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AMERICAN ACADEMY of FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

By

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To

Senate Special Committee on Aging

On

“Optimizing Longevity: From Research to Action”

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Chairman Scott, Ranking Member Gillibrand, and distinguished members of the committee, thank you for the opportunity to testify today. My name is Sarah Nosal, MD, FAAFP and I am a practicing family physician in the South Bronx. As the President-elect of the American Academy of Family Physicians (AAFP), I am honored to be here today representing the more than 130,000 physician and student members of the AAFP.

I currently serve as the Vice President for Innovation & Optimization and Chief Medical Information Officer at The Institute for Family Health, a federally qualified health center (FQHC) network with more than 27 locations in the Mid-Hudson Valley, Bronx, Manhattan, and Brooklyn. I am also an assistant professor in the Mount Sinai Department of Family Medicine & Community Health, where I focus on care of marginalized communities and the uninsured and share the role of medical director for Einstein Community Health Outreach, New York's oldest student-run free clinic.

While I am proud to now think of myself a New Yorker, I actually grew up just outside Washington, D.C. I always knew I wanted to be a doctor, and my journey to family medicine started as a grade schooler in the 80's, when I was troubled witnessing unhoused individuals – disproportionately veterans during that time in history – sleeping on sidewalks and street grates in the very heart of our nation's capital. I felt called to serve them but was not sure how. My mother, a social worker, told me that I could grow up to become the kind doctor who takes care of them. And so, I set my life's course to do just that.

While on my rotations in medical school, it became clear that to meet the needs of our most under-resourced patients and communities I needed to be the kind of physician who could do patient-centered, continuous, compassionate care for patients of all ages, across the life span, with them never aging out of my ability to care for them. The kind of medicine that allows me to do that is family medicine.

I am proud to be a family physician. I get to provide continuous, comprehensive medical care, health maintenance and education, and preventive services to patients across their entire lifespan – regardless of age, health goals, or challenges. Through enduring partnerships, family physicians lead care teams and help patients set goals; strive for wellness; prevent, understand, and manage acute and chronic illness; and navigate the complexities of the health system.

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Last month, Chairman Scott laid out his priorities for this Committee which identified four key aspects for someone to be considered "well:" having their physical health; financial security; a safe community to live in; and family and community support. Each of these are rooted in the very fundamentals of family medicine, and I applaud this Committee for recognizing their significance in ensuring that an individual is not just living longer but living longer and better. That mission is one shared by all family physicians.

I have practiced for more than two decades in an extremely under-resourced area of the South Bronx. Health outcomes in my county are ranked 62 of 62 in all of New York state. My personal patient panel approaches nearly 90 percent Medicaid beneficiaries. **In my office, I have the honor and privilege of taking care of not just patients, but families and communities.** When I first started in my current clinic, my patients, like I was, were primarily younger women. As I planted my roots and affirmed to them I was going to stay, they started to seek care for their pregnancies, bringing their babies and toddlers, aunts and brothers, parents, grandparents, and great grandparents. Caring for patients across the lifespan also means caring for families across generations, often seeing a family history play out before me rather than just reading or documenting it.

Family medicine's uniqueness as a specialty means that, while working with patients towards wellness goals or managing chronic illness, we can anticipate barriers or risks due to social drivers of health, personal medical history, or family or genetic history that might be pre-disposing them to worse outcomes. These histories can manifest in complex needs; frequent among them are dietary needs for patients managing risks, predisposition and multiple complex diseases. A typical patient of mine presents with cane in hand, living with HIV, diabetes, hypertension, and chronic kidney disease. Patient-tailored counseling on diet and physical activity is something I do in every visit. One tool that my clinic has developed to help guide patients with diet-influenced conditions and help them visually embrace and understand healthy, plant-forward eating is a series called "Healthy Plates Around the World." These culturally appropriate plates engage my patients in a familiar context to best portion their meals using foods they are accustomed to.

However, no matter how well-illustrated, the unfortunate reality is that fresh, whole, healthy foods are out-of-reach financially or otherwise inaccessible to most of my patients. This is but one of the health-related social needs (HRSN) that impacts them. A lack of safe and stable housing, reliable transportation, safe places to exercise, financial security, in addition to access to nutritious foods, all make it difficult – if not altogether impossible – for

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many of my patients to simply afford necessary medications and reliably make it to medical appointments is my office.

Research has consistently shown that unaddressed HRSN can influence the onset or worsening of many health conditions, including chronic diseases.[i] On more than one occasion when I asked a patient why they were not taking their insulin as directed, I would find out they did not have electricity in their apartment for weeks at a time after falling behind on the rent. A neighbor was allowing them to store their medications that require refrigeration, but that also meant they did not have it readily accessible.

The empirical evidence backs this lived experience. Housing instability – difficulty paying rent, eviction, and living in overcrowded conditions – is associated with delayed medical care, medication nonadherence, and increased emergency department visits. When we screen across our patient community, housing is consistently the most commonly identified social need of our patients with the fewest resources readily available. Another top identified need is safe transportation, from our rural clinic where patients have been known to walk long distances along roadsides without walkways to our urban clinics where a patient with walker in hand faces four flights of stairs at the subway up and back. The lack of safe, accessible transportation in both rural and urban areas makes health and health care equally inaccessible. Unsafe, inconvenient transportation impacts a person's ability to access medical care and is also associated with higher rates of unemployment, poverty, and chronic illness.[ii]

The majority of the older adults I see in my practice fall into the group of low-income seniors who are eligible for both Medicaid and Medicare, known as dual eligibles, and have an average of 2.2 HRSN compared to 0.9 for non-dual eligibles.[iii] What that means in real life is they have a rolling walker with chair due to severe osteoarthritis, are unable to use public transportation, are forced to piece together the healthiest meals they can from soup kitchens, pantries and limited food assistance benefits, while doing laps around their daughter's living room as their most accessible form of exercise.

Medicaid serves a critical need, providing coverage for patients and sustaining community health centers delivering care to these struggling communities. Those same Medicaid beneficiaries with diet-related conditions experience higher levels of food insecurity. One study found that nearly one-third of Medicaid enrollees with diabetes were food insecure,

in comparison to seven percent of those enrolled in private insurance.[iv] In another study, more than half of dual eligibles reported food insecurity.[v]

The U.S. Department of Agriculture's Supplemental Nutrition Assistance Program, otherwise known as SNAP, is a lifeline for those experiencing food insecurity. The program provides food benefits to low-income families to supplement their grocery budget. SNAP's healthy incentives programs (HIP) also help increase healthy food consumption by providing enrollees with a coupon, discount, gift card, bonus food item or extra funds. Program evaluations have shown that HIP participants consumed almost 1/4 cup more fruits and vegetables per day and had higher total household spending on fruits and vegetables than non-participants.[vi] Additionally, participants in one program redeemed more than $20 million dollars in nutrition incentives and produce prescriptions with the program generating an economic impact of about $41 million dollars.

However, there remains a gap in the nutrition needs of many individuals who are not enrolled in or eligible for SNAP benefits. An earlier cited study found that 29 percent of people with diabetes were not receiving SNAP benefits, and over two-thirds of uninsured individuals were not receiving SNAP benefits. Further, over 40 percent of Medicaid enrollees with diabetes who were receiving SNAP benefits remained food insecure. There is undoubtedly room for improvement to ensure SNAP and related programs better serve my patients who need them; to start, greater coordination and streamlined enrollment across safety-net programs such as SNAP and Medicaid, increased funding for benefits, improving public awareness about HIPs, and making it administratively easier for individuals to navigate and use said benefits. However, that alone will not solve my patient's challenges with accessing and adhering to healthy lifestyle choices.

While diet and exercise are critically important to health and wellness, we cannot ignore that these are not accessible choices for those who live in communities designed with them out of reach. **Food and exercise can only be medicine if they are equitably and easily available, safe, and accessible. As a family physician, I can recommend working out and having a healthy diet – but it is up to you, our elected leaders, to ensure the resources and support are in place to fill that prescription.** Congress has the opportunity to advance additional policies to address food insecurity, unstable housing, and other health-related social needs and improve health outcomes at the community, family, and individual level. For instance, policies that support free or reimbursable public transit or improve the safety and accessibility of sidewalks and bike lanes help improve

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transportation access and can influence better health outcomes for both individuals and communities.

In our free clinic, we provide free, whole, plant-forward food to patients on Saturday mornings. Patients will often come even during the weeks that they do not have a medical appointment. I encourage you all to explore federal investments such as additional grants or more sustainable funding streams to expand these types of community-based resources, particularly in communities like mine that remain food deserts.

Many states have utilized existing Medicaid authorities to begin addressing HRSN, including state plan authorities, section 1915 waivers, managed care in lieu of services and settings and section 1115 demonstrations. In December 2022, the Centers for Medicare and Medicaid Services announced that states can use section 1115 demonstrations to cover nutrition supports and HRSN case management, among other services, as reimbursable benefits under Medicaid for certain populations.

Nutrition support may include nutrition counseling and education; medically tailored meals; meals or pantry stocking for children under 21 or pregnant patients, including two months postpartum; fruit and vegetable prescriptions; and protein boxes. For example, under Massachusetts' section 1115 waiver, medically tailored meals may be provided to the whole household, not only the Medicaid beneficiary eligible for the service. This policy recognizes that a food-insecure parent will often give their nutrition supports to a hungry child, rather than feed themselves. Expansion of these types of policies would be life-changing and make wellness and longevity possible for my patients.

Some states have used other levers, such as community reinvestment requirements for Medicaid managed care contracts. Examples of community reinvestments addressing nutrition needs include building and maintaining community gardens, farmers markets, community-supported agriculture, farm partnerships, or grocery stores in food deserts. Federal policymakers could explore opportunities for expansion of these types of community investment requirements at the national level or ways to support ongoing state initiatives. To truly be successful and community-centric, any such policies must include appropriate guardrails with a clear definition of community reinvestment and transparency and accountability reporting requirements. Plans or other entities subject to community reinvestment requirements should also be required to solicit local input to ensure that the investments are culturally appropriate and address true community needs.

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Much of this work in the states is just getting off the ground. Therefore, **I strongly urge Congress and the Administration to support and further invest in these promising, innovative efforts that seek to address the root causes of poor health outcomes.**

Beyond Medicaid, the AAFP has supported legislation that would expand Medicare coverage of nutrition services for seniors with certain diet-impacted chronic conditions, such as diabetes, HIV, and hypertension. We have also supported legislation that would establish a four-year nationwide demonstration program through Medicare to provide medically tailored meals to eligible Medicare beneficiaries with diet-impacted conditions. I strongly encourage the Committee to consider these policies as you continue to explore opportunities to improve health across the lifespan.

There is also an opportunity for Congress to improve uptake of services that are newly covered but underutilized, particularly chronic care management (CCM). In 2015, Medicare began paying physicians for delivering non-face-to-face CCM through separate codes. These services are fundamental to the delivery of patient-centered, comprehensive primary care, including for seniors with diet-impacted conditions.

Unfortunately, operational challenges such as patient cost-sharing requirements limit uptake by patients who would truly benefit from this type of additional support. A 2022 study found that Medicare billing codes for preventive medicine and care management services are being underutilized even though primary care physicians were providing code-appropriate services to many patients. The median use of the preventive and care coordination billing codes was 2.3 percent among eligible patients.[vii]

Put otherwise: patients are informed of a copay and shared costs as required by Medicare, so subsequently many patients opt out of these services because of the financial barriers. In my experience, it is often the ones who stand to benefit most from these services. This rings true for many of the other new codes Medicare has implemented, including G2211, social determinants of health risk assessments, and community health integration services. Patients are living on fixed incomes and have not anticipated paying for these services and, understandably, are resistant or unable to do so. If we want to incentivize usage of these high-value services, we must waive patient cost-sharing.

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Removing cost-sharing for chronic care management and other primary care services increases access without increasing overall health care spending.[viii] Evidence indicates that reducing or removing cost barriers to primary care increases utilization of preventive and other recommended primary care services, which improves both individual and population health with long-term cost savings. While cost-sharing for most preventive services is currently waived across payers, many patients do not access all the preventive care recommended for them because they do not know what is or is not covered or they are concerned they might be charged for raising other health issues in the same visit. Therefore, **the AAFP urges Congress to consider legislation that would waive patient cost-sharing for chronic care management and other primary care services.**

As has been acknowledged by this Committee, we are all aging. Therefore, we must explicitly recognize the impact of health-related social needs across the lifespan and how they influence outcomes later in life. In particular, access to affordable health care coverage has positive long-term effects. Expanded Medicaid eligibility for pregnant women has been shown to increase their children's economic opportunity in adulthood through increased educational attainment and higher incomes.[ix] Children covered by Medicaid also pay more in cumulative taxes by age 28 compared to their peers who are not Medicaid-enrolled.[x]

If we want to give everyone the chance to age healthily and well, it is imperative Congress supports those programs which make it possible, regardless of a person's socioeconomic status or other demographics. In particular, cutting Medicaid does not just take away an individual's coverage and harm their health. It hurts entire families, has economic consequences, and jeopardizes community outcomes. Many of my young or middle-aged patients are caregivers for both children and older relatives. Any reforms that impede or altogether cut their health care coverage are likely to impact their employment, their ability to help their mother make rent, to take their grandma to the laundromat or her cardiologist appointment, or contribute in any productive, meaningful way to their community. **If we want to truly improve our nation's health to optimize longevity, it must start with investing in Medicaid and other safety-net supports – not cutting them.**

Health insurance coverage does not help patients if there is no access to care, however. Community health centers (CHCs), including FQHCs and rural health clinics, provide care to those in medically underserved areas and are often the only accessible health care setting for many individuals, including Medicaid beneficiaries and the uninsured.

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Nationally, Medicaid makes up 43 percent of community health center revenue.[xi] As a result, cuts to Medicaid would be a direct cut to CHCs and the communities they serve as well.

CHCs have a significant economic impact. In 2021, they supported more than 500,000 direct or indirect jobs nationally with nearly $85 billion in economic output. Both New York and Florida, which are proudly represented by this Committee's leadership, are in the top five of states that economically benefit from CHCs; the economic output is $6.1 billion in New York and $4.2 billion in Florida.[xii] Community health centers are also incredibly efficient in terms of health care spending. Research has consistently shown that health care costs for all patients served by CHCs – including Medicaid beneficiaries – are lower than costs for patients not served by CHCs.[xiii]

Further, many CHCs are working to combat our nation's primary care workforce shortage and training the next generation of family physicians by serving as Teaching Health Centers. The Health Resources and Services Administration's THC Graduate Medical Education (THCGME) program funds the development and implementation of residency programs in outpatient community-based settings in rural or medically underserved communities. Since the program's inception, it has trained more than 2,000 new primary care physicians and dentists – 61 percent of whom have been family physicians. Thanks to the THCGME program, our FQHC system has multiple family medicine residency programs across our region. Many of residents stay to continue serving these communities upon graduation.

Unfortunately, CHCs and THCGME are reliant upon a patchwork of inconsistent, temporary federal funding to stay afloat. At the moment, funding for both programs is only guaranteed through March 14. This, in addition to recent executive actions which have stoked confusion about what federal funding is or is not available, is an existential crisis for our nation's safety net. CHCs operate on such thin margins that even a threat to funding can paralyze our ability to deliver all of the care that is essential to meeting our patients' and community's needs.

For THCs, uncertainty about future funding for the academic year has led to some programs either closing their doors entirely or accepting fewer residents. To support and improve the quality of life for patients of all ages and in all communities, **I urge this Committee and your colleagues in Congress to make stable, long-term funding for CHCs and THCGME a priority** and to ensure that access to other key programs and

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community-level interventions is not disrupted. Failure to do so would run counter to the Committee's stated goals.

In closing, thank you again for the opportunity to provide this testimony. On behalf of the AAFP and as a family physician, I look forward to working with the Committee to advance policies that invest in the health and wellbeing of individuals across the lifespan at the person, family, and community level. We all have the same goal: to improve the lives of the people we serve.

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