"The Teaching Health Center Graduate Medical Education Program:

A Key to Solving the Nation's Primary Care Workforce Crisis"

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Chairman Alexander, Ranking Member Murray, and Distinguished Members of the Committee:

Thank you for inviting me to speak to you about the Teaching Health Center Graduate Medical Education Program, which we call "THCGME." I am a family physician and serve as the Chief Executive Officer of Cahaba Medical Care ("CMC"), a Federally Qualified Health Center with ten locations serving Bibb, Chilton, Perry, and Jefferson Counties. I am also the Residency Director of the Cahaba Family Medicine Residency, based in Centreville, AL. Cahaba Family Medicine Residency is Alabama's only Teaching Health Center and started its inaugural class in 2013. I am pleased to share that 71 percent of our graduated residents are now practicing in a Medically Underserved Area, a rate almost three times higher than in traditional residency programs.

As you can see, Cahaba's experience is proof that the THCGME program works and deserves to be extended this year. In 2018, Congress enacted a two-year reauthorization of the THCGME program through Fiscal Year 2019, getting us back to a more sustainable level of $150,000 per resident by providing $126.5 million in appropriations per year for FY18 and FY19. Without Congressional action, the program will lapse again on September 30, so I am very grateful that the Committee is holding such an early hearing and that the Chairman and

Ranking Member have introduced bipartisan legislation to provide a five-year extension. The leadership shown by Chairman Alexander and Senator Murray in recognizing the need for a robust extension of our program is greatly appreciated by the many teaching health center representatives here in the Committee room and our medical residents here and across the nation.

So that members of the Committee can best understand why reauthorization is so critical, please permit me to share some background about our own teaching health center programs, our residents, and our patients.

Cahaba Medical Care – Teaching Health Centers in Alabama

CMC serves a portion of central Alabama that includes Bibb, Perry, Chilton, and Jefferson Counties and currently employs 266 people. Prior to becoming a FQHC / THC, CMC employed 11 people. Today, CMC employs over 50 providers, including physicians, resident physicians, physician assistants, nurse practitioners, and licensed behavioral health counselors. Since the National Health Service Corps program is also the subject of today's hearing, I want to note that over 30 Cahaba providers, including faculty physicians, have utilized the National Health Service Corps loan repayment as a crucial incentive, since there are often salary constraints for physicians working in an non-profit setting.

The growth CMC experienced on the employee side has logically enabled us to serve far more patients, increasing from approximately 2,100 patients in 2012 to over 17,000 unique patients served and over 80,000 patient encounters in 2018. Each of CMC's 10 sites sits within a Health Profession Shortage Area for medical, dental, and behavioral health and offers comprehensive care to everyone no matter their insurance status. In our service area, 46 percent of the population lives at or below the federal poverty level, and 15 percent are uninsured. Among the patients seen by CMC, 17 percent are uninsured, 35 percent are Medicaid and 25

percent are Medicare. Also, there is a high burden of uncontrolled chronic diseases such as diabetes, hypertension, heart disease, mental health conditions, kidney disease, and late presentation of diseases such as lung and colon cancers. In order to meet the wide array of medical conditions that are also often coexistent with significant social, emotional, financial, and transportation barriers to receiving adequate care, CMC also employs a team of social workers and counselors to help address the patients care holistically.

CMC serves eight distinct communities, each of which has its own story, its own strengths, its own challenges, and its own gaps in the healthcare and other industries. One such community is Maplesville, AL, a small rural town in Chilton County. Prior to our opening a new clinic in 2015, Maplesville hadn't seen a new physician enter the community in over 50 years, and the one physician in the community was active only part time and nearing retirement. CMC purchased three buildings in the historic, but antiquated, downtown, and renovated them into a modern primary care clinic, fully equipped with a x-ray and in-house lab capabilities. Patient care began in late 2015 with a nurse practitioner. Then, a graduating resident from CMC's first THCGME Residency class, Dr. Andreia White, DO, originally from Marengo County, AL, joined as the second provider in August of 2016. Since that time, according to the Federal Uniform Data Services Mapper (UDSMapper), CMC has served over 50 percent of the low income population within Maplesville and has also helped to revitalize the small downtown square.

We were honored to host Senator Doug Jones at our Centreville campus after he had heard this and other stories about the communities we serve. During his visit, he learned more about our FQHC and the integral part the Teaching Health Center has played in training, recruiting, and retaining Family Medicine physicians to underserved communities in Alabama.

The Primary Care Physician Shortage and Teaching Health Centers

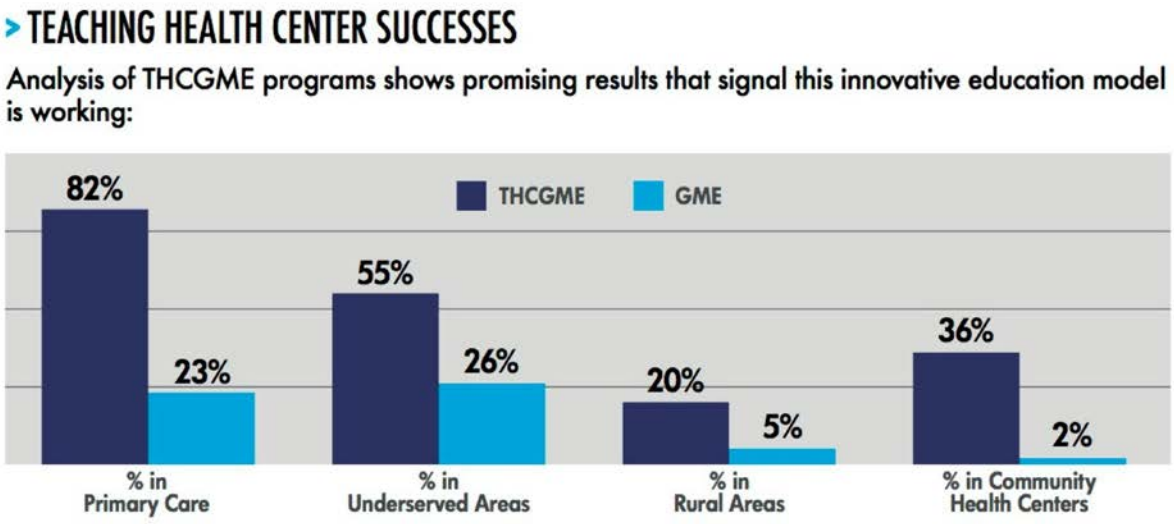
Beyond the borders of Alabama, the entire nation also faces a severe doctor shortage. In fact, by 2030 we will need more than 120,000 physicians to meet the growing demand for health care services across the country. According to the Association of American Medical Colleges, by 2030, the United States will require nearly 50,000 primary care physicians, and the shortage is being felt most deeply in health professional shortage areas (HPSAs) and medically underserved areas (MUAs). As many as 84 million people living in these areas experience disparities in health care access either because they are uninsured, or because they live in rural, urban, or suburban areas without enough primary care physicians. Additionally, we are reaching a critical time when the number of medical school graduates will be greater than the number of residency slots. Without a residency, medical school graduates are unable to obtain a medical license.

While patient care increasingly occurs in ambulatory settings, such as community health centers, medical education occurs mainly in inpatient hospital facilities, funded primarily by CMS under a Medicare formula. This hospital-based training produces a health care workforce whose skills and experiences are poorly matched to the primary care needs of the population, and who rarely choose to practice in rural or underserved areas. In order to address the changing healthcare system and address the disparities in the health care workforce, the THCGME model uses community-based ambulatory health centers, such as nonprofit community health centers and community consortia, to train primary care residents who will practice 21st century care in urban and rural underserved communities during their training and after they complete their residencies. During their residency training, THC residents practice in the approved primary

care specialties of Family Medicine, General Internal Medicine, Obstetrics and Gynecology, Pediatrics, Psychiatry and General Dentistry.

According to the 20th Report of the Council on Graduate Medical Education (COGME), "the shortage in primary care providers, particularly those capable of caring for adults with chronic disease (Family Medicine and General Internal Medicine), overshadows the deficits in all other specialties." One way to address the physician workforce shortage is to train resident physicians in underserved settings, based on the precept that training providers in areas of need will produce the workforce with the necessary skills to serve in underserved areas. Evidence has shown that resident physicians who train in health center settings are nearly three times as likely to practice in underserved settings after graduation. They are also 3.4 times more likely to work in a health center, compared to residents who did not train in health centers. The difficulties in recruiting community-based primary care physicians is also well documented; only investment in the community health care workforce pipeline will help meet the workforce demands. By moving primary care training into the community, THCGME programs are on the leading edge of innovative educational programming dedicated to meeting future health care workforce needs.

Analysis of the THCGME programs continue to show promising results:



Reauthorization Legislation

With the looming primary care shortage on the horizon, investments in graduate medical education training will be critical to meet the needs of the evolving healthcare delivery system. The THCGME program is one of the most reliable training models for primary care physicians and has an overwhelming documented success, but has been critically underfunded and is at the brink of collapse. Without immediately strengthening and expanding, the program will unravel just as it is beginning to produce the urban and rural primary care workforce that is desperately needed.

As I noted earlier, we were very grateful that as an initial step last year, Congress provided sufficient funding to bring the per resident allocation back up to a more sustainable level. We are very heartened that the Alexander-Murray bill would provide another element of sustainability by reauthorizing the THCGME program for five years. The last two reauthorizations were each for two years and did not always provide sufficient certainty for teaching health centers to make binding three-year commitments to all the recruits that they were authorized to hire. The longer timelines are so important because the training itself three years in duration and the medical student recruiting process starts one to two years prior to the training, and certainty of sustainable funding for training is utterly essential to recruit qualified medical graduates into Teaching Health Centers. We are so glad that Chairman Alexander and Ranking Member Murray have listened so carefully to our concerns and have expressed such strong support for THCGME by offering legislation to extend funding through FY24. What a difference it will make if Congress gives us stable funding for five years! We can budget more efficiently and ensure that we can keep our doors open for enthusiastic future doctors who are committed to practicing medicine in underserved communities. Primary care saves lives and

saves money and it is clear that the Alexander-Murray five-year reauthorization bill recognizes how the Teaching Health Center Graduate Medical Education program helps solve our primary care crisis. Simply put, the Alexander-Murray reauthorization proposal will improve medical education and save lives in many of our communities.

In addition to the Alexander-Murray proposal, I want to encourage the Committee to consider reauthorization legislation that the teaching health centers have worked on with Senators Collins and Jones, which would augment the $126.5 million current funding level by adding some additional appropriations to meet three of our other needs. We are grateful to Senators Collins and Jones for their willingness to work with supporters of the Teaching Health Centers. We are hopeful that Congress will consider favorably any proposal to help THCs restore some resident slots that were authorized by HRSA but not filled during the last couple years of uncertainty. Second, we are hopeful that Congress will include funding for a very modest increase in the per resident allocation to help offset inflation over the next five years. While Congress was very generous in restoring the $150,000 PRA in last year's law, our clinics and residency programs facing rising costs and we are hopeful that Congress can find some funds to help us preserve our purchasing power during this five-year reauthorization period.

Lastly, we are hopeful that Congress will include additional funding for expansion of the THCGME program to meet pent-up demand in many communities for a residency program such as Cahaba's. It has been five years since HRSA last approved a new Teaching Health Center in 2014 and many potential sponsors of such centers have reached out to our association asking for advice on how they can obtain such a designation and the accompanying funding. HRSA has correctly prioritized trying to sustain existing Centers for the past two years and we are hopeful that this reauthorization process will include additional funds that permit HRSA to solicit

proposals and approve entirely new centers or expansion of programs offered at existing centers. Every dollar spent on expansion will generate tangible benefits for your communities and those of other Senators. Lives will be saved, economic growth generated, and we will make a dent in the medical care shortage that plagues too many parts of our country to this day.

Thank you for giving me the time to testify this morning.