

Statement of

DR. JIM HOTZ

Clinical Services Director, Albany Area Primary Health Care

Before the Senate Health, Education, Labor and Pensions Committee
Subcommittee on Primary Health and Aging

April 9, 2014

Hello Chairman Sanders, Ranking Member Burr, and members of the subcommittee. Thank you for this opportunity to speak to you today about a program that is near and dear to my heart, the National Health Service Corps (NHSC). My name is Dr. Jim Hotz, and I am the Clinical Services Director for Albany Area Primary Health Care (AAPHC) in Albany, Georgia, an organization I helped found 35 years ago. Over these past 35 years, I have helped start and have been on the board of a variety of different organizations that have been attempting to provide a high quality medical home for the underserved of the nation. I have helped to start a community health center system, a regional AHEC, a family practice residency program, a regional planning agency, a regional rural HIV program, and a regional cancer control coalition. I have been chairman of a regional hospital board, an AHEC, a state primary care association and a statewide primary care workgroup and have been on the clinical faculty of two medical schools and a family practice residency program. All of these organizations are attempting to cope with the challenge of supporting local health care systems within the context of a diminishing supply of primary care clinicians. Unfortunately none of these local programs can solve what is a national workforce policy crisis. These experiences have made me realize how crucial it is to have this hearing on "Addressing Primary Care Access and Workforce Challenges: Voices from the Field." It is my belief that the NHSC is the single most effective policy innovation this country has ever developed to address the primary care workforce challenge. I am here today on behalf of the Association of Clinicians for the Underserved (ACU), which was founded by NHSC alumni over 15 years ago. The mission of the ACU is to insure the NHSC will continue to be an effective solution to the access needs of the medically underserved of this nation.

Medical school creates an apprenticeship learning environment where the student often has a life changing experience while working under the supervision of the inspirational master clinician. Exactly 40 years ago I had the direction of my life changed by Dr. William Roy. Health reform was a major issue in Washington at that time and I wanted to become involved. I asked my curriculum advisor at Ohio State if he could help me construct an experience in DC that would satisfy my community science requirement and allow me to use vacation time to work as a legislative aid in congress. I told him I wanted to be where "the action was" in health reform and he told me I needed to ride the "Happy Trail." I didn't know what that meant, except that it was a song sung by Roy Rogers. However, in Congress at the time were Congressman Dr. William Roy of Kansas and Congressman Paul Rogers of Florida – "Roy" and "Rogers." They had become the architects of the most dynamic health reform legislation since Medicare and Medicaid. Local DC pundits jokingly called it the "Happy Trails Legislation." Being a physician, Dr. Roy could offer clinical rotations for students to learn health policy and earn medical school credit and in

return he got cheap source of labor. A group of us worked with Dr. Brian Biles who was Dr. Roy's chief of staff to craft legislation on a menu of programs that were to serve as the infrastructure for health reform. The master blue print was put forth in "Building a National Health-Care System" by the Committee for Economic Development (CED) in April of 1973. This 105 page document was created by over 100 men who represented Fortune 500 companies, academic institutions or major foundations and felt the urgent need to address "the health care bill that increased sharply...between 1965 and 1972 national health expenditures rose from \$39 billion to \$83 billion, or from 5.9 to 7.6 per cent of GNP," and "Per capital annual expenditures rose from \$78 to \$394."

Dr. Roy, in an amazingly productive 4 year tenure, worked with Cong. Rogers to put into place an infrastructure to manage an effective, efficient health system based on the recommendations of these members of the CED who were in fact successful managers of effective and efficient business systems. Dr. Roy introduced the HMO act of 1972 that revolutionized health care financing and made prepayment legal and placed a premium on keeping people healthy. Yes, the HMO was delivered by a Kansas Obstetrician! Roy and Rogers collaborated to preserve and promote the community health centers program through a major restructuring and reauthorization bill in 1973. But the program Dr. Roy and Cong. Rogers were most proud of was the National Health Services Corps. They realized health care could only be effective and efficient if primary care was available in all communities. They saw the infant National Health Services Corps as the solution to the primary care distribution problem in this country. During a blizzard on December 31, 1970 and minutes before the midnight deadline, President Richard Nixon signed Public Law 91-623 the "Emergency Health Personal Act of 1970." In his award winning book "The Dance of Legislation," Eric Redman describes how the NHSC was born through the heroic efforts of Senator Warren Magnuson of Washington. But what isn't covered in the book is that Dr. Roy with Cong. Rogers adopted this infant legislation and allowed it to grow through a series of amendments over the next 4 years. These amendments helped shape the NHSC into the most effective program ever devised to distribute primary care clinicians to underserved communities. I helped work on the National Health Services Manpower Act (H.R. 14357) that added the scholarship component to the NHSC and greatly expanded the size and diversity of the field strength of the Corps. The vision of Dr. Roy was "any physician who practices...in an area designated to have a shortage...the Secretary shall pay in full the principle and interest of any outstanding educational loan." Now medical school could be affordable not only to the wealthy but even the inner city or poor farm kid could finance his dream of a medical education.

After using up all my vacation and elective time I returned to Ohio State intending to eventually go back to work in DC. Dr. Roy decided to run for Senate in the fall of 1974 but got beaten by Bob Dole in a very bitter campaign by less than 5,000 votes. I called and offered my condolences and asked for advice on my career. Dr. Roy said "join the NHSC and make a difference before you come back here!" I followed his advice and convinced Jim Bingle, my brother-in-law, to volunteer with me into the Commissioned Corps of the NHSC in 1978. I had lived with Jim during medical school and figured if he was dumb enough to live with me he probably was dumb enough to join the NHSC and make \$32,500 which was the starting salary back then. Through Cong. Roger's continuing efforts, the "Happy Trails" legislation flourished under President Carter and community health centers and the NHSC grew rapidly. Unfortunately with this rapid growth was some pain and the NHSC was having trouble finding a match for the two of us. I was finishing my Internal Medicine training at Emory in Atlanta and one of my instructors Dr. Neil Shulman offered to help place me in Georgia. He arranged a meeting with Dr. Jim Alley, Director of Public Health in Georgia and an appointee while Jimmy Carter was governor of Georgia. Dr. Alley arranged for Bingle and me to be assigned to Georgia to help develop a community health center in areas of greatest need. We were given several options for communities to serve and preferred Athens which was near Atlanta but were tricked into visiting several very poor counties in

South Georgia that had no doctors. Dr. Shulman wrote a humorous account of this adventure that was made into the movie "Doc Hollywood."

We initially worked at a Health System Agency in Albany, Georgia and with community groups wrote a grant and to develop a community health center program that became Albany Area Primary Health Care (AAPHC). Dr. Bingle and I remained in the Commissioner Corps for 6 years after which he left to return to Ohio and do a fellowship in cardiology. I stayed on and for the first 10 years of AAPHC every one of our recruits were from the NHSC and most were obligated scholars. Our success in those early year were a byproduct of the legislation of Dr. Roy and Cong. Rogers...the NHSC, Community Health Centers, and the Health System Agency...the Happy Trails Legislation indeed created a happy trail of access for the underserved of South Georgia.

During the past 35 years, AAPHC has had over 3 million patient visits in one of the poorest and most rural areas in the state. It is estimated that over 2 million of these primary care encounters were delivered by a clinician recruited through the NHSC. AAPHC now has offices at 14 different sites in 7 counties and last year had 33,267 users of our health care system. Over 75% of our patients are an ethnic minority, 80% live in poverty and 25% have no health insurance. We provide services from "womb to tomb" – Obstetrics to Geriatrics; from "head to toe" – Dentistry to Podiatry; and everything in between with Pediatrics, Internal Medicine, and Family Medicine and last year had 136,287 clinical visits.

The NHSC has been an invaluable "foot in the door" for our primary care recruiting. The swamps of Southwest Georgia are not a natural attraction for the medical professional of today. But once clinicians join our group they receive deep professional satisfaction from the practice environment we provide. Out of a total of 52 clinical providers currently employed by AAPHC, 24 have been recruited or retained using the NHSC. Currently we have 16 physicians, 2 dentists, 5 PAs and 1 Certified Nurse Midwife who were recruited or retained through the NHSC. Our overall clinical retention rate is 9 years and for our 24 NHSC awardees this tenure is:

- i. 1-10 years = 13 clinicians
- ii. 11-20 years = 7 clinicians
- iii. 20+ years = 4 clinicians

The NHSC has led to 286 years of service with an average tenure of 24.2 years.

Although the NHSC field strength has expanded to nearly 8,900 in 2013, the demand has greatly outstripped the supply and last year the NHSC received twice as many applications as it had resources to fill. Of those applications 6 came from AAPHC. Where once our recruiting was facilitated by the NHSC, we have not been able to secure loan forgiveness and have lost 3 recruits in the past year who said they would have come if the loan forgiveness was available. We have not been able to recruit a scholar since 2011 and are down to 3 scholars fulfilling an obligation and 4 clinicians who are currently enrolled in loan forgiveness.

Shelley Spires who has been in charge of recruiting at AAPHC for the past 13 years says the past couple years have been the most difficult she has experienced. For over a decade we had no vacant positions and we currently have 5. Several of these positions have been vacant for over a year. This is now my 36th year of recruiting for AAPHC and I completely agree with Shelley.

There are a number of reasons recruiting is so challenging. First and foremost is the overall shortage of primary care physicians being produced by the GME system of the United States. I chair the Georgia

Statewide AHEC Primary Care Work Group and since 2008 we have been conducting a summit and producing a detailed analysis of the problem and offering a series of recommendations to our state. The following is a brief review of the workforce problems we discovered:

- An American Journal of Medicine article (2008) predicted the GME “funnel” caused by the Balanced Budget Act of 1997 which capped Medicare funding for GME. The article forecast a rapid expansion of our total medical school enrollment from 18,560 in 2005 (2,800 DOs and 15,760 MDs) to 25,136 in 2012 (5,227 DOs and 19,909 MDs), but there would be no expansion of PGY1 slots. There were 24,269 such slots in 2005 and projected to be the same in 2012. Where once we imported 5,709 US and foreign International Medical Graduates (IMGs) to fill open slots, by 2012 there weren’t even slots available for 867 US medical school graduates. This prediction has largely held true and less and less of these graduates have gone into primary care.
 - This article also predicted a primary care shortage of 45,800 by 2025.
- A Journal of the American Medical Association article (2008) showed that even in the 3 major residency programs producing primary care, many were not staying in primary care:
 - Family Medicine
 - 3,018 and 95% Primary Care = 2,867
 - Internal Medicine
 - 8,550 and 45% General IM
 - Of General IM, 50% loss to hospitalist (NEJM 11/27/08) = 1,967
 - Pediatric Medicine
 - 2,645 and 61% Primary Care = 1,967
 - **Net Yearly Primary care production = 6,447**
- The Robert Graham Center in Annals of Family Medicine (2012) predicted a shortage of 52,000 primary care physicians in 2025 taking into account the ACA and change in residency production.
- The Association of American Medical Colleges predicts a shortage of 91,500 doctors by 2020 and in a report from this Subcommittee last year 1/29/2013 you stated “According to the Health Resources and Services Administration, we need 16,000 primary care practitioners to meet the need that exists today.”

AAPHC is now recruiting from a pool of primary care physicians that is shrinking at a time when demand is dramatically increasing. To make the situation even worse, we are recruiting physicians who are experiencing a substantial increase in educational debt. Many are either selling out to the highest bidder like well funded hospitalist programs, doing fellowships specializing in higher paying fields like cardiology or oncology that often pay 3 to 4 times what primary care does or they are signing up with programs that offer significant loan relief programs. Once the NHSC was the premier program for debt relief but now it cannot meet even 50% of the current demand. The maximum amount of loan relief was recently cut from \$155,000 for 5 years continuous service to now a max of \$100,000 for 5 years. For programs with HPSA scores of less than 14 the amount was reduced to \$30,000 for 2 years. This reduction comes in the face of medical school debt that now often exceeds \$250,000 for recent grads. The vision of Dr. Roy of the NHSC being a vehicle for relief of all medical school debt for practice in an underserved area is becoming a greater challenge given current NHSC resources.

How big is the problem and how big is the fix? In a 2008 NEJM article, the average debt was \$145,000 for public medical schools and \$180,000 for private school. However the total debt for all medical students was estimated to be \$2 billion...the amount we paid in 1 month for “cash for clunkers.” In a 5/28/2011 New York Times article, Bach and Kocher estimated “we could make medical school free for

roughly \$2.5 billion.” They recommended a payback for students choosing to specialize but none for those going into primary care.

For those who want a view from the trenches, I asked my 4 children to share their debt experience with this committee. All four were HOPE scholars at the University of Georgia and had zero debt at the time of graduation. All 4 were provided with health and auto insurance by me. They all lived on frugal budgets during medical school in the low cost cities of Macon and Augusta, Georgia. They went either to Mercer a private school that receives state support, or to the state school, the Medical College of Georgia (MCG). My oldest, George, is now an internist working with Floyd Memorial, the community hospital in Rome Georgia. My second son, Jim, is in Internal Medicine Residency at Indiana University and will be a chief resident next year, planning a career in primary care. My daughter, Mary, is in her first year of a primary care Internal Medicine program at the University of South Carolina - Greenville. My youngest son Steve is in his second year of medical school at Mercer University in Macon.

Here is the debt they face:

- George - Mercer University School of Medicine 2005-2009
 - Current debt \$227,329.55
 - Interest 2.1 to 7.65%
 - Minimum payment of \$ 1,536.58
 - Loan Payoff Date 3/7/37!
 - He is currently trying to make payments of \$3,886.09 to pay off in 10 years. He selected Rome to be near his wife’s family and to be able to work in a community like Albany. Unfortunately his area has no HPSA score above 14 and the hospital can only afford minimal debt relief. He likes his practice and does traditional office and hospital internal medicine, but admits once he starts a family he may need to reconsider his options. Currently he is my only child who is paying off his debt but he has communicated many times to his sister and brothers the reality of the debt crunch when it becomes payback time!

- Jim - Medical College of Georgia 2007-2011 (the lowest cost school in the state)
 - Current debt: \$224,446
 - Interest 6.8 to 7.9%

- Mary - Mercer University School of Medicine 2009-2013
 - Current debt \$313,009
 - Interest 6.8 to 7.9%

- Steve - Mercer University School of Medicine 2011-present
 - Current debt \$189,236
 - Interest 6.8 to 7.9%

- **Total debt of children = \$1,154,620**

Our Primary Care Workgroup in Georgia discovered that one way the medical schools financed their expansion was by increasing tuition. This had the unfortunate result of dramatically increasing medical school debt which had the unintended consequence of reducing the likelihood these students would choose a lower paying career in primary care. An article in Academic Medicine January 2013 explored the question “Can Medical Students Afford to Choose Primary Care?” The conclusion was that

“Graduates pursuing primary care with higher debt levels (\$250,000 to \$300,000) need to consider additional strategies to support repayment...use of federal loan forgiveness..)

Medical School Tuition in Georgia 2005-2012:

Emory	- 38,000 to 45,000	increase of 25.0%
MCG	- 10,850 to 24,726	increase of 108.6%
Mercer	- 30,220 to 41,457	increase of 37.0%
Morehouse	- 24,000 to 36,903	increase of 53.8%
PCOM (DO started 2008)	- 33,587 to 40,812	increase of 21.0%

AAPHC physicians like myself are on the clinical faculty at Mercer and MCG and each of my children either did 4-year rural continuity tracts at our practice or took multiple electives here. They each say these rotations helped convince them to select careers in primary care internal medicine and they expressed an interest in the NHSC and working at a community health center but wonder if the NHSC program will be a viable option for them when they graduate and if they be able to afford to stay in primary care

Today the NHSC places roughly 8,900 clinicians across the country. These placements are for doctors, dentists, dental hygienists, nurse practitioners, physician assistants, certified nurse midwives and a variety of mental health provider types. In fact, the largest group of providers is in mental health today, comprising 28% of the total field strength. These 8,900 providers provide care to nearly 10 million people across the country.

There are three main parts of the NHSC, including the Scholarship program, the Loan Repayment program and the recent Students to Service program that helps fourth year medical students choose primary care by paying off their debt in exchange for service. However, the largest part of the NHSC is the Loan Repayment program, and this is what most people think of when they speak of the Corps. The Loan Repayment Program pays off a portion of student debt for every year of service in a federal shortage area. These are not federal employees. Each placement is an employee of the site itself, which uses the NHSC Loan Repayment program as a recruitment tool – but it is more than that. It really is a way the federal government leverages local resources. While it isn't a required match of federal funds, each site pays their employee much more than the \$25,000 or \$15,000 they receive in federal loan repayment. So in essence, the federal government is only picking up a small slice of their compensation and getting all the benefits to boot. Being able to place a primary care clinician in an underserved area for \$25,000 or less per year is an incredible deal for the federal government for sure.

Current status of NSHC funding

Starting in 1974, funding for the NHSC had been through regular, annual appropriations. This changed under the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA). Both of these laws provided new mandatory funding for the program that was intended to better address the shortages across our country. However, recognizing this infusion, in FY2011 Congress dramatically decreased the appropriation, and then in FY2012 eliminated it altogether. The program now relies completely on this mandatory funding stream for 100% of its operations.

And the ACA funding ends in FY2016, meaning the program is completely defunded unless Congress chooses to either extend the mandatory funding, or once again provides funding through the annual appropriations process. I understand that neither of these routes will be easy to navigate. Our country faces record debt levels and there are nearly continuous negotiations on federal spending levels.

However, I really believe that based on the merits of the program, the NHSC can withstand any kind of debate that focuses on value, impact, and long-term savings.

Access to primary care saves lives and saves money, and the NHSC is designed to increase access where we need it most.

Last month the President proposed one way to address the funding issues facing the NHSC. His proposal expanded the program in FY2015 with a combination of annual appropriations and the creation of a new mandatory trust fund. Then for the following five years, the program would be funded at \$710 million per year through FY2020.

I would say there are positive and negative things about this proposal, but we applaud the President for putting it on the table. Just raising the issue, starting the debate about the future of this program is important, and we are very appreciative.

But the challenge is now in your hands. Is the NHSC a valuable program? Based on my 40 years of experience, I would say most definitely. Is the program threatened? Clearly. How should you fund it, and what funding level would achieve the goals of the program? That is up to you to decide. But I would urge you to do it sooner rather than later. The debt levels are exploding, primary care shortages are increasing and recruitment and retention in underserved areas is getting harder and harder.

Conclusion

It is amazing how fast these last 40 years have passed. Dr. Roy returned to practice medicine in Kansas, ran for office twice and lost, and has been a regular columnist for the Topeka Capital-Journal. Cong. Rogers went on to decades of distinguished service in Congress and died just a couple years ago. Their "Happy Trails" legislation has made an extraordinary contribution to increase health care access in this country. It has provided the path for my career and been a source for primary care over 3 million visits at AAPHC. Will it provide a trail for my children and other future primary care clinicians? Without the NHSC, what will be the solution? Neil Shulman and I along with one of my patients Vic Miller wrote a sequel book and screenplay to "Doc Hollywood." In this book "Where Remedies Lie" we describe what happens to "Doc Hollywood" as he confronts the challenges of providing primary care access to a rural region in the Deep South whose citizens are poor and black. His "Remedy" was a "Happy Trail" of the NHSC and the community health center program.

In a PBS interview in 1996, Dr. Roy stated how proud he was of his legislative legacy, but especially of the NHSC. "I'd worked hard on the National Health Services Corps to get physicians into rural and underserved areas," he told the reporter. Since its birth in 1970 over 45,000 primary care clinicians have used its help to go to underserved communities. It is one of the "crown jewels" of public health policy and may face extinction in 2016 if you do not act.

I just want to say thank you to the Subcommittee for holding this hearing, discussing the importance of the federal programs aimed at increasing access to primary care, and most of all, raising the profile of the National Health Service Corps. Dr. Roy 40 years ago inspired me to follow the "Happy Trail" that has led to a fulfilling career at AAPHC. The National Health Services Corps has been part of my life for 40+ years, and I can assure you it is the most effective program this country has ever devised to distribute primary care clinicians to the underserved communities. You are now the ones who must keep the "Happy Trail" open for the citizens you serve. I would be glad to answer any questions you may have.

APPENDIX 1

Current Loan Statement for one of the Hotz children. All loans are medical school-related.

Lower Payment						
Online Services Forms Mortgage Verification Go Paperless						
Account Summary Principal Balance: \$214,217.90 Last Payment: \$3,886.09 Received On: 03/07/14 Next Payment: 02/07/15 Total Due: \$1,057.77 Final Payment: 03/07/37 Account Status: Repayment SEE DETAILS						
Select*	Disbursement Date	Type of Loan	Current Principal Balance	Current Interest Rate	Outstanding Interest	Late Fees Due
<input type="checkbox"/>	08/22/2005	Direct Subsidized Stafford Loan	7,930.28	2.10	12.77	0.00
<input type="checkbox"/>	08/05/2006	Direct Subsidized Stafford Loan	8,393.59	6.55	42.17	0.00
<input type="checkbox"/>	07/14/2007	Direct Subsidized Stafford Loan	8,393.62	6.55	42.17	0.00
<input type="checkbox"/>	07/08/2008	Direct Subsidized Stafford Loan	8,393.53	6.55	42.17	0.00
<input type="checkbox"/>	08/22/2005	Direct Unsubsidized Stafford Loan	36,488.55	2.10	58.78	0.00
<input type="checkbox"/>	08/05/2006	Direct Unsubsidized Stafford Loan	42,880.78	6.55	3,356.31	0.00
<input type="checkbox"/>	07/14/2007	Direct Unsubsidized Stafford Loan	44,372.65	6.55	3,326.07	0.00
<input type="checkbox"/>	07/08/2008	Direct Unsubsidized Stafford Loan	39,435.76	6.55	2,535.03	0.00
<input type="checkbox"/>	05/10/2007	Direct Student Plus Loan	6,302.78	7.65	1,378.76	0.00
<input type="checkbox"/>	07/25/2007	Direct Student Plus Loan	10,129.83	7.65	2,100.46	0.00
<input type="checkbox"/>	07/25/2008	Direct Student Plus Loan	1,496.53	7.65	216.96	0.00