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Written Testimony

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before the
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Empowering Native American and Rural Communities
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Good morning, Chairman Smith and Members of the House Ways and Means Committee. Thank you for holding today's hearing, *Empowering Native American and Rural Communities*. Given the Committee's primary jurisdiction over the Medicare Graduate Medical Education ("GME") program, I appreciate your time in traveling out West to hear firsthand of the physician – and really, all health workforce – challenges we experience on a regular basis.

My name is Michael Kupferman, and I currently serve as Banner Health's senior vice president of physician enterprise and president of the Banner - University Medicine Division. In this role, I lead Banner's medical groups to advance value-based care, grow service lines and support academic medicine. I obtained my medical degree from the University of Pennsylvania and completed my residency in otolaryngology-head and neck surgery at the Hospital of the University of Pennsylvania and a fellowship in advanced head and neck surgical oncology at MD Anderson. I also received my MBA from the Kellogg School of Management at Northwestern University.

Banner Health is the state's largest private employer and largest nonprofit health care system. We are the primary clinical affiliate with the University of Arizona College of Medicine in Phoenix and the University of Arizona College of Medicine in Tucson. Of the 2,184 physician residents and fellows in the state, nearly 1,100, or 47 percent, train at Banner Health across 91 programs. This training is supported in part by Medicare, Medicaid and Banner Health. Last year, Banner spent more than $120 million on GME training. We invest in this space because we know it is critical for the state and the healthcare industry.

Many of these physicians will stay and practice medicine in Arizona upon graduation. Residents and fellows are not only important components of our medical workforce pipeline, but they also

are vital to our healthcare delivery models in diverse environments. This includes rural clinics and large academic hospitals. Medical residents allow us to extend care into underserved communities, enabling our current physician teams to stretch even further and serve Arizona's diverse veteran, Hispanic, Black, and Native American populations. Our resident learners deliver care at our local VA centers, rural hospitals, Indian Health Service facilities and tribal clinics across six large western states as part of Banner's mission.

Last summer, Banner Health and the University of Arizona College of Medicine - Phoenix announced an expansion of its GME programs by an additional 229 residency and fellowship positions. The full-scale effort began this year with the goal of placing more than 140 of these positions in family medicine and internal medicine programs to help increase access to primary care physicians in the state. We are making this investment because shortages continue to contribute to a widening gap in care for our most vulnerable patients, the elderly and those living in remote areas designated as "Health Professional Shortage Areas," also commonly referred to as "HPSAs."

On a national scale, 10,000 Americans become eligible for Medicare each day. The US Census Bureau projects that by 2030, one in five Americans will be over the age of 65; and within the decade, older Americans will outnumber children for the first time in US history. This trend is driving up the demand for health care services. Those projections become even more alarming knowing that 74 million Americans currently live in HPSAs, according to the Health Resources and Services Administration ("HRSA").

On a smaller scale – but still vast for us – Arizona is the 14th most populous state with more than 7.4 million residents and the sixth largest by size. This includes many remote rural areas and 22 Native American Tribes. We also are one of the fastest growing states. Our population has grown by 2 million people since 2000. Commensurate with this growth, our senior population (age 65+) has been growing too – up by 48 percent in the past decade. That means 17 percent of the state's population is on Medicare.

Given these statistics and our terrain, our health systems must have more physical points of care and wider provider networks in place. Since Arizona has become a healthcare destination for world-class quality care, accounting for more than 20 percent of the state's economy, innovation is key to treating patients with complex needs as well as for reaching them. Banner's physician enterprise is a part of that equation.

Our residency programs train physicians to manage and treat patients in a rapidly changing environment. As the population ages, unfortunately, so does our health care workforce. For instance, 31 percent of our active physician workforce is age 60 or older, and soon will be retiring. Our experienced nursing staff is also facing similar retirement rates.

The state of Arizona does a great job retaining medical residents who train here. It is the pipeline, however, that has us worried.

Over the next ten years, the country expects a shortage of 124,000 physicians. For Arizona, we estimate needing 3,600 physicians including 1,941 primary care physicians. This is our biggest gap, which we currently meet by 39 percent. Additional Arizona datapoints include:

- 42nd in the nation for active primary care physicians per capita;
- 31st in total active physicians per capita; and
- 43rd in active general surgeons per capita.

As previously mentioned, Arizona has the 14th largest population yet ranks 37th in resident physicians per capita. That's about 28.5 FTE per 100,000 population compared to the US rate of 43.8 per 100,000 population. Arizona would have to add 1,100 graduate medical education slots to attain a rank of 15th. Closing this gap requires significant financial investment.

This commitment is complicated by the fact that hospitals and health systems encounter additional challenges requiring resources. This includes rising operational expenses ranging from technology and IT equipment to pharmaceuticals, emergency readiness and much more. The challenges – along with a changing regulatory and payment landscape plus higher utilization rates due to longer life expectancy – make it difficult to hit our 2030 goal.

This is why a strong workforce pipeline is key. It is why I personally spend a lot of time concentrating on programs here in the state built around primary care to help our medical students transition into residency programs. Career development is one of the most successful paths for introducing the next generation of students to the field of medicine. We also are working with community leaders to increase our education capacity at our colleges of medicine. Last, but not least, we are increasing the capacity of our physician training programs. These are some of the steps that Banner pursues in developing its pipeline to meet projected demand.

On a federal level, the current cap on Medicare funding for GME programs is a barrier. The number of residency slots financed by Medicare was capped in 1996 for existing programs – but not for new programs. In 2020, Congress passed a historic increase to the Medicare graduate medical education program by adding 1,000 new Medicare-supported GME positions. These slots were prioritized for teaching hospitals in rural areas, hospitals training residents over their cap, hospitals in states with new medical schools and hospitals that care for underserved communities. It was the first increase in nearly 25 years and a critical first step toward addressing our country’s physician workforce shortage. As the head of Banner’s physician enterprise…I want to say, thank you.

We still need more GME investments, however. For example, we know that nearly 70 percent of residents will practice in the community where they completed their residency training.

Developing robust residency training programs can help address geographic imbalances in our physician workforce. It also enables us to serve rural and underserved communities throughout the state, including Arizona’s tribal communities. The end result: increased supply of physicians leads to increased access to health care services, which reduces overall morbidity and mortality.

At Banner, we take an “all-of-the-above” approach. From our vantage point it requires increased education capacity; simulation training; use of smart technology; rotation exposure and I will go one step further…developing value-based care models that incentivize primary care physicians to integrate with the communities that they serve. This is care coordination at its optimum and it is entrenched in Banner’s patient centric mission.

From a federal policy perspective, we take an equally expansive view. As a state’s population grows, we encourage an adjustment to the fixed 5-year residency cap. This would help keep pace with demographic changes and corresponding social determinants of health. Redistributing residency slots based on census tracks and rewarding rural track rotations should be taken into consideration, too. Last, continuing the gradual expansion of Medicare-supported medical residency positions would also bring much needed relief to a program as diverse as ours.

The bottom line is that Arizona confronts a growing disparate population. Large academic medical centers like ours are required to pursue new delivery methods of care; and if we are to successfully meet tomorrow’s health care needs, they must first be rooted in training.

In closing, I applaud you, Mr. Chairman and members of the Ways & Means Committee for your time in learning more about Arizona’s health care challenges. I am honored by the invitation to testify and look forward to answering your questions.