STATEMENT OF TIM JOSLIN
CEO, Community Medical Center
Before the
United States House of Representatives
Committee on Ways and Means
Subcommittee on Health

July 28, 2015

Mr. Chairman, Ranking Member McDermott, and members of the Subcommittee, my name is Tim Joslin and I am the Chief Executive Officer of the Community Medical Centers based in Fresno, California. I appreciate the invitation to testify today about rural health care disparities and the role of federally funded graduate medical education, known as GME.

Community Medical Centers is the largest health care provider in California's agricultural heart, the San Joaquin Valley. We are a not-for-profit, public benefit corporation operating four hospitals — Community Regional Medical Center in Fresno, Clovis Community Medical Center, Fresno Heart and Surgical Hospital, and Community Behavioral Health Center. Community Medical Centers accounts for one-third of all inpatient discharges in the five-county region. We run a

level-1 trauma center, a burn center, and an ambulatory care center. We are also the largest provider of inpatient Medi-Cal services and uncompensated care in the region. Our downtown Fresno emergency department is the one of the busiest in the state, with some 114,000 visits a year. We provide all this with the help of about 300 medical residents and fellows from the UCSF School of Medicine.

But our challenge is unique, and daunting. The rural San Joaquin Valley, though rich agriculturally, is very poor economically. Twenty-five percent of residents live in areas of concentrated poverty, making it the 5th poorest area in the country. In Fresno County alone, one-third of all children live at or below the poverty level. About 20% of Fresno County residents do not speak English, and one-third of adults have not obtained a high school diploma. The entire area's population has significantly higher than average rates of asthma, diabetes and obesity. Nearly one-third of the population qualifies as obese, for example. The Valley also has a higher than average incidence of chronic lung disease, likely due to its well-documented air quality issues.

To make these sobering statistics even worse, the San Joaquin Valley suffers from a doctor shortage. The Valley has 48 primary care physicians per hundred-thousand residents, well below the minimum recommended level of 60.

If need is the measure, our region of the country should have more physicians per capita, not fewer. Graduate medical education is the key to solving this inequity.

Community Medical collaborates with the University of California San Francisco to support the training of graduate medical students. We currently support some 250 medical residents studying in eight areas, including primary care and emergency medicine. And we support 50 fellows studying in 17 medical sub-specialties. This GME program is a critical feeder to the region's entire physician population, and we'd like to grow the program.

We are constrained, however. Our Medicare funding for GME positions is frozen at a 1997 level. Community Medical Centers has expanded the program on its own — beyond what Medicare funds — by investing well

over $400 million over the last 10 years. But considering that Community Medical Centers now shoulders more than $180 million in uncompensated care each year, the ability to expand our GME program on our own is financially limited. And this, in turn, limits our ability to provide our region's residents access to health care now and in the future.

In a region where the need for physicians is perhaps the greatest in the Country, we are at a disadvantage under the current federal system of allocating GME slots. Yet our ability to expand access to physicians is highly dependent upon the GME program. As the Institute of Medicine's recent report noted, "The location of one's medical school and GME training are predictive of practice location." Our own experience shows this. Close to 30% of our trained residents remain in the region to practice medicine.

The current GME allocation criteria and caps have led to significant geographic disparities, as noted in a recent Health Affairs report, and are most acutely felt in our region of California. For example, our region's population has increased by a third since 1997, yet our

federally funded resident positions have remained at the 1997 level. This contributes to the disparity we see in the ratio of physicians to population.

Community Medical Centers supports not only the expansion of GME, but equally critical, better allocation of GME slots to underserved regions within a state. We believe the policy goals of federally funded GME would be better served by a revised allocation system and urge this Committee to consider proposals. We believe this will directly lead to more efficient and effective health care in our rural, underserved region.

Thank you again for this opportunity.