconsin).
- Address inefficiencies in clinical experience scheduling and advocate for new clinical sites (California, Colorado, Connecticut, Hawaii, Idaho, Indiana, Maryland, Mississippi, New Jersey, Washington).
- Predict the need to increase nurse production which resulted in funding to more than double the students enrolled in nursing schools (North Dakota and Oregon).
- Coordinate scholarship programs (Colorado, Illinois, Indiana, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, and Vermont).

Recruiting nurses to the profession

- Create programs to increase interest and awareness of nursing to K-12 students (Arkansas, Colorado, Hawaii, Indiana, Mississippi, North Dakota, Washington).
- Build programs to diversify their nursing workforce including mentoring programs (Arkansas, California, Colorado, Connecticut, Illinois, Indiana, Louisiana, Michigan, Mississippi, New York, Pennsylvania, Washington, and Wisconsin).

Retaining nurses in the workplace

- Ensure the well-being of the nursing workforce and improve workplace environment (California, Colorado, Hawaii, Idaho, Indiana, Maryland, Mississippi, New Jersey, North Dakota, Pennsylvania, South Dakota, Washington, and Wisconsin).
- Create training opportunities for nurses at all levels and in all settings to advance leadership and professional practice (Arkansas, California, Colorado, Connecticut, Hawaii, Illinois, Indiana, Louisiana, Maryland, Mississippi, Montana, New Mexico, North Dakota, Pennsylvania, Washington, and Wisconsin).
- Promote continual learning and academic progression for nurses (Arkansas, California, Colorado, Connecticut, Hawaii, Indiana, Maryland, Pennsylvania, and Washington).

Advocate for changes to improve the stability of our state's nursing workforce

- Provide critical employer- education connections through statewide planning and implementation of programs (Colorado, Connecticut, Indiana, North Dakota)
- Leverage connections through state nursing stakeholders to pass critical legislation such as Nurse Licensure Compacts and respond to the future needs of the nursing workforce needs following the COVID pandemic (Louisiana, North Dakota, Oregon, Louisiana, West Virginia).

As your conversations continue and if the National Forum or the state nursing centers can be of any assistance or if you have questions, please do not hesitate to contact Patricia Moulton Burwell, PhD, Director of the National Forum of State Nursing Workforce Centers at info@nursingworkforcecenters.org

Sincerely,

Lanelle Weems, MSN, RN
President, National Forum of State Nursing Workforce Centers Board of Directors
Executive Director, Mississippi Center for Quality and Workforce

PA EDUCATION ASSOCIATION
655 K Street NW, Ste. 700, Washington, DC 20001
PAEAonline.org • 703-548-5538

Statement for the Record
Submitted to
U.S. House of Representatives Committee on Energy and Commerce
Health Subcommittee
"Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care"
April 19, 2023

The PA Education Association (PAEA), representing the 303 accredited PA programs in the United States, welcomes the opportunity to submit a statement for the record regarding current health workforce investments and legislation under consideration to strengthen these efforts.

As health systems and communities throughout the United States continue to grapple with growing shortages of health care providers, congressional action to expand existing workforce investments is critical. According to the Association of American Medical Colleges, the U.S. is anticipated to face a shortage of up to 124,000 physicians by 2034.[1] While currently funded workforce programs play an important role in ensuring a sufficient supply of well-trained providers, this projected shortfall illustrates the need for significantly higher levels of funding for all primary care disciplines to effectively meet demand for needed care.

[1] Association of American Medical Colleges. (2021). *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034.* https://www.aamc.org/media/54681/download.

Throughout its history, the PA profession has played a unique role in responding to primary care provider shortages. Originally founded in the mid-1960s specifically to address projected shortages of primary care physicians, PA education is based on an accelerated medical model that allows graduates to quickly enter the workforce. The typical PA program lasts approximately 27 months and is divided into a didactic, or classroom-based phase, followed by a clinical phase. During students' clinical year, they complete a series of clinical rotations in primary care, behavioral health, obstetrics and gynecology, surgery, and emergency medicine, among other specialties. Based upon this generalist training, graduates are equipped, once certified and license, to provide the full range of medical services patients expect and deserve, including diagnosing illnesses, developing treatment plans, and prescribing medications.

As Congress considers steps to strengthen current workforce programs, PAEA urges the subcommittee to dedicate particular attention to funding for the National Health Service Corps (NHSC). Prior to September 30, Congress must take action to prevent a lapse in mandatory funding for the NHSC scholarship and loan repayment programs. For over 50 years, the NHSC has been one of the federal government's largest investments in workforce distribution, making loan repayment and scholarship agreements with clinicians and students in exchange for a practice commitment in an underserved community.

In 2021, a supplemental investment of $800 million for the NHSC resulted in field strength growing from 13,053 providers in fiscal year 2019 to 20,215 providers in fiscal year 2022, an increase of nearly 55%.[2] This temporary funding increase allowed HRSA to provide awards to nearly all eligible applicants, thereby significantly increasing access to care in underserved communities. However, in the absence of adjusted mandatory funding levels, it is likely that HRSA will return to being unable to fund a majority of eligible applicants, reducing the

[2] Health Resources and Services Administration. (2022). *Bureau of Health Workforce Field Strength and Students and Trainees Dashboards.* https://data.hrsa.gov/topics/health-workforce/field-strength.

impact of a program that has a more than 80% retention rate for clinicians in underserved communities two years following their service commitment.[3]

PAEA applauds the subcommittee's attention to the NHSC through its consideration of the bipartisan Strengthen Community Care Act, which would reauthorize the NHSC's mandatory funding stream for five years. **As the subcommittee considers this legislation, PAEA urges members to adopt the mandatory funding levels proposed in the bipartisan Restoring America's Health Care Workforce and Readiness Act of $625 million in fiscal year 2024, $675 million in fiscal year 2025, and $825 million in fiscal year 2026.** These funding levels would allow for the maintenance of current field strength while allowing for continued growth to mitigate future shortages.

PAEA appreciates the opportunity to provide the Association's perspective on existing workforce investments and looks forward to serving as a resource to members and staff. Should you require additional information or have questions, please contact Tyler Smith, Senior Director of Government Relations, at tsmith@PAEAonline.org or 703-667-4356.

[3] Health Resources and Services Administration. (2023). *Justification of Estimates for Appropriations Committees.* https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf.

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Statement
of the
American Hospital Association
for the
Subcommittee on Health
of the
Committee on Energy and Commerce
of the
U.S. House of Representatives

Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care

April 19, 2023

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide the subcommittee with information for its hearing on Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care.

SUSTAINING THE HEALTH CARE WORKFORCE

Health care careers are often a calling, and a qualified, engaged and diverse workforce is at the heart of America's health care system. However, long building structural changes in the health care workforce, combined with the profound toll of the COVID-19 pandemic, have left hospitals and health systems, including post-acute and behavioral health care providers, facing a national staffing emergency that could jeopardize access to high-quality, equitable care for patients and the communities they serve.

Prior to the COVID-19 pandemic, hospitals were already facing significant challenges that were making it difficult to sustain, build and retain the health care workforce. In 2017, the majority of our nursing workforce was close to retirement, with more than half aged 50 and older, and almost 30% aged 60 and older. Yet, nursing schools had to turn away over 90,000 qualified applicants in 2021, according to the American Association of

Colleges of Nursing, due to lack of faculty and training sites. Hospitals faced similar demographic trends for physicians, with data from the Association of American Medical Colleges indicating that one-third of practicing physicians will reach retirement age over the next decade. Hospitals also were reporting significant shortages of allied health and behavioral health professionals. Congress should consider the following policies to help sustain the nation's workforce:

- **Address nursing shortages by investing in nursing education and faculty.** Schools of nursing continue to need more faculty, preceptors and clinical training sites to support students, new graduates and prospective students. The Future Advancement of Academic Nursing Act would provide those vital resources to support the needs of nursing students, help retain and hire diverse faculty, modernize nursing education infrastructure, and create and expand clinical education opportunities.

- **Provide scholarships and loan repayment.** Title VIII Nursing Workforce Development programs such as Nurse Corps help bolster the advanced practice and nursing workforce by addressing the shortage of nursing faculty and clinical sites, as well as funding nursing schools located in rural and underserved communities. The CARES Act reauthorized these critical programs through 2024. Reauthorizing and funding these programs remain a necessity. Congress should ensure nursing students are eligible to receive such benefits to attend high-quality nursing schools regardless of the educational institution's tax status and ensure parity of treatment for hospitals and their workers regardless of tax status in federal health programs, including those enumerated in the Public Health Service Act.

- **Reauthorize and increase funding for the National Health Service Corps.** This program awards scholarships and assists graduates of health professions programs with loan repayment in return for an obligation to provide health care services in underserved rural and urban areas. The AHA supports the Strengthening Community Care Act of 2023 (H.R. 2559) to extend funding for community health centers and the NHSC. The NHSC is a critically important program for both giving clinicians support to offset the substantial cost of their education, while also incentivizing practice in underserved rural and urban health professional shortage areas across the country

- **Increase GME slots**. Address physician shortages, including shortages of behavioral health providers, by increasing the number of residency slots eligible for Medicare funding.

- **Support foreign-trained health care workers**. Support expedition of visas for foreign-trained nurses and continuation of visa waivers for physicians in medically underserved areas.

- **The National Nursing Workforce Center Act of 2023 (H.R. 2411).** The AHA supports this legislation to provide grants to state and regional nursing workforce centers to support research to bolster the evidence base for what types of nursing workforce programs are most effective in attracting and retaining the nursing workforce.

- **Investigate travel nurse agency practices**. We urge Congress to direct the Government Accountability Office to study the business practices of travel nurse staffing agencies during the pandemic, including potential price gouging and excessive profits, increased margins that agencies retain for themselves, impact of increased reliance on travel nurses in rural areas, and how these practices contribute to workforce shortages across the country.

- **Allow for innovative staffing models to develop**. Severe workforce constraints prompted hospitals and health systems to develop innovative new staffing models that better enable clinicians to practice at the top of their licenses. Hospitals need flexibility to test, evaluate and — when the evidence supports it — implement new models. That is why we urge policymakers to avoid the use of restrictive staffing rules that limit innovation and threaten to exacerbate health care access challenges, such as nurse staffing ratios or levels. The AHA believes staffing ratios are a static and ineffective tool that does not guarantee a safe health care environment or quality level to achieve optimum patient outcomes. They also usually are informed by older care models that do not consider advanced capabilities in technology or inter-professional team-care models.

SUPPORTING THE WELL-BEING OF THE HEALTH CARE WORKFORCE

The traumatic impact of COVID-19 has amplified the need for support and efforts to improve clinician well-being, destigmatize mental health and address overall wellness. Addressing well-being cannot be entirely isolated from the other efforts to improve the work lives and well-being of the health care workforce, including mitigating workplace violence and expanding access to behavioral health care.

Nurses, physicians and other staff on the front lines of care in U.S. hospitals, emergency departments (EDs) and health care systems experience high rates of violence. A survey of registered nurses working in hospitals showed that, during the pandemic, 44% reported experiencing physical violence and 68% reported experiencing verbal abuse.[1] Despite the near-daily occurrence of abuse directed toward health care workers, there is no federal law that protects them by specifying consequences for acts of violence or intimidation.

[1] https://journals.sagepub.com/doi/full/10.1177/21650799211031233

The AHA urges Congress to consider the following policies to support the well-being of the health care workforce:

- **Protect health care workers from violence**. Congress should enact H.R. 2584, the Safety from Violence for Healthcare Employees (SAVE) Act. This legislation would provide federal protections for health care workers against violence and intimidation, as well as provide grant funding to hospitals for violence prevention programs, coordination with state and local law enforcement and physical plant improvements.

- **Continue to provide grant funding support to well-being focused initiatives**. Thanks to the Dr. Lorna Breen Health Care Provider Protection Act of 2022, the health care field received important funding for projects that help support well-being in their workplaces. We encourage Congress to provide additional support for projects and collaborative efforts to scale successful practices on well-being across the health care field, especially those efforts that link well-being with hospital efforts to improve quality and the patient experience.

- **Consider funding projects to identify and evaluate successful practices on how behavioral health issues are considered in licensure and application processes.** Many clinicians fear losing their license or ability to practice based on questions relating to their mental health that may be overly broad or invasive. These questions may inadvertently serve to stigmatize mental health issues and can create barriers for clinicians to seeking appropriate treatment and decrease clinician well-being. We urge Congress to remove barriers for certain types of licensed practitioners to provide remote services (e.g., licensed addiction counselors, family therapists) to expand access to needed care.

OTHER PRIORITY PROGRAMS

Children's Hospitals Graduate Medical Education (CHGME) Program Reauthorization

The CHGME program supports graduate medical education programs at children's hospitals that train resident physicians. Freestanding children's hospitals typically treat very few Medicare patients and, therefore, do not receive Medicare funding to support medical training of residents; the CHGME program helps offset this inequity in funding. In addition to teaching the next generation of physicians and conducting research on childhood diseases, these hospitals provide lifesaving care to many medically underserved children in rural and inner-city areas as well as for those with complex medical needs. Currently, CHGME hospitals train 56% of the nation's pediatricians and 54% of the pediatric subspecialists who care for children living in all 50 states. Unlike Medicare's GME program, CHGME is funded through annual appropriations. The program has enjoyed bipartisan congressional support since its inception in 1999. Maintaining a strong CHGME program for another five years is critical for both the

children's hospitals' patients and the future health of all children. **The AHA supports reauthorizing the CHMGE program with at least $385 million in annual funding.**

340B Drug Pricing Program

For more than 30 years, the 340B Drug Pricing Program has allowed hospitals to stretch limited federal resources to directly improve patients' access to care by expanding health services to the patients and communities they serve as well as reducing the price of outpatient pharmaceuticals. 340B hospitals achieve savings by purchasing drugs at a discount. The amount of that discount depends on drug companies' pricing decisions, with the discount increasing the more drug companies decide to raise the prices of their drugs.

Hospitals use 340B savings in many ways to meet the unique needs of the patients and communities they serve. This includes the provision of a range of vital programs and services, such as the provision of free or discounted drugs to low-income patients, free care for uninsured patients and support for behavioral health clinics and community health programs. In fact, in the most recent year for which information is available, 340B hospitals provided nearly $68 billion in total benefits to their communities.[2] 340B hospitals also are responsible for a majority of hospital care (77%) to the nation's Medicaid patients.[3] **The AHA urges Congress to continue to protect this critical program and oppose efforts to cut its benefits, which would result in reduced access to quality care for the patients and communities served by 340B hospitals.**

The AHA is alarmed by the actions of several drug companies to unlawfully restrict access to 340B discounted drugs for 340B hospitals that have established arrangements with community and specialty pharmacies. These actions have resulted in significant financial impact to 340B hospitals at a time when hospitals are already facing a number of financial challenges and threatened the ability of 340B hospitals to maintain patient programs and services that are supported by 340B savings.

The AHA has strongly supported the Health Resources and Services Administration (HRSA) in its efforts to enforce the requirements for drug companies set forth in the 340B statute and encourages HRSA to strengthen its own oversight of drug companies' behavior through an invigorated Administrative Dispute Resolution (ADR) process. This would allow 340B providers to bring claims for relief where they have been overcharged including cases where 340B pricing has been unlawfully denied by drug companies through contract pharmacies. In addition, it could permit providers to address certain behaviors on the part of some drug companies that force hospitals to report burdensome data to the drug companies' own third-party vendor in exchange for some limited relief on their unlawful efforts to deny 340B pricing through contract pharmacies. Finalizing the ADR proposed rule is a priority for the AHA and our 340B

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[2] https://www.aha.org/news/headline/2022-10-11-blog-340b-program-helps-advance-health-patients-communities

[3] https://www.healthaffairs.org/content/forefront/30-years-340b-preserving-health-care-safety-net

members as we believe it will improve HRSA's oversight of the 340B program and bring much needed accountability that can help protect 340B providers.

The Securing the U.S. Organ Procurement and Transplantation Network (OPTN) Act (H.R. 2544). The AHA supports this legislation to increase the budget and make programmatic improvements to the OPTN. At the same time, we urge Congress to direct HRSA to provide needed oversight to those organizations with which it chooses to contract to ensure the coordination, timeliness and smooth functioning of the system.

CONCLUSION

The AHA appreciates your recognition of the challenges ahead and the need to examine America's health care workforce issues. We must work together to solve these issues so our nation's hospitals and health systems, post-acute and behavioral health care providers can continue to care for the patients and communities they serve.

April 17, 2023

The Honorable Young Kim
1306 Longworth House Office Building
Washington, DC 20515

Dear Congresswoman Kim:

On behalf of the nursing students and health professionals at West Coast University (WCU), I want to extend my thanks to you for your leadership in sponsoring H.R. 2411, the National Nursing Workforce Center Act. West Coast University is proud to support this legislation which provides opportunities for public-private partnerships to support workforce training and development and strengthen our national healthcare and nursing workforce.

West Coast University first opened its doors in Los Angeles in 1909 and today offers a diverse range of health care programs across six campuses in Southern California, Texas, and Florida. WCU is well known for its preeminent undergraduate, master's, and doctorate nursing programs, and offers undergraduate degree programs in dental hygiene, as well as master's and doctorate programs in health administration, occupational therapy, and pharmacy.

West Coast University is playing a critical role in expanding access to nursing education and addressing workforce shortages among healthcare professionals. We are committed to preparing the next generation of healthcare professionals and leaders through academic excellence and investment in our campus facilities which provide state-of-the-art technology to advance health care education. We utilize the most advanced technology available to provide students with real life experiences in modalities that are accessible to all types of learners.

We appreciate your strong, principled leadership and are grateful to you for sponsoring this legislation to support public-private partnerships that will invest in and support the nursing workforce in the United States. We are proud to support this legislation and look forward to continuing our work with you to promote and strengthen our country's healthcare and nursing workforce.

Sincerely,

D. Scott Casanover
General Counsel/Senior Vice President of Government Affairs