James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
james.madara@ama-assn.org

March 20, 2023

The Honorable Bernie Sanders
Chairman
Committee on Health, Education,
Labor and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

The Honorable Bill Cassidy
Ranking Member
Committee on Health, Education,
Labor and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

Dear Chairman Sanders and Ranking Member Cassidy:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to comment on the Senate Committee on Health, Education, Labor and Pensions' request for comment concerning health care workforce shortages. Prior to the COVID-19 pandemic, the U.S. was already facing a rising shortage of physicians largely due to the growth and aging of the general population and the impending retirement of many physicians.[1,2] Now, in part due to the increased physician burnout associated with COVID-19, there is a projected shortage of between 54,100 and 139,000 physicians by 2033. This number includes a projected primary care physician shortage of between 21,400 and 55,200, as well as a shortage of non-primary care specialty physicians of between 33,700 and 86,700.[3]

This shortage has been further exacerbated by the fact that, in just the first two months of the pandemic, approximately 1.5 million health care jobs were lost and employment in this sector remains below pre-pandemic levels.[4] Further, a 2022 Definitive Healthcare report revealed that in the last quarter of 2021, the greatest number of health care workers that left the workforce were physicians (117,000) with internal medicine and family practice being the most impacted by these losses.[5]

As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA is committed to ensuring that there is proper access to physicians for all patients and that physicians are well supported in their role as leader of the health care team. If workforce barriers for physicians are reduced, and burnout is addressed, it will help to increase the number of physicians in the U.S., which will lead to healthier communities and ultimately a healthier country as access to much-needed medical care increases.

[1] https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage.
[2] https://www.aamc.org/download/472888/data/physicianworkforceissues.pdf.
[3] AAMC (2020, June) The Complexities of Supply and Demand: Projections from 2018 to 2033. Retrieved from AAMC:https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf.
[4] https://www.definitivehc.com/sites/default/files/resources/pdfs/Addressing-the-healthcare-staffing-shortage.pdf.

Rural Hospitals

Rural hospitals play a very important role within communities. For example, in "2020, rural hospitals supported one in every 12 rural jobs in the U.S. as well as $220 billion in economic activity in rural communities."[5] However, between 2010 and 2021, 136 rural hospitals closed.[6] These closures have contributed to unequal access and distribution of providers since 20 percent of the U.S. population lives in rural communities, only 10 percent of physicians practice in such areas.[7] On top of this, with our aging physician workforce it is projected that there will be about a quarter fewer rural physicians practicing by 2030.[8]

In order to help curtail this shortage **more rural residency positions should be created**. "Residents often continue to practice in locations where they complete GME training, which ultimately influences the distribution of the health care workforce. A 2020 study found that 56 percent of the residents who completed their training between 2010 and 2019 were still practicing in the state in which they trained at the end of 2019, and a 2015 study found that a similar portion of family medicine residents practiced within 100 miles of their training site after completing their training."[9] Unfortunately, the physicians who are most likely to practice in rural regions, such as those graduating from medical schools in rural areas, declined by 28 percent between 2002 and 2017.[10] This decrease is compounded by the fact that in 2016 and 2017 only 4.3 percent of incoming medical students were from rural backgrounds.[11]

The shortages in rural communities are even further compounded by the cap that has been placed on residency slots. When Congress enacted the Balanced Budget Act of 1997 it placed a limit (or cap) on the funding that Medicare would provide for GME.[12] This meant that most hospitals would receive direct medical education (DGME) funding and indirect medical education (IME) support only for the number of allopathic and osteopathic full-time equivalent (FTE) residents it had in training in 1996.[13] Until the cap is significantly raised, the shortage of primary care physicians will never be truly resolved. **Therefore, it is essential that we invest in our country's health care infrastructure by providing additional GME slots so that more physicians can be trained and access to care can be improved.**

Additionally, "Cap-Flexibility," which would allow new and current GME teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), would begin to help to remedy the physician shortage we are currently experiencing. "Giving these [rural] hospitals more time to establish their caps will help them start more programs and attract more residents to their communities before the Medicare-funded resident caps are set."[14]

---

[5] https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf.
[6] https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf.
[7] https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf.
[8] https://www.nejm.org/doi/full/10.1056/NEJMp1900808.
[9] https://www.gao.gov/assets/gao-21-391.pdf.
[10] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00924.
[11] https://www.aamc.org/news-insights/attracting-next-generation-physicians-rural-medicine.
[12] https://www.congress.gov/bill/105th-congress/house-bill/2015.
[13] https://www.ama-assn.org/education/improve-gme/compendium-graduate-medical-education-initiatives.
[14] https://www.gao.gov/assets/gao-21-391.pdf.

Teaching Health Center Graduate Medical Education (THCGME) and Rural Residency Planning and Development (RRPD) Program

"Recruitment and retention of health professionals has long been a persistent challenge for rural providers."[15] As such, only about one-third of hospitals located in rural areas are training over their Medicare GME caps.[16] To try and bolster the number of providers in rural communities the THCGME program was created. "The primary goal of the THCGME Program is to increase the number of primary care physician and dental residents training in community-based ambulatory patient care settings. The training opportunities created for THCGME-supported residents build the workforce and improve the distribution of the nation's primary care workforce in economically disadvantaged areas, through an emphasis on rural and other underserved communities and populations. Teaching Health Centers are located predominantly (80 percent) in community-based health centers, such as Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, Rural Health Clinics, and Tribal Health Centers that provide primary care services in underserved areas. In Academic Year (AY) 2016-2017, the majority of THCGME residents (83 percent) spent part of their training in medically underserved and/or rural communities, and these residents provided more than 795,000 hours of patient care."[17]

The RRPD program improves and expands "access to health care in rural areas by developing new, sustainable rural residency programs or rural track programs (RTPs) that are accredited by the Accreditation Council for Graduate Medical Education (ACMGE), to address the physician workforce shortages and challenges faced by rural communities. This program provides start-up funding to RRPD award recipients to create new rural residency programs that will ultimately be sustainable long-term through viable and stable funding mechanisms, such as, Medicare, Medicaid, and other public or private funding sources."[18]

The services that THCGME and the RRPD program provide are very important; moreover, they expose residents to rural communities that are underserved earlier in their career, which promotes these physicians remaining and caring for these communities throughout their career. Since there are so many positive benefits to THCGME and RRPD, these programs should be expanded. One form of expansion would be to **increase funding for THCGME and RRPD.** This would help to create more residency training slots and thus would increase the overall pool of physicians.

Additionally, for Rural Teaching Hospitals, their current cap is 130 percent of the 1996 cap. However, since these hospitals provide such an important and needed service, **the cap should be increased to meet the current needs of our country and should not be stagnant, but rather, should be able to be increased as needed.** Also, **the cap building period should be increased**. It may take longer for rural programs in underserved areas to build up their training programs; moreover, it is important to ensure that these programs have the best opportunity to build the most robust program that they can. Therefore, the cap building period should be at least 10 years if not longer to ensure that the program is the most successful that it can be.

---

[15] https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf.
[16] https://www.gao.gov/assets/gao-21-391.pdf.
[17] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/about-us/reports-to-congress/report-to-congress-thcgme-2019.pdf.
[18] https://www.hrsa.gov/grants/find-funding/HRSA-23-037.

Furthermore, additional support should be provided so that more institutions are incentivized to create rural training track programs. The Consolidated Appropriations Act, 2021 made some positive changes to the rural track programs (RTPs), including removing the separately accredited requirement, allowing urban hospitals to create multiple RTPs and receive an RPT cap adjustment for each new RPT started, and excluding residents training in an RTP from the three-year rolling average while in the five-year cap building phase. However, additional leniencies and funding would help to increase the creation of these important tracks.

Also, **holistic changes to the rural physician working environment need to be made.** Students need to be recruited earlier in life. Programs should be created and must involve identification very early of students in high schools who want to commit to practice medicine. Additionally, communities that need health professionals should be educated about medical education, and encouraged to help groom and assist local students with getting into medical school. Moreover, pathway programs and holistic outreach (mentors, interview prep, etc.) are necessary. Medical schools and residency programs should develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements and provide early and continuing exposure to those programs for medical students and residents. Finally, once individuals choose residencies in rural areas, support systems are needed. The creation of groups and communities will help to make residents invest in the specialty and the community in which they are serving long term.

Physician Burnout

The AMA is deeply concerned about the intensifying mental health and burnout crisis among physicians and other health care professionals, which has only been exacerbated by COVID-19. More than half of all physicians in the U.S. report experiencing substantial symptoms of burnout, with the most severe symptoms occurring among those working at the front lines of medicine in fields such as emergency medicine, family medicine, and internal medicine.[19] In addition, physicians are at a significantly increased risk of suicide compared to the general population, with suicide rates 40 percent higher in males and 130 percent higher in females.[20]

Physician burnout poses a major challenge for the U.S. health care workforce, and this has only been exacerbated by the COVID-19 pandemic. Physician burnout can lead to devastating consequences and requires system-level solutions, as well as initiatives and programs that encourage physicians and medical students to seek help as needed.

The AMA has been working at both the federal and state levels to improve physician mental health and burnout, including advocating for the Dr. Lorna Breen Health Care Provider Protection Act, which was signed into law last year. **Additional funding in support of the programs created through the Dr. Lorna Breen legislation should be provided to continue to positively impact physician mental health and wellbeing.**

Additionally, many of the key causes of physician burnout are systemic factors, rather than individual factors. These main drivers include physician task load (PTL), inefficiencies and disorganization of the practice, poor work-life integration, and administrative burdens induced by electronic health records

[19] https://www.npr.org/2020/08/22/904695784/as-pandemic-persists-health-care-heroes-beginning-to-crack-under-the-strain.
[20] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5483979/.

(EHRs) and documentation. When researchers from Yale School of Medicine, Veterans Affairs, Minneapolis Medical Research Foundation, and the AMA surveyed clinicians to identify remedial stressors that contribute to burnout, similar results were found. **Predictors of burnout were shown to include poor control over workload, insufficient documentation time and excessive electronic medical record time at home—highlighting potential interventions to address burnout. As such, additional funding should be provided to create programs that support physician wellness and work to address the factors that lead to burnout.**

Prior Authorization

Prior authorization (PA), which is the requirement that a physician practice obtain approval from a health plan prior to delivering care to a patient, places a significant burden on physicians and their staff. As recognized by the Surgeon General, PA is a leading cause of workforce burnout.[21]

Burnout is "associated with job demands related to workload, time pressure, and work inefficiencies, such as burdensome administrative processes which divert clinicians' attention away from patients and detract from patient care."[22] PA is a highly labor resource-intensive opaque process that detracts from timely access to care and undermines physician decision-making.

A recent AMA survey of 1,001 physicians across specialties found that the average practice completes 45 PAs per week, with physicians and their staff spending the equivalent of two full business days (14 hours) per week exclusively on PA, taking precious time away from patient care. [23] Not surprisingly, eighty-eight (88) percent of physicians reported the burden associated with PA as high or *extremely* high. In fact, thirty-five (35) percent reported having staff who work exclusively on PA. In a recent MGMA survey, a large majority of practices reported that PA requirements had increased in the last 12 months, underscoring that PA is a growing pain point for physicians and is only getting worse over time.[24]

The demanding and time-consuming nature of PA is due in part to its complexity and opacity. Health plans ask for clinical information that needs to be extracted from the electronic medical record and sent with the request. This creates an intensive back and forth between the practice and the payer as additional requests and additional documents are exchanged, often through manual methods, such as faxes and portals. What makes this process even more challenging is the lack of transparency. Each health plan has different PA requirements, and given that these lists are propriety, providers are left in the dark trying to track down which service requires PA, and which documentation is needed to obtain an approval.

---

[21] HHS, Addressing Health Worker Burnout, The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce (2022) Available at: https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf.

[22] National Academies of Medicine, "Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being," Oct. 2019. Accessed at: https://nam.edu/wp-content/uploads/2019/10/CR-report-highlights-brief-final.pdf.

[23] American Medical Association, "2022 AMA Prior Authorization (PA) Physician Survey," March 2023. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[24] MGMA, 2022 https://www.mgma.com/data/data-stories/virtually-all-medical-groups-say-payer-prior-autho (88% of MGMA respondents also reported that PA was "very or extremely burdensome").

Moreover, the requirements frequently change. For example, a large national health system will hire two to three full-time staff that do nothing but monitor health plan bulletins for changes to PA rules.[25]

One of the downstream effects of this tedious task is that PA "takes the joy out of medicine."[26] There is no guarantee that a PA request will be approved. When a request is denied, this can contribute to a feeling of devaluation among providers as they have little to no control over the recommended course of treatment.[27] The appeals process "adds insult to injury" by forcing physicians to fight for care that the patient should have been approved for in the first place. The Kaiser Family Foundation recently found that eighty-two (82) percent of submitted appeals were fully or at least partially overturned.[28] Physicians want what is best for their patients, but the PA process means someone else is making decisions for the patient, outside of clinical reasoning. Regardless of years of training, physician expertise is constantly undermined. Many PA determinations are made by people who have never actually cared for a patient, and many payer requirements are not based on best practices or evidence-based guidelines,[29] again adding to the utter frustration of this onerous administrative policy.

More alarmingly, PA delays have significant negative effects on patient care and clinical outcomes.[30] Eighty-nine (89) percent of physicians reported that PA had a somewhat or significant negative impact on patient outcomes, and thirty-three (33) percent of physicians reported that PA delays caused an adverse event, such as hospitalization, permanent impairment, or even death, for a patient in their care.[31] When a patient is unable to access care due to bureaucratic hurdles, it causes physicians to lose faith in the system. The patient harms caused by PA only serve to contribute to the emotional exhaustion and low sense of personal accomplishment that many physicians feel at work, not to mention the possible moral injury,

---

[25] AHA, Addressing Commercial Health Plan Abuses to Ensure Fair Coverage for Patients and Providers. Dec. 2020. https://www.aha.org/system/files/media/file/2020/12/addressing-commercial-health-plan-abuses-ensure-fair-coverage-patients-providers.pdf.

[26] Prior Authorization is a Nightmare (2019) Available at: https://www.youtube.com/watch?v=fXsx6eoBUW8.

[27] Lack of control has been identified as one of the main drivers of burnout. See AMA, "What really drives doctor burnout and how to fix it" Sept. 2022. Available at: https://www.ama-assn.org/practice-management/physician-health/what-really-drives-doctor-burnout-and-how-fix-it?utm_source=twitter&utm_medium=social_ama&utm_term=9105129560&utm_campaign=PS2.

[28] KFF, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021". Feb 2023. https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/?utm_campaign=KFF-2023-Medicare&utm_medium=email&_hsmi=244325042&_hsenc=p2ANqtz-95MmRl8bjGH1WPz9_iUlYwKzW2q_vSwBfK5b8wRyh7l9nbHkuwja5LjJNejE41JrdsxK310FKSUXiSFQi7rrQCqt_Jcg&utm_content=244325042&utm_source=hs_email.

[29] 31% of physicians report that PA criteria are rarely or never evidence-based. American Medical Association, "2022 AMA Prior Authorization (PA) Physician Survey," March 2023. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[30] 94% of physicians report PA causes care delays. American Medical Association, "2022 AMA Prior Authorization (PA) Physician Survey," March 2023. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[31] Adverse event is defined as: e.g., death, hospitalization, disability/permanent bodily damage, or other life-threatening event. See American Medical Association, "2022 AMA Prior Authorization (PA) Physician Survey," March. 2023. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

compassion fatigue, and/or PTSD[32] from the knowledge that a life-threatening event or even death could have been avoided.

When we asked our member physicians at an AMA House of Delegates meeting for the first word that came to mind when thinking of PA, "nightmare" was a common choice.[33] The process's unreasonable and untenable financial impacts compound this dread: a large health system estimated that in 2019 it failed to obtain roughly $3.6 million in lost revenue due to cancellations and rescheduling due to PA delays.[34] As physicians become more and more overwhelmed by PA hurdles, some have decided to leave their practice or have reduced their patient load as a result.[35] Staffing shortages are undoubtedly linked to the PA problem. As noted in the following testimonials,[36] navigating the capricious PA paradigm has also led physicians to consider early retirement:

> I have no admin back-up. All prior authorizations are done by me. As a psychiatrist, I book my schedule as tightly as possible, so these extra phone calls, being on 'perma-hold' for 10-25 minutes, takes a big bite out of my time. Not to mention that they often are on the mainland, and there is a 2-3 hour difference in time zones between Hawaii and California. Not to mention the 5-6 hour difference to the East Coast, so its hard to do this at the end of the day for me. A colossal waste of my time, a never-ending source of frustration, and frankly, another thing to push me towards retirement, and I know that there is still a shortage of private psychiatrists in my state.
> – Dr. Dennis L., Hawaii

> I feel that prior-auth has been one of the worst things to affect physicians' lives, along with Medicare and insurance companies' constant assault on physicians' ability to do the right thing in the most efficient manner for their patients. This is all labelled as 'monitoring' so that patients are getting proper care. It is a huge wastage of resources. One can write a big dossier about everyday examples of this. I have heard from many many excellent physicians that this is the main driving force behind physicians' consideration of early retirement, and that includes myself.
> – Dr. Vinod S., Illinois

PA is a major "culprit" when it comes to health care burnout.[37] In 2018, the AMA "reached across the aisle" and signed a consensus statement along with other stakeholders, including several health plan

---

[32] HHS, Addressing Health Worker Burnout, The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce (2022) Available at: https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf.

[33] Video montage obtained from AMA Interim House of Delegates Meeting 2018, see Prior Authorization is a nightmare (2019) https://www.youtube.com/watch?v=fXsx6eoBUW8.

[34] AHA, Addressing Commercial Health Plan Abuses to Ensure Fair Coverage for Patients and Providers, Dec. 2020. https://www.aha.org/system/files/media/file/2020/12/addressing-commercial-health-plan-abuses-ensure-fair-coverage-patients-providers.pdf.

[35] See e.g. "I have 6 full time and 1 part time staff to support 1 physician and 1 physician assistant. They spend so much time with PA's and insurance issues that we struggle to answer the phone when a patient calls. It leads to frustration on everyone's part. It's getting worse, please help!– Dr. Roscoe N., Arizona" Available at: https://fixpriorauth.org/stories.

[36] Source https://fixpriorauth.org/stories.

[37] Quoting AMA President Dr. Jack Resneck. Available at: https://www.medpagetoday.com/publichealthpolicy/workforce/99793.

organizations, to "right-size" the PA problem.[38] However, health plans have shirked the agreement,[39] resulting in ever-increasing PA burdens which in turn escalate the ever-growing burnout issue. We applaud the Committee for tackling the administrative barriers that lead to burnout and urge you to adopt legislation in line with our PA Principles[40] and the previously mentioned Consensus Statement, which focuses on automation, transparency, clinical validity, continuity of care, and volume reduction. These recommendations are a step forward in allowing physicians to care for their patients in accordance with their ethos and expertise and could help restore the joy and reward that inspired health care workers to pursue medicine in the first place.

Loan Repayment and Scholarship Programs

The AMA believes that the cost of medical education should never be a barrier to the pursuit of a career in medicine. However, medical education remains the most expensive post-secondary education in the United States. Nearly 75 percent[41] of medical school graduates have outstanding medical school debt, with the median amount being $200,000.[42] This number will only continue to significantly increase as the cost of medical school continues to rise. In fact, for first year students in 2020-2021, the average cost of attendance increased from the prior year for public medical schools by 10.3 percent, making it likely that medical students will have to carry even larger student loans in the future in order to graduate.[43]

In general, reducing medical student indebtedness promotes diversity within medicine and may lead to an increase in the primary care physician workforce as well as other undersupplied specialties. Rising medical school debt disproportionately impacts students who are low income. Due to the cost of medical school many low-income individuals are completely deterred from attending medical school in the first place. According to a national survey, the cost of attending medical school was the number one reason why qualified applicants chose not to apply.[44] Additional surveys by the Association of American Medical Colleges (AAMC) support this conclusion and found that underrepresented minorities cited cost of attendance as the top deterrent to applying to medical school.[45] Since minority students are more likely to enter primary care than their white counterparts, the immense debt burden of medical school has not only precluded diversity among physicians, but also has limited the potential number of primary care physicians and thus diminished improvement in patient care in underserved communities.[46] With recent health reforms seeking to eliminate health care disparities among the U.S. population, increasing the number of historically underrepresented physicians is important to ensure a health care workforce that is more reflective of the general population. As such, **the immense debt burden experienced by**

---

[38] AMA, Consensus Statement on Improving Prior Authorization (2018) Available at: https://edhub.ama-assn.org/data/multimedia/10.1001ama.2018.0080supp1.pdf .

[39] 2021 update: Measuring progress in improving prior authorization. Available at: https://www.ama-assn.org/system/files/prior-authorization-reform-progress-update.pdf.

[40] AMA, Prior Authorization and Utilization Management Reform Principles (2017). Available at: https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf.

[41] https://www.aamc.org/system/files/2020-07/2020%20GQ%20All%20Schools%20Summary.pdf.

[42] https://www.aamc.org/system/files/2020-07/2020%20GQ%20All%20Schools%20Summary.pdf.

[43] https://www.aamc.org/data-reports/reporting-tools/report/tuition-and-student-fees-reports/.

[44] https://www.researchgate.net/publication/324523861_Doctors_of_debt_Cutting_or_capping_the_Public_Service_Loan_Forgiveness_Program_PSLF_hurts_physicians_in_training.

[45] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760863/.

[46] https://www.researchgate.net/publication/324523861_Doctors_of_debt_Cutting_or_capping_the_Public_Service_Loan_Forgiveness_Program_PSLF_hurts_physicians_in_training.

America's physician workforce must be remedied and one important tool to do that is to provide more scholarships and loan repayment programs through the federal government.

National Health Service Corps (NHSC)

Health Professional Shortage Areas (HPSAs) are used to identify areas, populations, groups, or facilities within the U.S. that are experiencing a shortage of health care professionals. There are more than 8,300 federally-designated HPSAs where dire access issues persist for patients in both rural and urban underserved communities, and in both primary and specialty care.[47] According to the latest data released by the Health Resources and Services Administration (HRSA), 99 million people live in primary medical HPSAs in the U.S.[48] HRSA estimates that an additional 37,000 providers are required to eliminate all current primary care, dental, and mental health HPSAs.[49] Within that, Louisiana alone has 524 HPSAs.[50] **With the existing and projected physician shortage, and the increased demands that have been placed on physicians during the pandemic, additional support for programs like the NHSC is desperately needed.**

The NHSC provides scholarships and loan repayment options for health care providers that are willing to serve in HPSAs for a designated period of time. The NHSC has three loan repayment programs: the NHSC Loan Repayment Program, the NHSC Substance Use Disorder (SUD) Workforce Loan Repayment Program, and the NHSC Rural Community Loan Repayment Program. The NHSC also has a scholarship program. Physicians are eligible for all of these programs, though each program has a different service commitment and amount that can be forgiven. See chart below:

Table 1: Requirements of National Health Service Corps (NHSC) Programs, Fiscal Year 2020

NHSC program	Maximum total funding	Years of service	Location
Loan repayment programs			
General Loan Repayment Program	$50,000 (full-time service)[a] $25,000 (half-time service)	2 years	NHSC site with HPSA score of 14-26
	$30,000 (full-time service) $15,000 (half-time service)	2 years	NHSC site with HPSA score of 1–13
Substance Use Disorder Workforce Loan Repayment Program	$75,000	3 years	NHSC substance use disorder facility
Rural Community Loan Repayment Program	$100,000	3 years	Rural NHSC substance use disorder facility
Students to Service Loan Repayment Program	$120,000	3 years	NHSC site with a designated minimum HPSA score of 14
Scholarship Program	Tuition, education-related expenses, and $1,419 monthly stipend	1 year for each year of scholarship support, with a minimum of 2 years of service	NHSC site with a HPSA score of at least 18 in 2020 (higher for some disciplines)

Source: GAO analysis of Health Resources and Services Administration (HRSA) data. | GAO-21-323

[51]

Physicians seeking repayment through these programs must be a provider (or be eligible to participate as a provider) in Medicare, Medicaid, and the State Children's Health Insurance Program, as appropriate and must have qualifying loans.

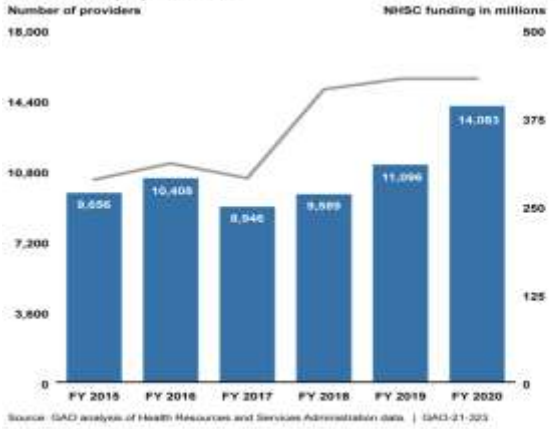
[47] https://www.aamc.org/news-insights/attracting-next-generation-physicians-rural-medicine.
[48] https://data.hrsa.gov/topics/health-workforce/shortage-areas.
[49] https://data.hrsa.gov/topics/health-workforce/shortage-areas.
[50] https://data.hrsa.gov/topics/health-workforce/shortage-areas.
[51] https://www.gao.gov/assets/gao-21-323.pdf.

The NHSC Scholarship Program (NHSC SP) "awards scholarships to students pursuing eligible primary care health professions training."[52] However, only "4 percent of providers ha[ve] received NHSC funding during their time in school through the NHSC Scholarship Program."[53] As such, this program has the highest proportional rejection rate at 89 percent.[54] Since scholarships help to diminish the financial burden of medical school from the outset, which promotes greater diversity in applicants, and ultimately a greater diversity in the physician workforce, additional funding should be provided to bolster the scholarship aspect of the NHSC program.

Furthermore, "[i]n fiscal year 2020, 43 percent of the 11,102 providers who newly applied to NHSC programs did not receive funding"[55] and physicians were among the providers with the highest proportions of rejected applicants. This is in part because "HRSA prioritizes funding to providers serving in HPSAs with more severe provider shortages...."[56] However, 40 percent of rejected applicants were providing care at sites with HPSA scores that were in the upper half of possible scores.[57] Furthermore, 33 percent of HPSA sites had vacancies for primary care physicians, demonstrating the continued need for more physicians.[58]

It has been shown that with additional federal funds more providers are hired, and thus more care can be provided.

Figure 1: National Health Service Corps (NHSC) Providers and Program Funding, Fiscal Years (FY) 2015–2020



Source: GAO analysis of Health Resources and Services Administration data. | GAO-21-323

Note: This includes providers serving in the five national NHSC programs: the General Loan Repayment Program, Substance Use Disorder Workforce Loan Repayment Program, Rural Community Loan Repayment Program, Students to Service Loan Repayment Program, and Scholarship Program.

[59]

If additional NHSC funding was available, applications from physicians working at care sites that are in the upper half of HPSA scores would be the next to receive funding from HRSA. Moreover, the NHSC

[52] https://nhsc.hrsa.gov/scholarships/overview.
[53] https://www.gao.gov/assets/gao-21-323.pdf.
[54] https://www.gao.gov/assets/gao-21-323.pdf.
[55] https://www.gao.gov/assets/gao-21-323-highlights.pdf.
[56] https://www.gao.gov/assets/gao-21-323-highlights.pdf.
[57] https://www.gao.gov/assets/gao-21-323-highlights.pdf.
[58] https://www.gao.gov/assets/gao-21-323.pdf.
[59] https://www.gao.gov/assets/gao-21-323.pdf.

program, both scholarship and loan repayment, are extremely beneficial for physicians and for the communities they serve since they increase health centers' care capacity.

In addition to providing additional funding, the NHSC program should provide intensive and frequent counseling to NHSC scholars as they enter and then proceed through the NHSC program. Through briefings, as well as frequent written communications, the NHSC Administration should emphasize the dynamic nature of the HMSA Placement Opportunity List and the possibility of changes in placement options at any time. Moreover, counseling should highlight the extent of any financial commitments that a scholar may have to incur to develop a Private Practice Option opportunity and the future possibilities of obtaining a Private Practice Option and/or a federal placement. Moreover, the NHSC program should try not to impose changes in assignment options during the last year of the obligee's education, to avoid disruption of any personal and family plans of the physician applicants.

Finally, **the NHSC should be expanded to include more scholarships, greater loan forgiveness, and the inclusion of all medical specialties in need.** Moreover, when programs are added, such as the Maternity Care Target Area[60] **additional resources should be expended to ensure that physicians know about these additional care pathways**. Furthermore, **the NHSC program should be expanded to include service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas**. By adding more programs and specialties to the NHSC better care will be provided within HPSAs and additional physicians will benefit from this valuable program.

National Institutes of Health (NIH) Graduate Medical Education Training Programs

The NIH sponsors a wide variety of training programs including 18 medical specialty and subspecialty programs which have been accredited by the Accreditation Council for Graduate Medical Education (ACGME). The NIH also collaborates with extramural training partners that sponsor accredited clinical training programs.[61] **These training programs are important and unique and additional NIH programs should be supported so that additional physician specialists can be cultivated, and more medical research can be accomplished.**[62]

Indian Health Service (IHS)

American Indians and Alaska Natives are disproportionately affected by many chronic conditions, including heart disease, cancer, diabetes, and stroke, as well as unintentional injuries (accidents).[63] American Indians and Alaska Natives are three times as likely as white individuals to be diagnosed with diabetes and to receive late or no prenatal care.[64] Additionally, American Indians and Alaska Natives have a lower life expectancy than their White counterparts.[65] This is only compounded by high provider staff shortages serving these populations: the "overall vacancy rate for providers— physicians, nurses, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, physician assistants, dentists, and pharmacists—was 25 percent" within the IHS.[66] Moreover, "financial barriers are a

[60] https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.
[61] https://www.cc.nih.gov/training/gme1.html.
[62] https://www.cc.nih.gov/training/gme/programs1.html.
[63] https://minorityhealth.hhs.gov/nahm/health-disparities/.
[64] https://minorityhealth.hhs.gov/nahm/health-disparities/.
[65] https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62.
[66] https://www.gao.gov/products/gao-18-580.

commonly cited reason for American Indian or Alaska Native students not pursuing or staying in medical school."[67] As such, it is imperative to strengthen programs that not only support diversifying our health care work force but also help to provide much needed medical care to our underserved American Indian and Alaska Native populations.

The loan repayment program within IHS provides $40,000 to physicians who serve for two years in health facilities that serve American Indian and Alaska Native communities.[68] "Opportunities are based on Indian health program facilities with the greatest staffing needs in specific health profession disciplines. Loan repayment program participants, can extend their contract annually until their qualified student debt is paid off."[69] However, the payments received through the loan repayment program are taxable**. In order to align this loan repayment program with other similar programs the loan repayments received should be tax free.**

Moreover, compensation for IHS physicians should be increased to a level competitive with other Federal agencies and additional funding should be provided to this program to increase the number of providers that can be supported. Furthermore, in conjunction with the improvement of service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation within the IHS. Additionally, increased continuing education opportunities should be provided for physicians serving these communities, especially those in remote areas, and increased peer contact should be provided, both to maintain a high quality of care and to avert professional isolation.

Support for Physician-Led Teams

Physician-led teams should be provided with additional support. While allied health professionals play an important role in team-based health care, the high-stakes field of medicine demands education, expertise, acumen, coordination, and robust patient management that can best be delivered by a physician-led team. Recent AMA surveys found that 91 percent of patients view physicians' education and training as vital for optimal care, 75 percent would wait longer and pay more to be treated by physicians, and 95 percent said it is important for physicians to be involved in their diagnosis and treatment.

While all health care professionals play a critical role in providing care to patients, their skillsets are not interchangeable with that of fully educated and trained physicians. This is fundamentally evident based on the difference in education and training between the distinct professions. Physicians complete four years of medical school plus a three-to-seven-year residency program, including 10,000-16,000 hours of clinical training. But it is more than just the vast difference in hours of education and training; it is also the difference in rigor and standardization between medical school/residency and non-physician programs that matter and must be assessed. During medical school, students receive a comprehensive education in the classroom and in laboratories, where they study the biological, chemical, pharmacological, and behavioral aspects of the human condition. This period of intense study is supplemented by two years of patient care rotations through different specialties, during which medical students assist licensed physicians in the care of patients. During clinical rotations, medical students continue to develop their clinical judgment and medical decision-making skills through direct experience managing patients in all

[67] https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.02289.
[68] https://www.ihs.gov/loanrepayment/.
[69] https://www.ihs.gov/loanrepayment/.

aspects of medicine. Following graduation, students must then pass a series of examinations to assess a physician's readiness for licensure. At this point, medical students "match" into a three-to-seven-year residency program during which they provide care in a select surgical or medical specialty under the supervision of experienced physician faculty. As resident physicians gain experience and demonstrate growth in their ability to care for patients, they are given greater responsibility and independence. Non-physician programs do not have similar time-tested standardizations. Moreover, the physician assistant education model assumes that in practice, physician assistants will engage in supervision by, or collaboration with, a physician. As such, it is important to provide resources and support for physician-led team-based care.

Heath Care Costs and Outcomes

There is strong evidence that increasing the scope of practice of non-physicians has resulted in increased health care costs. For example, a high-quality study published by the *National Bureau of Economic Research* in 2022 compared the productivity of nurses and physicians (MDs/DOs) practicing in the emergency department using Veteran's Health Administration data. The study found that nurses use more resources and achieve worse health outcomes than physicians. Nurses ordered more tests and formal consults than physicians and were more likely than physicians to seek information from external sources such as X-rays and CT scans.[70] They also saw worse health outcomes, raising 30-day preventable hospitalizations by 20 percent, and increasing length of stay in the emergency department. Altogether, nurses practicing independently increased health care costs by $66 per emergency department visit.[71] The study found that these productivity differences make nurses more costly than physicians to employ, even accounting for differences in salary.[72] Moreover, not only does the increased resources used by nurses' result in increased costs and longer lengths of stay, but it also means patients undergo unnecessary tests, procedures, and hospital admissions.

In addition, a recent study from the Hattiesburg Clinic in Mississippi found that allowing nurses and physician assistants to function with independent patient panels under physician supervision in the primary care setting resulted in higher costs, higher utilization of services, and lower quality of care compared to panels of patients with a primary care physician. Specifically, the study found that non-nursing home Medicare ACO patient spend was $43 higher per member, per month for patients on a nurse/physician assistant panel compared to those with a primary care physician which equated to an additional $10.3 million in spending annually. Similarly, patients with a nurse/physician assistant as their primary care provider were 1.8 percent more likely to visit the ER and had an eight percent higher referral rate to specialists despite being younger and healthier than the cohort of patients in the primary care physician panel. On quality of care, the researchers examined 10 quality measures and found that physicians performed better on nine of the 10 measures compared to the non-physicians.

Other studies further suggest that nurses tend to overprescribe and overutilize diagnostic imaging and other services, contributing to higher health care costs. For example, a 2020 study published in the *Journal of General Internal Medicine* found 3.8 percent of physicians (MDs/DOs) compared to eight percent of nurses met at least one definition of overprescribing opioids and 1.3 percent of physicians

[70] *Productivity of Professions: Lessons from the Emergency Department*, Chan, David C. and Chen, Yiqun, NBER, Oct. 2022.
[71] *Id.*
[72] *Id.*

compared to 6.3 percent of nurses prescribed an opioid to at least 50 percent of patients.[73] The study further found that, in states that allow independent prescribing, nurses were 20 times more likely to overprescribe opioids than those in prescription-restricted states.[74]

Furthermore, multiple studies have also shown that nurses order more diagnostic imaging than physicians, which increases health care costs and threatens patient safety by exposing patients to unnecessary radiation. For example, a study in the *Journal of the American College of Radiology*, which analyzed skeletal x-ray utilization for Medicare beneficiaries from 2003 to 2015, found ordering increased substantially—more than 400 percent—by non-physicians during this time frame.[75] A separate study published in *JAMA Internal Medicin*e found nurses ordered more diagnostic imaging than primary care physicians following an outpatient visit. The study controlled for imaging claims that occurred after a referral to a specialist.[76] The authors opined this increased utilization may have important ramifications on costs, safety, and quality of care. They further found greater coordination in health care teams may produce better outcomes than expanding nurses' scope of practice.

The findings are clear non-physicians tend to prescribe more opioids than physicians, order more diagnostic imaging than physicians, and overprescribe antibiotics[77]—all of which increase health care costs and threaten patient safety.

Access to Care

Proponents of scope expansion have argued that it is necessary to expand access to care. This promise has been made for years by nurses and physician assistants seeking scope expansions at the state-level, but it has not proven true. In reviewing the actual practice locations of primary care physicians compared to nurses and physician assistants, it is clear that physicians and non-physicians tend to practice in the same areas of the state. This is true even in those states where, for example, nurses can practice without physician involvement. The Graduate Nurse Demonstration Project (the Project), conducted by the Centers for Medicare & Medicaid Services (CMS), confirmed this as well.[78] One goal of the Project was to determine whether increased funding for Advanced Practice Registered Nursing (APRN) programs would increase the number of nurses practicing in rural areas. The results found that this did not happen. In fact, only 9 percent of alumni from the program went on to work in rural areas. Moreover, the AMA has mapped the locations of primary care physicians and nurses nationwide in 2013, 2018, and 2020 and

[73] MJ Lozada, MA Raji, JS Goodwin, YF Kuo, "Opioid Prescribing by Primary Care Providers: A Cross-Sectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns." Journal General Internal Medicine. 2020; 35(9):2584-2592.

[74] *Id*.

[75] D.J. Mizrahi, et.al. "National Trends in the Utilization of Skeletal Radiography," Journal of the American College of Radiology 2018; 1408-1414.

[76] D.R. Hughes, et al., A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. JAMA Internal Med. 2014;175(1):101-07.

[77] Sanchez GV, Hersh AL, Shapiro DJ, et al. Brief Report: Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. Open Forum Infectious Diseases. 2016:1-4. Schmidt ML, Spencer MD, Davidson LE. Patient, Provider, and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices. Infection Control & Hospital Epidemiology. 2018:1-9.

[78] The Graduate Nurse Education Demonstration Project: Final Evaluation Report, Centers for Medicare and Medicaid Services. August 2019. https://innovation.cms.gov/files/reports/gne-final-eval-rpt.pdf.

each time the results showed that nurses tend to practice in the same areas of the state as physicians, irrespective of scope of practice laws.

Furthermore, workforce studies in various states have shown a growing number of nurses are not entering primary care. For example, the Oregon Center for Nursing found only 25 percent of nurses practice primary care. Similarly, the Center for Health Workforce Studies conducted a study on the nurse workforce in New York that found, "[w]hile the vast majority of NPs report a primary care specialty certification, about one-third of active NPs are considered primary care NPs, which is based on both NP specialty certification and practice setting." In addition, the study found newly graduated nurses were more likely to enter specialty or subspecialty care rather than primary care.[79] In short, the evidence is clear that expanding scope for non-physicians will not lead to better access to care in rural America.

Rather than support an unproven path forward, **Congress should consider proven solutions to increase access to care, including supporting physician-led team-based care, including telehealth expansion, increasing residency positions, enhanced loan forgiveness programs for physicians in rural and underserved communities, and supporting students from underserved areas to pursue medical education.**

Physician Payment

Need for inflationary based updates to physician payment

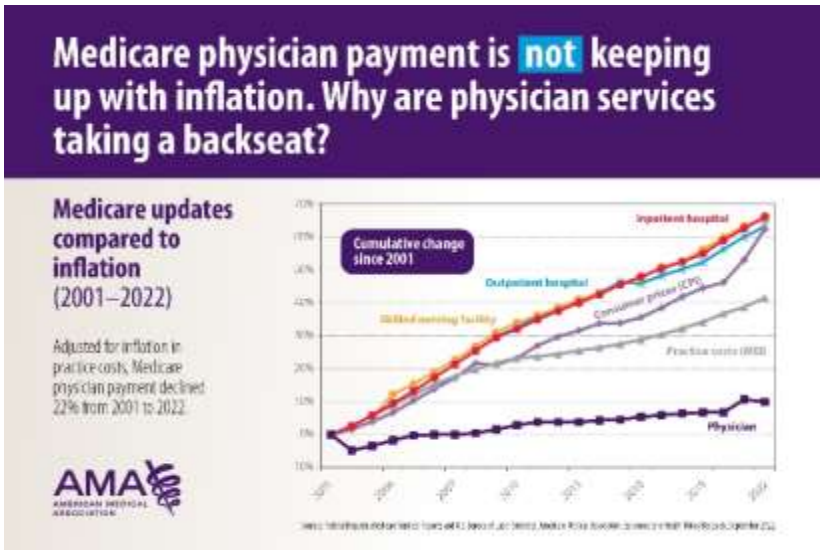
The AMA is deeply alarmed about the growing financial instability of the physician payment system due to a confluence of fiscal uncertainties physician practices face related to statutory payment cuts, lack of inflationary updates, the ongoing impact of the pandemic, and significant administrative barriers. The physician payment system is on an unsustainable path that threatens patients' access to physician services. Last year, physicians faced yet another round of real dollar Medicare pay cuts triggered by the flawed Medicare budget neutrality rules and congressional PAYGO rules. Congress acted at the last minute to avert portions of the 8.5 percent cut—but did not stop the cuts completely. Physicians were cut by two percent in 2023 with additional cuts in 2024. These cuts come on the heels of two decades of stagnant payment rates. Adjusted for inflation in practice costs, the value of **Medicare physician pay fell 22 percent** from 2001 to2021 because physicians, unlike other Medicare providers, do not get an automatic yearly inflation-based payment update.

In its 2021 annual report, the Medicare Trustees expressed concern that, although the physician payment system put in place in 2015 avoided the significant short-range physician payment issues, it "nevertheless raises important long-range concerns that will almost certainly need to be addressed by future legislation." The Trustees noted, for example, that "the law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases."

The Medicare physician payment system lacks an adequate annual physician payment update, unlike those that apply to other Medicare provider payments. As indicated in the charts below, physicians are the only Medicare provider not receiving an inflationary update in 2023. This is particularly destabilizing as

[79] Martiniano R, Wang S, Moore J. A Profile of New York State Nurse Practitioners, 2017. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; October 2017.

physicians, many of whom are small business owners, contend with a wide range of shifting economic factors when determining their ability to provide care to Medicare beneficiaries.



While we appreciate that Congress passed legislation that, again, averted severe Medicare payment cuts that, if enacted, would have severely impeded patient access to care. However, this pattern of last-minute stop gap measures must end. Last year, the AMA responded to a bipartisan **Congressional Request for Information (RFI)** on strategies that federal lawmakers should consider to stabilize Medicare physician payment, reduce regulatory burden, and improve the Medicare Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) programs. As the Committee looks to create a sustainable physician workforce, **annual Medicare physician payments equal to the full Medicare economic index (MEI) should be enacted. Additionally budget neutrality rules should be reformed to provide an annual update the reflects practice cost inflation.**

The AMA is engaged with our national specialty and state medical association Federation partners to determine the best path forward to lead the Medicare payment system to a more sustainable track. The AMA, along with our Federation partners, developed the Characteristics of a Rational Medicare Physician Payment System, endorsed by over 120 state medical and national specialty societies, including those representing primary care, surgical care, and other medical specialties. These core set of principles serve as the basis for reforming the broken physician payment system. We are also working to increase awareness of the problems in the current system among Members of Congress and look forward to working with you to seek permanent solutions.

Reconciliation of Budget Neutrality

Given the statutory authority for budget neutrality adjustments to be made "to the extent the Secretary determines to be necessary," current law allows CMS to account for past overestimates of spending when applying budget neutrality. Congress should consider requiring a look-back period (as have been implemented in other payment systems) that would allow the Agency to correct for overestimates and return inappropriately reduced funding back to the payment pool.

In addition, the $20 million threshold that establishes whether RVU changes trigger budget neutrality adjustments was established in 1989—three years before the current physician payment system took effect. There have been no adjustments for inflation. As a result, the amount should be increased to $100 million to best account for past inflation.

Recommendations to improve MIPS and APM programs

The AMA strongly believes that Congress must amend MIPS to allow a more flexible approach to incentivizing quality improvements and reducing unnecessary costs, while addressing health inequities. The check-the-box requirements and zero-sum game of the existing MIPS program doom it to failure. The MIPS MVPs (Value Pathways), which aim to hold physicians accountable for the quality and cost during an episode of care, around a specific condition, or for a public health priority, represent an opportunity for improvement. Unfortunately, due to statutory barriers, MVPs are repeating the same mistakes as the traditional MIPS program.

In our response last year's Congressional RFI on ways to improve Medicare Access and CHIP Reauthorization Act (MACRA), we offered nine recommendations to address the fundamental flaws in MIPS, allow MVPs to improve the clinical relevance of MIPS and provide a bridge to transition to APMs, and promote the intended goals of MACRA to improve quality, reduce costs, and leverage health information technology in Medicare while reducing burdens. We encourage you to review these recommendations and appreciate the opportunity to work with you to provide input on the vital issue of the stability of our Medicare Physician Payment System.

Piling on these latest cuts in the midst of high inflation, workforce shortages, and soaring physician burnout will have negative consequences as older Americans struggle to find access to the primary care physicians and specialists they need. The cuts will disproportionately affect small, independent, and rural physician practices, as well as those treating low-income or other historically minoritized or marginalized patient communities.

Legislation that would help to alleviate the current and impeding physician shortage.

- The "Resident Physician Shortage Reduction Act" would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new slots. A share of these positions would be targeted to hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas (HPSAs), hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps.
- The "Conrad State 30 and Physician Access Reauthorization Act," would enhance the underlying stability of the program by reauthorizing the Conrad 30 waiver policy for an additional three years. The bill also makes targeted improvements by requiring greater transparency in employment contract terms, outlining a process for providing up to 45 waivers per state, and protecting spouses and children of physicians who participate in the program. Most importantly, the legislation provides physicians who practice in underserved areas or at Department of Veteran's Affairs facilities for five years priority access within the green card system, thereby helping to address the current physician green card backlog.
- The "Physician Shortage GME Cap Flex Act" would help to address our national physician workforce shortage by providing teaching hospitals an additional five years to set their Medicare

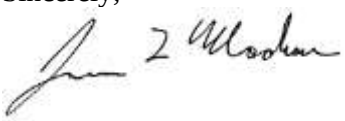
Graduate Medical Education (GME) cap if they establish residency training programs in primary care or specialties that are facing shortages.

- The "Resident Education Deferred Interest (REDI) Act" (HR 1202) if passed, will allow borrowers to qualify for interest-free deferment on their student loans while serving in a medical or dental internship or residency program.
- The "Medical Student Education Authorization Act" would reauthorize the MSE Program which provides grants to public institutions of higher education to expand or support graduate education for physicians and focuses these grants to institutions in states with the most severe primary care provider shortages.
- The "Specialty Physicians Advancing Rural Care Act," or the "SPARC Act," would amend the Public Health Service Act to authorize a loan repayment program to encourage specialty medicine physicians to serve in rural communities experiencing a shortage of specialty medicine physicians.
- The "Indian Health Service Health Professions Tax Fairness Act of 2022" would amend the Internal Revenue Code to exclude payments made under the Indian Health Service Loan Repayment Program (IHS LRP) and certain amounts received under the Indian Health Professions Scholarships Program (IHPSP) from gross income payments.
- The "Substance Use Disorder Workforce Act" and the "Opioid Workforce Act" would provide 1,000 additional Medicare-supported graduate medical education (GME) positions in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine.

Conclusion

The physician workforce shortage is well documented, and the pandemic has only served to magnify these workforce issues and other structural problems. The AMA thanks the Committee for this request for information and for the careful consideration of solutions to improve the physician shortage in this country. We look forward to working with the Committee and Congress to seek bipartisan policy solutions that will ensure that patients are provided the best care possible and that barriers are addressed to resolve the physician workforce shortage and preserve patient access to care.

Sincerely,



James L. Madara, MD