AMERICA'S PHYSICIAN GROUPS

March 20, 2023

The Honorable Bernard Sanders, Chairman
Committee on Health, Education, Labor & Pensions
428 Senate Dirksen Office Building
Washington, D.C., 20510

The Honorable Bill Cassidy, Ranking Member
Committee on Health, Education, Labor & Pensions
428 Senate Dirksen Office Building
Washington, D.C., 20510

Dear Chairman Sanders and Ranking Member Cassidy:

America's Physician Groups (APG) appreciates the opportunity to respond to the committee's request for information on health care workforce shortages. For many years, the United States has lacked a comprehensive healthcare workforce strategy at the federal level, and the unfortunate results are increasingly obvious. For a variety of reasons, including the looming retirements of those born during the Baby Boom years, growing numbers of physicians, nurses, and other clinicians are leaving the practice of medicine. This trend is exacerbated by an inadequate pipeline to fill those highly trained positions. The issue is especially acute for value-based care organizations, which rely on teams of practitioners to coordinate patient care in a comprehensive, patient-centered manner, and for providers in rural and other underserved communities. APG members regularly rate the national workforce shortage as a top concern.

In recent years, members of Congress have worked in bipartisan fashion to fund and grow the number of residency slots for new physicians and other clinicians. APG and its members greatly appreciate those legislative policies, but more needs to be done to ensure that the clinical workforce—especially for primary care practitioners—is robust enough to meet the needs of a population of patients that is also aging and dealing with an increased burden of multiple chronic conditions. The following response provides a high-level framework that you and your colleagues may consider as you work to alleviate the clinical workforce shortage.

About America's Physician Groups

APG is a national association representing more than 360 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models and Medicare Advantage (MA). APG members collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for roughly 90 million patients, including nearly 30 percent of MA enrollees.

Our motto, "Taking Responsibility for America's Health," underscores our members' preference for being in risk-based, accountable, and responsible relationships with all payers, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal

incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide.

The Need for a National Clinical Workforce Strategy

The workforce challenges facing the nation's health care sector are considerable. A survey by the Association of American Medical Colleges projects a physician shortage from anywhere between 37,800 to 124,000 over the next decade, with just under half of the shortage stemming from a lack of primary care doctors.[1] Similarly, the U.S. Department of Health and Human Services (HHS) estimates that the U.S. needs to add 3.6 million nurses by 2030 to meet the health needs of Americans. That translates to roughly 50,000 new registered nurses each year through 2030.[2]

As Congress well knows, developing a highly skilled clinical workforce requires major investments of time, money, education, and training. With those challenges in mind, APG supports the creation of a national framework for health care workforce investment guided by the following principles:

- The need to invest adequate federal dollars to support overall investment in this vitally important workforce
- The need to create adequate numbers of education and training slots and faculty positions, and scholarship support for students
- The imperative of increasing the diversity of the health care workforce at all levels, including clinical
- The need to drastically increase federal graduate medical education (GME) funding to support primary care training slots, and diversify locations of training beyond inpatient hospitals
- Particular attention to incentivizing training for a diverse corps of health care workers who come from, and intend to remain in, rural and other underserved communities
- Polities to ensure that, once educated and trained, health care professionals work at the top of their licenses; can engage in modern delivery strategies, such as the provision of telehealth across state lines; and are distributed across the country where their skills are needed.

Such a national framework should support value-based care and incentivize physicians to enter into such models. As you and your colleagues consider workforce policies, keep in mind the Centers for Medicare & Medicaid Services (CMS) goal to have 100 percent of beneficiaries in Medicare—and most Medicaid beneficiaries—in accountable relationships with their providers by 2030. As detailed below, appropriate federal workforce policies to complement this value-based care strategy will be essential to achieving this goal.

[1] IHS Markit Ltd. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Washington, DC: *AAMC*; 2021. https://www.aamc.org/media/54681/download

[2] U.S. Department of Health and Human Services. "Supply and Demand Projections of the Nursing Workforce: 2014-2030." July 21, 2017. *Health Resources and Services Administration. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nchwa-hrsa-nursing-report.pdf*

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Building the Workforce for Value-Based Care

APG's members are committed to being held accountable for the costs and quality of patient care and offering care that is patient-centered and highly coordinated. They participate in a variety of value-based care models, including accountable care organizations such as the ACO REACH model, and are often in delegated arrangement with MA health plans, in which they are fully at risk for the costs and quality of patient care. At the core of these models is an emphasis on high-quality primary care that serves to keep patients as healthy as possible and minimizes unnecessary or repeat hospitalizations, which can harm patients' overall health and wellbeing.

Many of APG's member organizations work to create primary care teams that are led by physicians, and augmented with other health care professionals, including advanced practice nurses, physician associates and physician assistants (collectively known as advanced practice professionals, or APPs), as well as mental or behavioral health providers and others. Ensuring adequate numbers of all types of these professionals able to staff these highly engaged and coordinated teams is essential. APG is grateful that Congress enacted legislation last year to create 200 new graduate medical education (GME) slots in fiscal year 2026, with 100 of these slots specifically allocated to psychiatry and psychiatry subspecialties, and no restrictions on the remaining positions.

Because physicians typically lead the highly engaged and coordinated primary care teams at APG member organizations, guaranteeing that the nation has an adequate supply of primary care physicians is essential. Such a supply should include both allopathic and osteopathic physicians, internal medicine specialists, family medicine practitioners, and more. APG's members believe that the nation's medical schools do not do enough to encourage students to apply for residencies in primary care, and in fact actively steer them into specialties. APG encourages your committee and members of Congress to examine what more can be done to incentivize medical schools and students alike to pursue primary care residencies.

An important component of such a strategy is continuing to increase the number of primary care GME training slots, and to create many more non-hospital-based slots. APG's members believe that hospital-based primary care training slots are often mostly oriented toward producing hospital-based internal medicine specialists or hospitalists, rather than primary care providers who will serve in community settings. APG encourages your committee and members of Congress to explore additional avenues for creating community-based primary care residencies that will more closely reflect the care and locations in which primary care providers are most likely to serve patients. These avenues should include a dramatic expansion of the Health Resources and Services Administration's Teaching Health Center Graduate Medical Education (THCGME) program, which supports primary care training for residents in community-based ambulatory facilities.

As noted, APPs constitute an integral part of care teams, and ensuring adequate supplies of these professionals is also critical. According to the American Association of Nurse Practitioners, there are more than 355,000 nurse practitioners (NPs) licensed in the United States; 88.0% of NPs are certified in an area of primary care, and 70.3% of all NPs deliver primary care. As is the case for registered nurses, there is much more demand than there is existing capacity in nursing schools to train individuals for this

profession. Your committee and members of Congress should explore polices to expand the number of nursing schools and slots, as well as support for bridge programs that enable students to continue on from community college programs that equip them with associates' degrees and obtain both BSN and master's or advance practice nursing degrees.

Similar dynamics appear to characterize the nation's physician assistant/associate (PA) programs, in that there are inadequate numbers of slots to meet demand for PA training programs. Here again, APG encourages your committee and members of Congress to explore ways to expand these programs. Because higher pay in specialties continues to draw far more PAs into specialty care than primary care, however, APG recommends exploring particular incentives to encourage greater enrollment in primary-care-oriented programs and potentially additional scholarship support for PAs who will commit to careers in primary care.

Given the importance of teams in providing value-based care, APG also encourages your committee and members of Congress to explore ways to stimulate more interprofessional education (IPE) and collaboration of clinicians. As noted by Kyler Godwin et al, Interprofessional collaboration (IPC) has been shown to improve health care quality and patient safety but insufficient IPE training exists. The VA Quality Scholars (VAQS) program is a model for such IPE training and should serve as inspiration to develop more incentives and requirements for both health systems and schools of health care professions training to engage in IPE.[3]

Meeting the Needs of Rural Populations

Forty-six million Americans live in rural areas, and rural communities make up more than two-thirds of the federally-designated Health Professional Shortage Areas (HPSAs).[4] APG agrees with many of the recommendations made by the Council on Graduate Medical Education (COGME) for strengthening the clinical workforce in rural America.[5] Two COGME recommendations are particularly worth implementing—one to eliminate regulatory and financial barriers that inhibit the development of rural residency programs, and another to prompt test alternative payment models (APMs) in rural areas that enhance team-based, interprofessional education and care, in part by increasing the number of community and team-based rural training programs receiving public graduate medical education financing.

Making Optimal Use of the Health Care Workforce

Two important artificial constructs limit the flexibility and adaptability of the health care workforce: Limits on scope of practice and state-based licensure. Both areas are largely under the

[3] Godwin, K. M.; Narayanan, A.; Arredondo, K.; Miltner, R. (Suzie); Bowen, M.E.; Gilman, S.; Shirks, A.; Eng, J.A.; Naik, A. D.; Hysong, S.J. "Value of Interprofessional Education: The VA Quality Scholars Program." *Journal for Healthcare Quality.* 43(5): p 304-311, Sept./Oct. 2021. DOI: 10.1097/JHQ.0000000000000308

[4] Center for American Progress. (Feb. 9, 2022). "How States Can Expand Health Care Access in Rural Communities." https://www.americanprogress.org/article/how-states-can-expand-health-care-access-in-rural-communities/

[5] https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/reports/cogme-april-2022-report.pdf

control of states and state-based licensing boards. At a time when the U.S. population is highly mobile, and when both advances in technology and the poor overall distribution of the health care workforce is driving greater provision of telehealth and other forms of remote care, your committee and members of Congress should explore strategies for moving beyond limits on health care professionals' scope of practice and state-based licensure.

These are complicated topics that go to the heart of the nation's federalist system, and many states and national organizations such as the Federation of State Medical Boards have evolved their policies to enable clinicians to obtain licenses more easily in multiple states. Nonetheless, additional steps to create a more flexible health care workforce are needed. APG encourages your committee and members of Congress to hold hearings on creating parallel systems of national licensure of clinical professionals that both individuals and states could opt into over time. APG also encourages your committee to explore what incentives could be provided to states to encourage changes that would allow all clinical professionals to work to the maximum scope of their licenses.

Increasing Workforce Diversity

Although gaps in the literature persist, diversity in the clinical workforce is deemed key to serving marginalized populations of patients and providing culturally competent care. Your committee and members of Congress should consider policies that ensure such diversity. Among these are even greater federally-funded scholarship programs for minority students pursuing health care professional degrees in return for working in underserved communities.

Conclusion

The Senate HELP Committee is well-positioned to understand the drivers of the nation's health care workforce shortage and develop policies to correct the problems. APG welcomes further opportunities to work with the committee on this and other important health care matters. Please contact Matt DoBias, vice president of congressional affairs, at mdobias@apg.org or Jennifer Podulka, vice president of federal policy, at jpodulka@apg.org.

Sincerely,

Susan Dentzer

Susan Dentzer
President and CEO