AMA
AMERICAN MEDICAL ASSOCIATION

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Ms. Hemi Tewarson
Executive Director
National Academy for State Health Policy
1233 20th St., N.W., Suite 303
Washington, DC 20036

Dear Ms. Tewarson:

Thank you for the invitation to participate in the National Academy for State Health Policy's (NASHP) recent meeting on the health care workforce. We appreciate being asked to come to the table to share the perspective of the American Medical Association (AMA) and our physician and student members on these critical issues. As a follow-up to this meeting, we offer some additional background, information on AMA resources, and other guidance on many of the issues discussed at the meeting. We hope you will find this information helpful as you draft your publication.

Supporting physician wellness and preventing burnout

Even before the COVID-19 pandemic, physician burnout, depression, and suicide were widely recognized as posing a major challenge for the U.S. health care system—impacting nearly every aspect of clinical care. Recent studies show a national burnout rate of 43.9% among physicians in practice,[1] including private practice, academic medical centers, outpatient clinics, and many other clinical settings.[2] More than 40% of physicians do not seek help for burnout or depression for fear of disclosing it to a state licensing board or credentialing body. Nine percent of physicians said they have had thoughts of suicide.[3] Because the burnout, fatigue, depression, and other mental health issues of physicians and health care providers impact nearly every aspect of clinical care, the AMA strongly supports laws and policies that reduce barriers in ways that facilitate physicians and health care providers' seeking assistance. This is a public health issue of the highest priority. Unfortunately, unnecessary barriers discourage physicians, medical students, and other health care professionals from seeking help.

NASHP can play a key role in reducing barriers by joining the AMA in urging states to enact laws and support other policies that provide strong confidentiality protections for physicians, medical students, and other health care professionals seeking care for wellness, fatigue, or burnout-related issues. These laws appropriately and effectively balance public safety concerns with efforts to reduce harms associated with depression, burnout, and career fatigue. At least five states—Arizona, Delaware, Indiana, South Dakota, and Virginia—have recently enacted these kinds of laws, and the AMA is already working to urge all state medical societies to introduce similar legislation in their respective 2023 state legislative sessions. We urge NASHP to join us in this effort in support of physician health programs, which for years have

[1] Shanafelt TD, West CP, Sinsky C, et al Changes in burnout and satisfaction with work-life integration in physicians and the general US working population between 2011 and 2017. Mayo Clin Proc. 2019;94(9):1681– 1694. doi: 10.1016/j.mayocp.2018
[2] Physician Burnout & Depression Report 2022: Stress, Anxiety and Anger. Medscape. January 21, 2022. https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664#8
[3] "A Tragedy of the Profession: Medscape Physician Suicide Report 2022." March 4, 2022. Available at https://www.medscape.com/slideshow/2022-physician-suicide-report-6014970

provided evidence-based care to physicians and helped them safely return to practice. For more information, please consult the AMA's Advocacy Resource Center Issue Brief: Confidential care to support physician health and wellness.

NASHP can also be instrumental in addressing physician and provider burnout by encouraging medical and other health care professional licensing boards to eliminate stigmatizing questions that may exist on initial licensure and license renewal applications. The AMA is working to urge these boards to revise applications that include problematic and potentially illegal questions requiring disclosure whether the physician or health care provider has ever been diagnosed with a mental illness or substance use disorder (SUD) or ever sought counseling for a mental illness. The AMA agrees with the Federation of State Medical Boards (FSMB) that, "a history of mental illness or substance use does not reliably predict future risk to the public."[4] The AMA wants to encourage treatment rather than create a culture of fear.

Accordingly, these questions about past diagnosis or treatment are strongly opposed by the AMA, the Dr. Lorna Breen Heroes' Foundation, FSMB, and The Joint Commission. Nearly half of the states have eliminated these types of questions already, and we would welcome the opportunity to work with NASHP to encourage the remaining states with stigmatizing questions to follow suit and support physicians and medical students seeking care for wellness, fatigue, or burnout. The AMA's Advocacy Resource Center Issue Brief: Confidential care to support physician health and wellness contains more information on this, and other legislative and regulatory strategies to foster physician and health care provider wellness.

Prior authorization and gold carding

Prior authorization is an enormous burden on physicians, with 88% of physicians describing their prior authorization burden as high or extremely high. It also leads to patient harm, with 34% of physicians reporting that prior authorization has led to a serious adverse event for a patient and 24% reporting that prior authorization led to a patient's hospitalization. The AMA encourages lawmakers and other stakeholders to consider how the volume of prior authorization is impacting patients, physicians, and the health care system. While these programs may reduce the amount health insurers are paying on care in the short-term, delaying or denying medically necessary care is not an appropriate or effective long-term solution to reducing costs. Prior authorization, if used at all, must be used judiciously, efficiently, and in a manner that prevents cost-shifting onto patients, physicians, and other providers. For additional information and actionable solutions for policymakers and lawmakers, such as gold carding, please find the attached AMA Advocacy Resource Center Issue Brief on prior authorization and AMA's Ensuring Transparency in Prior Authorization model bill. NASHP's support of our national prior authorization campaign would be welcome.

It might be notable to NASHP, that in addition to the information above, the AMA also has created a National Managed Care Legal Database. This tool is a powerful and comprehensive legal database covering state and federal laws that address many of the issues that arise between payers and physicians. We would be happy to host a webinar to provide additional details about the database. We believe our database could be a useful resource for NASHP.

[4] Physician Wellness and Burnout, Report and Recommendations of the Workgroup on Physician Wellness and Burnout, Adopted as policy by the Federation of State Medical Boards, April 2018, pages 10-11. Accessible at https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf.

Diversity and maldistribution of the workforce

Pathway programs

The AMA is an ardent supporter of increasing diversity of the physician workforce, including through implementation of "pathway programs." Students need to be recruited earlier in life. Programs should be created that (1) involve identification of high school students, for example, who want to commit to practice medicine; (2) educate communities that need health professionals about medical education; and (3) encourage communities to help foster interest, mentor, and assist local students with getting into medical school. Finally, it is important to consider that support systems need to be in place throughout a student's academic journey. For example, even once medical students choose residency programs, support systems are still needed. The creation of support systems, groups, and communities will help to make residents invest in their chosen specialty and in the community in which they are serving—for the long term. The AMA's Council on Medical Education recently issued a report entitled Promising Practices Among Pathway Programs to Increase Diversity in Medicine, which may help inform NASHP's recommendations related to pathway programs.

Scholarship and loan repayment programs

Scholarship and loan repayment programs are viable solutions to improve the physician workforce and promote diversity in medicine. In a Merritt Hawkins survey, 34% of physicians completing a residency in 2019 cited student loan debt as a major concern.[5] In 2020, 73% of medical students graduated with an average of about $200,000 in student debt.[6] According to the survey, each $50,000 increase in medical school loan debt is associated with increased psychosocial stressors.[7] Students with higher aggregate amounts of medical student loan debt were more likely to express high levels of stress, delay getting married, and report that they would choose to not become a physician again, if given the opportunity.[8] With the cost of medical school constantly increasing—for first year students in 2020-2021 the average cost of attendance increased from the prior year for public medical schools by 10.3%—it is likely that medical students will have to carry even larger student loans in the future in order to graduate.[9] In general, reducing medical student indebtedness promotes diversity within medicine and may contribute to a reduction in the shortage of physicians.

It is notable that medical education remains the most expensive postsecondary education in the United States. According to surveys of the Association of American Medical Colleges, underrepresented minorities cited cost of attendance as the top deterrent to applying to medical school.[10] For example, physicians who are most likely to practice in rural regions, such as those graduating from medical schools in rural areas, declined by 28% between 2002 and 2017.[11] This decrease is compounded by the fact that in 2016 and 2017 only 4.3% of incoming medical students were from rural backgrounds.[12] Moreover, students coming from families in the lowest income quintile have never made up more than 5.5% of medical students.[13] With recent health reforms seeking to eliminate health care disparities amongst the U.S. population, increasing the number of historically underrepresented physicians is important to ensure a health care workforce more reflective of the general population. As such, we would encourage NASHP

[5] https://www.merrittthawkins.com/uploadedFiles/MerrittHawkins_Final_Year_Medical_Residents_Survey_2019.pdf.
[6] https://store.aamc.org/physician-education-debt-and-the-cost-to-attend-medical-school-2020-update.html
[7] https://www.tandfonline.com/doi/full/10.3402/meo.v19.25603.
[8] *Id.*
[9] https://www.aamc.org/data-reports/reporting-tools/report/tuition-and-student-fees-reports/
[10] Grayson, M. S., Newton, D. A. and Thompson, L. F. (2012), Payback time: the associations of debt and income with medical student career choice. Medical Education, 46: 983–991.
[11] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00924.
[12] https://www.aamc.org/news-insights/attracting-next-generation-physicians-rural-medicine.
[13] https://www.aamc.org/media/5776/download?attachment.

to support scholarship and loan repayment programs among the solutions for increasing the diversity of the physician workforce.

Graduate medical education funding

During the meeting it was suggested that current Graduate Medical Education (GME) funding be used to help fund nurse practitioner (NP) and physician assistant (PA) training. We would strongly urge NASHP not to recommend this in your publication, as GME funding for physicians is already woefully insufficient to train the current number of medical school graduates and is one of the reasons for the current physician shortage. Any further reductions would exacerbate existing workforce shortages. As you likely know, the Balanced Budget Act of 1997 (P.L. 105-33), limited Medicare's funding for GME—most hospitals would receive direct graduate medical education and international medical education support only for the number of allopathic and osteopathic full-time equivalent (FTE) residents it had in training in 1996; in other words, the number of positions Medicare supported in each hospital in 1996 was established as the upper limit in terms of the number of positions or slots that Medicare would fund in those institutions thereafter. As U.S. medical schools have increased enrollment, residency training positions at teaching hospitals have not kept up with the larger pool of applicants, limited by the cap on Medicare support for graduate medical education. According to AAMC, there has been a 52% increase in medical student enrollment since 2002, but only a 17% increase in funded GME slots. The average number of applications for each slot has increased from approximately ten to more than 60 applicants. While the AMA was pleased with recent Congressional action adding 1,000 new Medicare-supported GME positions in the Consolidated Appropriations Act, 2021, many more Medicare-supported GME positions are needed to alleviate the physician shortage. We would encourage NASHP to join us in supporting the elimination of the cap on Medicare GME slots and to increase overall funding for medical school graduates. Doing so would improve the physician workforce and promote diversity within medicine.

Scope of practice

Education and training

Supporting physician-led care teams is a top priority for the AMA and our members. The AMA believes every member of the care team has a vital role to play in caring for patients. Based on multiple surveys, we know that patients want and expect physicians leading their health care team—with 95% of patients indicating they want physicians involved in their diagnoses and treatment decisions. This expectation is born out of patients understanding that physicians have the highest level of education and training compared to other health care professionals.

As you may know, physicians complete four years of medical school, three to seven years of residency training, and more than 10,000-16,000 hours of clinical experience prior to becoming a fully licensed physician. Physicians must also pass a series of exams during and after medical school and residency training. By sharp contrast NPs complete two to three years of graduate level education and 500-720 hours of clinical experience and PAs complete two to two-and-a-half years of education and training and 2,000 patient care hours.

While these differences are drastic, there is more to this issue than that. It is also the difference in rigor and standardization across programs. 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 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.

NP programs do not have similar time-tested standardizations. For example, between 2010-2017, the number of NP programs grew by more than 30%, with well over half of these programs offered mostly or completely online, meaning less in-person instruction and hands-on clinical experience. Plus, many programs require students to find their own preceptor to meet their practice hours requirement, resulting in much variation among students' clinical experiences. While NPs must pass a national certifying exam, they are not required to practice in that area. For example, a NP certified in primary care can practice in cardiology, dermatology, neurology, or other specialties without obtaining any additional formal education or training. Given the difference in education and training, it is no surprise that care led by nonphysicians can also result in higher overall costs, lower quality of care, and lower patient satisfaction. For all these reasons, the AMA continues to support physician-led care and believes patients deserve care led by a physician.

Access to care

Expanding the scope of practice of nonphysicians is often promoted as a solution to multiple challenges facing our health care system, including access to care in rural areas. Data and facts, however, very clearly show state laws expanding the scope of practice of nonphysicians do not necessarily lead to increased access to care in rural areas. The AMA has a series of GEOMAPs showing the practice location of physicians and nonphysicians in each state in the country—across three points in time (2015, 2018, and 2020). These maps clearly demonstrate that nonphysicians tend to practice in the same area of the state as physicians. This is true irrespective of state scope of practice laws. In addition, many states with laws supporting physician-led care have seen a greater overall increase in the number of NPs in the state compared to states that allow NPs to practice without any physician involvement. Other studies also support these findings, including the 2019 Graduate Nurse Demonstration Project (the Project), conducted by the Centers for Medicare &Medicaid Services.[14] One goal of the Project was to determine whether increased funding for advanced practice registered nurse (APRN) programs would increase the number of APRNs practicing in rural areas. The results found that this did not happen. In fact, only 9% of alumni from the program went on to work in rural areas.

Moreover, workforce studies in various states have shown a growing number of NPs are not entering primary care. For example, the Oregon Center for Nursing found only 25% of NPs practice in primary care.[15] Similarly, the Center for Health Workforce Studies conducted a study on the NP 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 NPs were more likely to enter specialty or subspecialty care rather than primary care.[16] In short, the claim that scope expansions will lead to increased access to care has not proven true.

[14] 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. Accessed
[15] Oregon Center for Nursing (2020). Primary Care Workforce Crisis Looming in Oregon: Nurse Practitioners Vital to Filling the Gap, but Not Enough to Go Around. Portland, OR, Oregon Center for Nursing, pg. 16.
[16] 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

Based on all the above, we encourage NASHP to consider proven solutions to increase access to care, including many discussed above such as loan repayment and scholarship programs, pathway programs, and increased GME funding. In addition, the expansion of telehealth has led to improved access to care in rural areas. While much work needs to be done to expand broadband access, increase digital literacy, and ensure patients have the tools and internet access they need in their homes for telehealth, the future is bright.

In addition, we want to make sure you are aware of AMA's Health Workforce Mapper (the Mapper). The Mapper is a free online tool using the same underlying data as the GEOMAPs previously mentioned. The Mapper illustrates the geographic distribution of the health care workforce and allows the user to create custom state-specific maps based on their needs. It also includes a population health explorer which includes patient health data, including morbidity and mortality rates, health behaviors, social and economic factors, and the physical environment, all of which can impact the overall health of a community. Finally, the Mapper allows the user to layer in detail about the health care infrastructure, including location of hospitals, rural health clinics, and even highways. We encourage you to visit the Mapper yourself and would be happy to set up a time to provide a tutorial on how to use or discuss in more detail.

Licensure and compacts

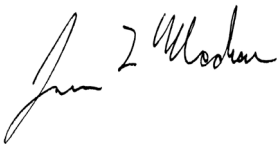
Finally, during the meeting, there was discussion around aligning practice standards across states and/or licensing. The AMA continues to be a strong proponent of the state-based licensure system and believes health care professionals should be licensed in the state where the patient is located. The AMA also supports the Interstate Medical Licensure Compact (IMLC), as a mechanism for physicians interested in practicing in multiple states to obtain an expedited licensure in other states. The IMLC creates the path for expedited licensure in multiple states while also maintaining state authority over the practice of medicine. We were encouraged when 39 states, plus DC and Guam, joined the IMLC in just five short years. Other health professional compacts have seen similar success, including compacts for nurses, psychologists, and physical therapists. Like the IMLC, these compacts focus on license portability and do not preempt state laws related to scope of practice.

The APRN Compact, which was mentioned on the call, by contrast has not found traction within the states. For example, only three states joined onto the original APRN Compact adopted in 2015 and only three states have joined the most recent version of the APRN Compact adopted in 2020. This is likely because unlike all other health professional compacts, which focus on license portability, the APRN Compact supersedes state scope of practice laws and prescribing laws and applies to all four types of APRNs (nurse anesthetists, nurse midwives, NPs, and clinical nurse specialists). The 2020 version of the APRN Compact goes further in allowing all four types of APRNs with an APRN Compact license to practice independently in any 2020 APRN Compact state, despite state law that may require physician supervision or collaboration. This includes state laws that allow APRNs to practice and/or prescribe independently after a certain number of hours or years of practice. This language would also impact scope of practice laws in more than 40 states that require physician supervision, direction, collaboration, or some other level of physician involvement for nurse anesthetists providing anesthesia care and laws in more than 25 states that require physician supervision, collaboration, or some other level of physician involvement for NPs to diagnose, treat, or prescribe. This includes states that have recently enacted legislation and many states that have transition to practice laws that require physician supervision or collaboration for a certain number of hours or years prior to NP independent practice. Many of these laws were advocated for and supported by state and national NP organizations.

As previously mentioned, every other health professional licensure compact retains state authority over scope of practice laws. The AMA strongly objects to the use of interstate compacts as a mechanism through which to grant independent practice to APRNs or grant prescriptive authority where such authority does not currently exist. Not only is this deceptive, but it also has the potential to threaten patient care and safety. For all of these reasons, we strongly urge NASHP not to support the APRN Compact in its upcoming publication.

In conclusion, the AMA would like to thank you, again, for the opportunity to participate in your recent roundtable meeting on health care workforce. We look forward to continued engagement with NASHP on all issues important to physicians, medical students, other health care professionals, and our patients and look forward to hearing from you on how we can continue to be helpful as you draft your upcoming publication. While we have included contact information for each subject matter expert throughout this letter, should you have any additional questions on any of the issues raised above you can also directly reach out to Kim Horvath, Senior Attorney, Advocacy Resource Center at kimberly.horvath@ama-assn.org. We look forward to hearing from you and to our future collaboration.

Sincerely,



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