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330 East Algonquin Road • Suite 1
Arlington Heights, IL 60005
Phone: 847.952.5100
Fax: 847.228.9755
www.acofp.org

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March 20, 2023

VIA ELECTRONIC SUBMISSION

Senator Bernie Sanders
Chair, U.S. Senate Committee on Health, Education, Labor, & Pensions
332 Dirksen Office Building
Washington, DC 20510

Senator Bill Cassidy
Ranking Member, U.S. Senate Committee on Health, Education, Labor, & Pensions
455 Dirksen Office Building
Washington, DC 20510

Dear Chairman Sanders and Ranking Member Cassidy:

On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to comment on the U.S. Senate Committee on Health, Education, Labor, & Pensions (HELP Committee) request for information on the root causes of the current health care workforce shortage and potential ways to address it.

ACOFP is the professional organization representing more than 20,000 practicing osteopathic family physicians, residents, and students throughout the U.S. who are deeply committed to advancing our nation's healthcare system by improving healthcare delivery and outcomes and ensuring that patients have access to high-quality care.

We focus our comments on the following issues: (1) addressing the family physician shortage through compensation and training, (2) recruiting providers to rural and underserved areas, and (3) reducing physician burnout.

Our full comments are detailed on the following page. Thank you for the opportunity to share our feedback with you. Should you need any additional information or if you have any questions, please feel free to contact ACOFP at advocacy@acofp.org or (847) 952-5100.

Sincerely,

Bruce R. Williams, DO, FACOFP
ACOFP President

Addressing the Family Physician Shortage Through Compensation and Training

When considering the current health care workforce shortage, it is critical to specifically address the family physician shortage. As more family physicians reach retirement age, the U.S. is facing shortages of 18,000–48,000 primary care physicians by 2034.[1] More needs to be done to address this shortage and increase the number of residents choosing family medicine. Significantly higher reimbursement for specialists relative to primary care physicians contributes to the current imbalance between primary and specialty care. Both compensation and training are key tools to address the health care workforce shortage overall, as well as the family physician shortage.

Primary care physicians are poorly compensated relative to their peers in specialty services. From 2003 to 2004, the ratio of average annual income for a specialty physician compared to a primary care physician in the U.S. was 1.6:1. In 2017, the median compensation in radiology, procedural, and surgical specialties had an almost twofold difference compared to primary care physicians. Data from the Medical Group Management Association indicates that from 1995 to 2004, the median income for primary care physicians increased by 21.4 percent, while that for specialists increased by 37.5 percent. The median compensation for nonsurgical procedural specialties, surgical specialties, and primary care in 2017 was $426,000, $420,000, and $242,000, respectively. This compensation gap is associated with the reduction in medical students choosing primary care careers and the shift of hospital graduate medical education (GME) priorities away from primary care.[2]

Moreover, medical students are financially incentivized to choose specialty training (e.g., cardiology or pulmonary medicine) over primary care because of higher reimbursement for certain specialty medicine services, such as high-cost imaging, testing, and procedures.[3] Recent efforts to increase Medicare reimbursement for primary care services have been positive steps toward payment equalization. However, a significant reimbursement differential still exists between primary care and specialty care, which neither reflects the inherent complexity of providing evaluation and management services nor the significant value these services provide to patients and to the Medicare program overall. We urge you to consider and support incentives for medical students to choose family medicine, including:

- Providing financial support for medical education in the form of loans, loan forgiveness, and loan deferment;
- Equalizing reimbursement between various settings of care (i.e., office, outpatient clinic, emergency department) and between family medicine and specialty medical services; and
- Enhancing reimbursement by rewarding care that is proven to ensure high-quality patient outcomes and patient satisfaction.

In addition, more training opportunities are needed for medical students choosing family medicine, and medical education funding and programs must be preserved and expanded, including the Teaching Health Center GME (THCGME) program and Title VII. Also, while we appreciate the historic increase in Medicare-funded GME slots in the *Consolidated Appropriations Act, 2021* and in the *Consolidated Appropriations Act, 2023*, more must be done to fill the provider gap. To meet this need, we urge you to support additional increases in the number of Medicare-funded GME slots and prioritize primary care residency programs.

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[1] *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034.* Association of American Medical Colleges website. Published June 2021. https://www.aamc.org/media/54681/download.

[2] National Academies of Sciences, Engineering, and Medicine. *Implementing High-Quality Primary care: Rebuilding the Foundation of Health care.* Washington, DC: The National Academies Press. 2021. doi.org/10.17226/25983.

[3] Shi L. *The Impact of Primary Care: A Focused Review.* Scientifica (Cairo). 2012. doi:10.6064/2012/432892.

Recruiting Providers to Rural and Underserved Areas

Rural Americans face poor access to health care. Rural and urban health care discrepancies have been highlighted throughout the COVID-19 pandemic, including disproportionately high incidence and mortality rates in nonurban areas during some periods of the pandemic.[4] ACOFP is committed to treating vulnerable populations, including rural patients, and Congress can play a key role in addressing this goal.

We recommend that the HELP Committee support policies that promote the recruitment of physicians in rural areas. For example, ACOFP supports S. 230, the *Rural Physician Workforce Production Act*, which was introduced on February 2, 2023. The bill is designed to enhance Medicare reimbursement and improve the current structure of the Medicare-funded GME program to increase the number of medical residents and physicians operating in rural areas. As you know, physicians are more likely to practice medicine where they trained so the bill would help ensure a pipeline of physicians in rural areas. We urge you to address the rural physician workforce shortage by supporting the *Rural Physician Workforce Production Act*.

Reducing Physician Burnout

ACOFP supports federal programs to address physician burnout and promote physician wellness to establish a culture of well-being among the physician community. We recognize important steps that have been made to address physician wellness, such as the passage of the *Dr. Lorna Breen Health Care Provider Protection Act* which establishes grants to promote mental health and resiliency among health care providers and allows grants for mental and behavioral health training, and the introduction of the *Physician Wellness Program Act of 2022*. We urge the Committee to continue their work on developing policies that promote physician well-being.

We also urge the Committee to support legislation that will reduce administrative burdens, including reducing burdensome paperwork requirements across federal programs to allow physicians more time to treat patients. Cumbersome electronic health record (EHR) systems, utilization management policies (such as prior authorization), and continuously changing regulatory rules are forcing doctors to spend more time on administrative tasks rather than patients. According to recent studies, doctors spend approximately half their time on EHRs and desk work, in addition to completing paperwork after hours. For every hour a physician spends on clinical time, nearly two hours are spent on EHR and administrative tasks every day.[5]

Burdensome paperwork requirements are contributing to the physician shortage and are inhibiting appropriate patient care.[6] Many physicians, burned out by paperwork requirements, decide to retire early or leave medical practice for another profession, especially those in small, rural, and solo practices where they do not have the resources to manage all the paperwork requirements.[7] As more of these practices are forced to close or relocate, healthcare shortage areas widen, and more communities lose access to care.

ACOFP is committed to ensuring all Americans have access to quality health care. We stand ready to work with you in developing solutions to bolster our health care workforce.

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[4] Ullrich F., Mueller K. *COVID-19 Cases and Deaths, Metropolitan and Nonmetropolitan Counties Over Time (update).* RUPRI Center for Rural Health Policy Analysis Rural Data Brief. Published December, 2022. https://rupri.public-health.uiowa.edu/publications/policybriefs/2020/COVID%20Longitudinal%20Data.pdf.