AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

By

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To

U.S. Senate Committee on Finance

On

"Bipartisan Medicare GME Working Group Draft Proposal Outline and Questions for Consideration"

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Dear Chairman Wyden and Senators Cornyn, Menendez, Cassidy, Bennet, Tillis, Cortez Masto, and Blackburn:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write to express our appreciation for the Committee's continued interest in health care workforce issues and specifically on much needed reforms for Graduate Medical Education (GME) programs.

The AAFP has long been concerned about the shortage of primary care physicians in the U.S., particularly the supply of family physicians, who provide comprehensive, longitudinal primary care services for patients across the lifespan, including chronic disease management, treatment of acute illnesses, and preventive care. Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. Studies have shown that more than 127,000 deaths could be averted through an increase in the number of primary care physicians.[i]

Most physicians are trained at large academic medical centers in urban areas, and evidence indicates physicians typically practice within 100 miles of their residency program.[ii] As a result, the current distribution of trainees leads to physician shortages that are particularly dire in medically underserved and rural areas. According to the Health Resources and Services Administration (HRSA), 7.3 percent of U.S. counties do not have a primary care physician and by 2036 rural communities will have 27 percent fewer family physicians than needed to meet demand in these areas.[iii]

The AAFP has previously submitted recommendations to the Committee on ways to support primary care, especially in rural and underserved communities. The Academy believes that any expansion of Medicare GME slots should be targeted specifically toward hospitals and programs in areas and specialties of need, including by considering which ones have a proven history of training physicians who ultimately practice in physician shortage areas. And although not under the Senate Finance Committee's jurisdiction, support for and expansion of the Teaching Health Center Graduate Medical Education (THCGME) program through HRSA is key to increasing the number of primary care physicians, especially in rural and underserved areas.

The AAFP has reviewed the Committee's Bipartisan Working Group draft policy recommendations for Medicare GME policy reforms and addressed many of the questions for consideration below.

SECTION 2. Additional and Improved Distribution of Medicare GME Slots to Rural Areas and Key Specialties in Shortage

Q: How many additional Medicare GME slots are needed to address the projected shortage of physicians? To address the disproportionate shortage of primary care doctors and psychiatrists, what percentage of new Medicare GME slots should be dedicated toward these two specialties?

AAFP Response: The AAFP has not identified a specific number or percentage of slots needed to address the projected shortage of physicians, specifically family physicians. AAFP policy is that effective health care systems should have a physician workforce that includes around 50 percent of physicians focused on primary care. Therefore, the Bipartisan Working Group should use that representative percentage when determining an appropriate number of GME slots needed. However, the number of GME slots is not the chief concern when it comes to

expanding access to care through the GME program. Instead, the AAFP believes that the *distribution* of slots should be the focus of these GME reforms, particularly reforms that support primary care and are prioritized for residencies that are located in rural and underserved communities.

We further encourage the Committee to consider ways to reimagine our country's GME system so that it better supports and invests in primary care, including an expansion of training in community-based settings. Our current approach to GME primarily focuses on training physicians in large academic hospitals, which fails to acknowledge the community-based nature of primary care and leads to physician shortages in medically underserved and rural areas. The Academy has long supported strengthening training opportunities in community-based settings that will directly support primary care and particularly family physicians.

Q. What additional Medicare GME policies should Congress consider to encourage more residents to enter these specialties?

AAFP Response: In addition to increasing the percentage and amount of GME slots for primary care, Congress should continue to support and expand the THCGME program. The THCGME program is the only federal program that trains physicians and dentists in community-based settings with a focus on rural and underserved communities. After completing their training, THCGME graduates work in underserved communities at higher rates than traditional GME graduates.[iv] The AAFP urges the establishment of new THCs and the expansion of existing THCs, both through increased federal funding and removal of burdensome regulatory requirements.

To date, the THCGME program has trained more than 2,027 primary care physicians and dentists in community-based settings, 61 percent of whom are family physicians. However, the program has received piece-meal, short-term reauthorizations from Congress. This fails to consider the fact that family medicine residencies are three-year programs, meaning many medical students are dissuaded from applying to THC residencies because they have no certainty that the program will even be around long enough for them to complete their training. We have unfortunately seen this instability result in some THCGME programs accepting fewer or no new residents for the next year or closing their program entirely—such as the recent closure of the Northwestern McGaw Family Medicine Residency Program at Humboldt Park in Chicago. This program was one of the original THCGME programs,[v] and its patient care has an emphasis on the underserved.

For these reasons, the AAFP strongly cautions against another short-term extension. Instead, the AAFP supports legislative efforts, such as H.R. 2569, the Doctors of Community (DOC) Act, that would permanently authorize the THCGME program. Absent a permanent solution, we urge Congress to, at a minimum, provide a multi-year reauthorization that provides sufficient funding levels to support the true per-resident costs to each program.

In addition to supporting THCGME, the AAFP also supports HRSA's Rural Residency Planning and Development Program (RRPD). This program provides start up grants to create new rural residency programs, including rural track programs (RTPs), that are accredited by the Accreditation Council for Graduate Medical Education (ACGME). Creating residencies in rural areas can be particularly difficult and these grants are essential to help mitigate those challenges. The AAFP, along with numerous other organizations, supports H.R. 7855, the Rural

Residency Planning and Development Act of 2024 which authorizes a dedicated funding line for the RRPD program.

Q: Would the proposed changes to the definition of rural hospitals in the CAA, 2023 GME allocation formula outlined above improve the distribution of slots to rural communities? Beyond the proposed changes to the definition of rural hospitals, is it necessary to provide further clarification in the existing statute to ensure that CMS allocates GME slots to particular categories as specified in the CAA, 2023 GME allocation formula?

AAFP Response: The AAFP supports the proposed policy changes to the definition of rural hospitals in the CAA. We also support an updated definition of rural to align with other CMS-defined criteria (all people and territory in an area with less than 50,000 people) and using that parameter to allocate at least 10 percent of slots to rural hospitals, regardless of their Health Professional Shortage Area (HPSA) score.[vi] The AAFP appreciates the work CMS has undertaken in recent years to promote health and health equity in rural and underserved communities, and we believe this change would support goals of delivering better care where patients most need it. The AAFP supports H.R. 8235, the Rural Physician Workforce Preservation Act, which would directly address this issue. That legislation passed favorably out of the House Ways and Means Committee, and we would encourage similar action in the Senate.

The AAFP has repeatedly advocated that, in addition to prioritizing geographic and population HPSAs using HPSA scores, CMS also prioritize hospitals or programs based on the proportion of their trainees that ultimately go on to practice in HPSAs. By adding this "impact factor" to the proposed methodology for prioritizing applications, CMS would be able to ensure that the physicians trained using these new residency positions ultimately go on to care for underserved populations throughout their career, not just for the duration of their residency training. CMS has shared with the AAFP that the addition of this "impact factor" would require a change in statute, and we would be very supportive of legislative efforts to achieve that change.

Q: How should Congress approach the role of hospitals which engage in "rural reclassification," wherein a hospital changes its designation from urban to rural, then back to urban within one calendar year for the purposes of receiving Medicare GME payment?

AAFP Response: Additional transparency and data is necessary to ensure that GME slots are being allocated appropriately and most effectively for the communities they serve. The AAFP supports policies that would provide authority to the Secretary of Health and Human Services to utilize existing data and to collect any additional data necessary to enable tracking, research, and analysis on the impact of federal GME funding on the geographic and specialty distribution of the physician workforce, as well as other outcomes of interest to the health of the public. This data should also include analysis of the benefits and potential negative outcomes that may result from rural reclassification.

Q: How could Congress improve the recruitment of physicians to work in rural or underserved communities? For example, would adding criteria to allocate GME slots for hospitals affiliated with centers of excellence, HBCUs, or MSIs and for hospitals affiliated with non-academic hospital settings improve the distribution of physician training and recruitment in rural and underserved areas?

AAFP Response: The AAFP has long supported policies that aim to diversify the health care workforce. The lack of a diverse physician workforce has significant implications for public health. Physicians who understand their patients' languages and understand the larger context of culture, gender, religious beliefs, sexual orientation, and socioeconomic conditions are better equipped to address the needs of specific populations and the health disparities among them. Several studies show that racial, ethnic, and gender diversity among physicians promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.

Evidence has also shown that students from backgrounds currently underrepresented in medicine are more likely to care for underserved populations in their careers and are more likely to practice primary care.[vii] Therefore, the AAFP would support policies to expand slots at historically Black colleges and universities and minority serving institutions. Beyond the expansion of GME slots at these institutions, the AAFP supports additional policies that would increase diversity and greater access to care in rural and underserved communities.

These policies include supporting the reintroduction and passage of the Strengthening America's Health Care Readiness Act, which increases investment in the National Health Service Corps and, notably, allocates 40 percent of the funding for racial and ethnic minorities and students from low-income urban and rural areas.

The AAFP also recognizes the important role that International Medical Graduates (IMGs) play in addressing physician shortages in rural areas and increasing the racial and ethnic diversity of the physician workforce. IMGs are twice as likely to practice primary care as their non-IMG counterparts and often work in rural and underserved areas.[viii] Currently, resident physicians from other countries who complete their residency training in the United States are required to return to their home countries for two years before they can apply for re-entry. The AAFP continues to urge Congress to pass S.665, the Conrad State 30 and Physician Access Act, which would expand the number of J-1 visa waivers and provide immigration certainty to the thousands of IMGs caring for patients in underserved communities. The Conrad 30 Waiver Program allows IMG physicians to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years. Over the last 15 years, the program has brought more than 15,000 foreign physicians to underserved and rural communities.

Q: Would increasing the cap for hospitals in states with the lowest number of GME slots, rather than for all hospitals, improve distribution of GME slots to areas with workforce shortages?

AAFP Response: The AAFP supports increasing the cap for GME slots, especially for rural areas. Directing GME slots to areas of greatest need, and specifically in support of primary care residencies, is critical for attracting physicians to underserved areas. Physicians who are trained in rural communities are five times more likely to remain in practice in those areas in comparison with their colleagues who are trained elsewhere[ix]. The AAFP strongly supports S.230, the Rural Physician Workforce Production Act, which would increase the GME cap for rural areas specifically. Given that states with the lowest number of GME slots are likely to also be in rural and underserved areas, increasing the cap of GME slots in these areas would be a step towards increasing access to care.

Q. How can Congress help incentivize Medicare GME in Indian Health Service facilities?

AAFP Response: The AAFP has highlighted the need for increased GME in Indian Health Service (IHS) facilities. In addition to supporting increased funding for IHS GME slots, the Academy also supports policies that would create formalized partnerships between IHS facilities and academic medical institutions. These partnerships provide shared faculty and staff, as well as clinical support and experienced program knowledge. We also support clinical fellowship programs at IHS health facilities. Along with numerous other stakeholders, the AAFP has supported these fellowships that provide training and foster community, both of which are key to retaining and recruiting all types of health care professionals at IHS facilities.

As stated previously, the AAFP strongly supports permanently funding the THCGME program for which tribal entities are eligible to receive. IHS health facilities are already receiving THCGME funding, but Congress and the agencies could do more in terms of outreach and education to tribal entities to encourage them to apply for THCGME funding.

SECTION 3. Encouraging Hospitals to Train Physicians in Rural Areas

Q. What barriers exist for hospitals in rural and underserved areas to launch new residency programs supported by Medicare GME? What revisions to IME payment are needed in order to improve financial support for rural hospitals interested in establishing residency training programs, or otherwise improve the Medicare GME program to support rural hospitals?

AAFP Response: Resource constraints and funding uncertainties are two significant barriers that exist for hospitals nationwide that would like to start new residency programs, particularly for those in rural and underserved areas. Small, rural, and safety net hospitals all operate on extremely thin margins, and few have the financial resources to stand up an entirely new residency program without outside assistance.[x] Additionally, residency slots are most often distributed as 1.0 full-time-equivalent (FTE) per fiscal year—with CMS sometimes even awarding fractional FTE positions. This is incredibly challenging, particularly for small and rural hospitals, as it introduces serious funding uncertainty and deters many programs from being able to expand. While fractional FTE awards may be workable in large academic institutions where there are multiple funding options available, it would be a barrier for small residencies that do not have similarly deep resources. We would strongly support legislation that would align GME awards with program lengths, so that a hospital applying to train residents in a three-year program can request up to three FTE residents per fiscal year.

Q. What programs under the jurisdiction of the Senate Finance Committee can provide targeted outreach and technical assistance to rural hospitals so they can apply for Medicare GME slots?

AAFP Response: As mentioned above, the AAFP supports S. 230, the Rural Physician Workforce Production Act (which is under Senate Finance jurisdiction), a bill that would remove the caps on rural hospitals specifically. This bill would also provide additional GME reimbursement to urban hospitals that send residents to rural health facilities during one of their rotations. Providing these additional funds to not only rural facilities but also to urban facilities to encourage their residents to serve in these communities would provide greater access to care and may influence a resident that currently serves in an urban hospital to spend time working in a rural area that they might then choose to continue to practice in.

In terms of greater technical assistance to rural hospitals, the Committee should consider extending authority to the Center for Medicare and Medicaid Innovation (CMMI) or another appropriate body to study what GME reforms could be made to better support rural GME.

Although the AAFP is supportive of current CMMI efforts to explore alternative payment models for primary care[xi], the agency lacks the authority to study the inequities and potential solutions related to the maldistribution of GME slots. CMMI could be tasked with exploring the unique technical assistance needed for rural communities and their health care systems to encourage those communities and health care facilities to establish or expand GME programs.

The AAFP also encourages the Committee to consider a program like the Quality Payment Program for Small, Underserved and Rural Support (QPP-SURS) established through the Medicare Access and CHIP Reauthorization Act (MACRA).[xii] This program provided technical assistance to small, rural and independent physician practices navigating Merit-based Incentive Payment System (MIPS) requirements at no cost to the practices. The Committee could consider using this model to establish a similar program for small and rural hospitals as they consider establishing or expanding their GME programs.

The AAFP would also like to acknowledge the Committee's support of the Collaborative Care Model (CoCM). Along with expanded and targeted support for GME and THCGME in rural or underserved communities, CoCMs can be a parallel tool for ensuring access to all aspects of primary care, particularly as it relates to behavioral and mental health care.

Q. Should guardrails be put in place to ensure patient outcomes and a resident's educational experience are not negatively impacted by an extension of flexibilities that allow teaching physicians to use telehealth to train resident physicians?

AAFP Response: The AAFP strongly believes telehealth policies should advance care continuity and the patient-physician relationship and should be leveraged to enable higher-quality, more personalized care by making care more convenient and accessible for patients. The AAFP strongly supported CMS' decision to temporarily expand the "primary care exception" during the COVID-19 public health emergency to allow Medicare to make payments to teaching physicians for certain lower and mid-level complexity services. This change provided educational training opportunities for applicable medical residents, expanded patient access to primary care, and improved relational continuity of the patient and primary care physician in teaching centers. Expanding the primary care exception benefitted patients and primary care training programs alike, and we are concerned the return to the previous policy has been disruptive to primary care training programs, as well as created unnecessary barriers to high-value primary care for patient. The AAFP feels strongly that with guardrails put in place that appropriately account for patient outcomes and a resident's educational experience that this exception should be made permanent.

Although supportive of these guardrails the AAFP must note the importance of a permanent and expanded adoption of the "primary care exception." The absence of high-value services on the primary exception list discourages their integration in residency training and day-to-day medical practice. Family physicians across the country have reported a shortage of supervising physicians in their locales, making the requirement that a supervising physician be physically present for a level 4 or 5 visit particularly challenging. Permanently expanding the primary care exception to include these specific services could help improve utilization of recommended preventive care services. Without this permanent expansion there will not only be a negative impact on physician training but could also undermine patient outcomes in the long term.

Q. What other telehealth flexibilities should the working group consider that would benefit resident physicians who are being trained in teaching hospitals, particularly those located in rural or underserved areas?

AAFP Response: The AAFP supports permanent telehealth policies that would include coverage of and proper payment for audio-only telehealth services across programs. Physicians should be appropriately compensated for the level of work required for an encounter, regardless of the modality or location. Payment should reflect the equal level of physician work across modalities while also accounting for the unique costs associated with integrating telehealth into physician practices. The AAFP strongly urges Congress to pass S. 1636, the Protecting Rural Health Access Act, which would ensure rural and underserved community physicians can permanently offer telehealth services, including audio-only telehealth services, and provide payment parity for these services.

This legislation would also permanently remove geographic and originating site restrictions to ensure that all Medicare beneficiaries can access telehealth services at home. Telehealth visits can also enable physicians to get to know their patients in their home and observe things they normally cannot during an in-office visit, which can contribute to more personalized treatment plans and better referral to community-based services.

As stated previously, the AAFP strongly believes telehealth policies should advance care continuity and the patient-physician relationship. We would support residents permanently being permitted to provide care via telehealth with the same level of supervision from the teaching physician as occurs during their in-person office visits. As the Committee considers permanent changes to telehealth, the AAFP does urge you to ensure that the flexibility to offer telehealth services be balanced with safety and quality, in addition to promoting and supporting the medical home.

Q. How can existing rural track programs be strengthened and expanded through Medicare GME?

AAFP Response: The AAFP has long advocated for substantial changes to rural track programs. The first issue in need of modification is the restriction to not allow cap adjustments for existing “spokes.” Currently rural tracks are set up in a “hub and spoke” model where the hub is the urban teaching hospital, and the spoke is the rural training site. However, CMS did not allow an increase to an existing rural track training (RTT) program “spoke.”

The Academy recommends that cap adjustments for existing "spokes" be permitted. Not doing so will only hinder rural hospitals that have previously developed rural training tracks in expanding their existing programs and facilities as opposed to only incentivizing them to open new facilities. It is both expensive and difficult to open new sites of training. The difficulty in developing a rural infrastructure (faculty, staff, etc.) makes the expansion of existing sites as much, if not more, useful than adding new sites, and should be considered a viable option. We support allowing existing rural track “spokes” to expand by adjusting their cap.

The second issue identified by the AAFP, and other stakeholders is the definitions and nomenclature used for describing new, non-separately accredited rural track programs. In comments to CMS, the AAFP included a chart and description that offers an alternative to the current definitions for these new programs.

SECTION 4. Establishment of Medicare GME Policy Council to Improve Distribution of Slots to Specialties in Shortage

Q. Should Congress include additional specifications for a GME Policy Council in order to improve its success in allocating GME slots to physician specialties projected to be in shortage?

AAFP Response: If a GME Policy Council were to be created, the AAFP believes that at least one of the seats must be designated for a primary care physician. In addition, given the AAFP's support of THCGME funding permanence and program expansion, we suggest including a consultant role with a THCGME subject matter expert or THCGME program administrator. This THCGME representative can provide valuable insight into creating and maintaining a successful GME program in rural and underserved areas. If unable to retain a seat on the Council itself, one should be appointed in an official advisory role to the Council. Finally, the AAFP believes that any entity created to monitor GME financing strategies to accomplish national workforce goals should be required to establish accountability measures that would be utilized as a condition for sustained GME payments.

Q. Does the existing Council on Graduate Medical Education (COGME), a federal advisory committee that assesses physician workforce trends, fulfill the goals of this new Medicare GME Policy Council? How can Congress enhance the work of the COGME?

AAFP Response: The AAFP would like to ensure that COGME continues to have strong primary care representation, particularly from family medicine. Although COGME can and has provided recommendations to CMS and Congress on how to address many of the issues outlined in this policy review, the Council lacks any authority to require CMS to take action to address those recommendations. If Congress cannot extend that authority to COGME, then establishing a new Medicare GME Policy Council that does have actual authoritative powers would be welcomed, but only if the new Council has sufficient primary care representation.

SECTION 5. Improvements to Medicare GME Treatment of Hospitals Establishing New Medical Residency Training Programs

Q: How much time do hospitals with low GME caps need to reset their caps? Should additional hospitals be eligible to reset their low GME caps? What should be the eligibility criteria of these additional hospitals?

AAFP Response: As stated above, distribution of slots to hospitals in rural and underserved areas, as well as those that are designated for primary care, should be prioritized. The AAFP has long supported eliminating or extending the time window for programs in HPSAs. But again, as stated above, the AAFP advocates that CMS also prioritize hospitals or programs based on the proportion of their trainees that ultimately go on to practice in HPSAs. Extending the time and window for GME programs that can illustrate this "impact factor" would further address primary care shortages in rural and underserved areas.

SECTION 6. Improvements to the Distribution of Resident Slots Under the Medicare Program after a Hospital Closes

Q. Would the proposed changes to the formula for redistributing slots from closed hospitals improve the distribution of GME slots to regions of the country facing greater physician shortages?

AAFP Response: Yes. The AAFP supports the proposed changes.

Q. What additional policies should Congress consider to improve the distribution of unused GME slots to areas facing the greatest projected shortage of physicians?

AAFP Response: As stated previously, we encourage Congress to statutorily require CMS to use our "impact factor" to best determine the redistribution of unused slots to underserved and rural communities. The AAFP's data clearly illustrates that the utilization of our impact factor adds significant value to GME sponsoring institutions and should be used in the determination decisions of the distribution of new GME slots as well as the redistribution of unused slots.

SECTION 7. Improving GME Data Collection and Transparency

Q: What additional information should teaching hospitals report, in addition to what is proposed above, in order to improve accountability of federal GME investments?

AAFP Response: The Academy strongly applauds the policy provisions proposed in the outline to require data collection on federal GME programs and dissemination of that data. We have advocated for legislation that would do precisely this, given that CMS has stated that they are not statutorily authorized to do so. Having this data will help address our nation's current maldistribution of physicians and allow us to target the allocation of GME slots toward hospitals and programs in areas and specialties of need, including by considering which ones have a proven track record of training physicians who ultimately practice in physician shortage areas.

In addition to these important data collection reforms, the Committee should also consider stricter reporting requirements related to the closure of a teaching hospital or dissolution of a GME slot or program. These closures and program terminations are incredibly disruptive to the communities they serve and to the residents that must find a new GME slot to complete their residency programs. An annual report or financial viability attestation could provide greater transparency into the financial health of these programs and facilities. If a facility fails to provide such an attestation, additional investigation into the stability of the program should be considered. Any reporting that would give residents advanced notice of an impending closure would allow greater time for them to find a GME slot at another facility or could be used to explore the need for additional funding opportunities to ensure the continuation of a GME program and prevent the closure of the related facility.

In addition to collecting top level data on the amounts of Direct Graduate Medical Education (DGME) vs. Indirect Medical Education (IME) payments, further details about the utilization of IME should be considered. Transparency of how IME dollars are spent could illustrate the need for increased IME in some locations but may also show if these funds being used in unintended ways in other locations. If a program is not utilizing IME funds in the way they are intended, those funds could be shifted elsewhere to support the creation of additional GME slots.

Q: It is of interest to track whether residents trained in primary care continue to practice in this specialty because primary care training is frequently a precursor to other residency training. Are there other specialties that teaching hospitals should similarly report?

AAFP Response: The AAFP would like to note that the definition of "primary care" is not interchangeable with the definition of "family medicine." Beyond simply tracking "primary care," it would be beneficial to further delineate between primary care subspecialties and track the practice choices of residents in each of them. Determining the specific primary care needs of a

community or patient population and whether residency slots in those communities are addressing those specific needs can further ensure that these programs are most beneficial for increasing access to care.

We thank the Committee for the opportunity to respond to this policy outline regarding GME reform. The AAFP looks forward to working with you to ensure the implementation of reforms that best support family physicians and the patients they serve. If you have any questions, please contact Megan Mortimer, Manager of Legislative Affairs at mmortimer@aafp.org.

Sincerely,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

Founded in 1947, the AAFP represents 130,000 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, www.familydoctor.org.

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[iv]The Health Of Us Primary Care: 2024 Scorecard Report: No One Can See You Now: Five Reasons Why Access to Primary Care Is Getting Worse (and What Needs to Change)

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