COMMITTEE ON
ENERGY & COMMERCE
CHAIRMAN FRANK PALLONE, JR.

MEMORANDUM

May 31, 2019

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Investing in America's Health Care"

On **Tuesday, June 4, 2019, at 10:00 a.m. in the John D. Dingell Room, 2123 of the Rayburn House Office Building**, the Subcommittee on Health will hold a hearing entitled, "Investing in America's Health Care."

I. PUBLIC HEALTH PROGRAMS

A. H.R. 2328, Community Health Investment, Modernization, and Excellence Act of 2019

The Health Center Program provides grant funding to health centers that serve medically underserved populations. These grants provided 18 percent of total revenue for health centers in 2017, the most recent year for which data is available.[1] Health centers also rely on other federal funding sources including Medicaid and Medicare, which provided 45 percent and seven percent of health center revenue respectively in 2017.[2]

The Community Health Center Fund (CHCF), provided $11 billion in direct appropriations over the period of fiscal year (FY) 2011 through FY 2015 to the Health Center Program: $9.5 billion in operational support, and $1.5 billion for health center construction and renovation. The increased funding provided to the CHCF has increased the number of health center locations in the Health Center Program from 8,156 locations in FY 2010 to nearly 12,000 locations today.[3] The CHCF also increased the number of patients served by health centers. Between FY 2010 and FY 2017, health centers grew from serving 19.5 million patients and

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[1] Sara Rosenbaum et al., *Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding*, Kaiser Family Foundation (March 26, 2019) (www.kff.org/report-section/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained-issue-brief-9291/).

[2] *Id.*

[3] Congressional Research Service, *Federal Health Centers: An Overview* (May 2017) (R43937).

providing almost 77 million patient visits to serving 27.2 million patients and providing approximately 110 million patient visits.[4]

The CHCF has been renewed several times since its creation in 2010, most recently in the Bipartisan Budget Act (BBA) of 2018 which appropriated $3.8 billion for FY 2018 and $4 billion for FY 2019.[5]

The National Health Service Corps (NHSC) Program provides financial support to health professional students and primary care providers who commit to serve in medically underserved communities in urban, rural, and tribal areas, in the form of scholarships and loan repayment assistance. As of September 2018, NHSC field strength included 10,939 care providers, with physicians, nurse practitioners, and mental and behavioral health professionals among the highest represented disciplines.[6] NHSC clinicians are closely integrated with Federally Qualified Health Centers (FQHCs). Over 60 percent of NHSC clinicians currently serve in health centers, making up 15 percent of health center clinical staff.[7] The NHSC Program is funded through $310 million in mandatory funding through the CHCF, specifically for the NHSC. NHSC funding was last extended in the BBA of 2018 for two years.[8]

H.R. 2328, The Community Health Investment, Modernization, and Excellence (CHIME) Act, introduced by Reps. O'Halleran (D-AZ) and Stefanik (R-NY), extends funding for CHCF for five years, with an annual increase in funding of $200 million each year, starting with an appropriation of $4.2 billion in FY 2020, eventually increasing to $5 billion by FY 2024. The bill also extends funding for the NHSC for five years, with an annual increase of $15 million each year, starting with an appropriation of $325 million in FY 2020, eventually increasing to $385 million by FY 2024.

B. HR. 1943, the Community Health Center and Primary Care Workforce Expansion Act

H.R. 1943, The Community Health Center and Primary Care Workforce Expansion Act, introduced by Rep. Clyburn (D-SC), would extend funding for CHCF for five years, with an

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[4] Department of Health and Human Services, *Fiscal Year 2013 Health Resources and Services Administration Justification of Estimates for Appropriations Committees,* (www.hrsa.gov/about/budget/budgetjustification2013.pdf); Department of Health and Human Services, *Fiscal Year 2020 Health Resources and Services Administration Justification of Estimates for Appropriations Committees,* 62 *(https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2020.pdf).*

[5] Pub. L. 115-123.

[6] Department of Health and Human Services, *Fiscal Year 2020 Health Resources and Services Administration Justification of Estimates for Appropriations Committees,* 63 (https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2020.pdf).

[7] *Id.*

[8] Pub. L. 115-123.

initial increase in funding to $6.1 billion for FY 2020, followed by annual ten percent increases in funding in the four years following FY 2020, up to approximately $9 billion in 2024. The bill also authorizes an additional $4.6 billion for capital projects at Community Health Centers. H.R. 1943 extends funding for NHSC for five years, with an initial funding boost of 174 percent over current levels for FY 2020, to $850 million, followed by annual ten percent increases in funding in the four years following FY 2020, up to approximately $1.24 billion in 2024.

C. H.R. 2815, Training the Next Generation of Primary Care Doctors Act of 2019

The Teaching Health Center Graduate Medical Education (THCGME) program was established to increase training of primary care medical and dental residents in community-based settings, such as FQHCs or Rural Health Clinics.[9] THCGME is administered by the Health Resources and Services Administration (HRSA), and currently supports approximately 728 residents at 56 teaching health centers across the country.[10] Physicians trained under teaching health center programs are more likely to practice in underserved communities compared to traditional GME residents. In academic year 2017-2018, 82 percent of THCGME residents trained in a medically underserved and/or rural community compared to 23 percent of traditional GME residents.[11] Since 2011 the program has supported the training of over 880 new primary care physicians and dentists.[12] The program was most recently reauthorized for two years through FY 2019 as part of the BBA of 2018 at $126.5 million a year.

H.R. 2815, introduced by Reps. Ruiz (D-CA), McMorris Rodgers (R-WA), Torres Small (D-NM), and Roe (R-TN), reauthorizes funding for the THCGME program for FY 2020 through FY 2024, and includes an additional $125.5 million over five years for expansion.

D. H.R. 2822, Family to Family Health Information Center Reauthorization Act of 2019

Family to Family Health Information Centers provide information, education, technical assistance, and peer support to families of children and youth with special health care needs. The centers are staffed by family members with experience in using health services for children and youth with special needs. Centers are located in every state, territory, and one center is dedicated to assisting Indian tribes. Deploying strategies like the ones used in Family to Family Health Information Centers has been shown to reduce out-of-pocket costs for families and to improve

[9] The THCGME program trains Family Medicine, Internal Medicine, Pediatrics, Internal Medicine-Pediatrics, Obstetrics and Gynecology, Psychiatry, General Dentistry, Pediatric Dentistry and Geriatrics residents.

[10] Health Resources and Services Administration, *Teaching Health Center Graduate Medical Education Program* (accessed: May 23, 2019) (https://bhw.hrsa.gov/grants/medicine/thcgme).

[11] American Association of Teaching Health Centers (accessed: May 23, 2019) (http://aathc.org/know-the-facts/).

[12] *Supra* note 10.

transitions from pediatric to adult health care systems as well as physical and behavioral functions.[13] In 2017, Family to Family Health Information Centers provided services to 184,000 families and made referrals to approximately 85,500 health professionals.[14] The program was last extended in the BBA of 2018, funding $6 million for each of FY 2018 and 2019.[15] Funding for the program will expire without Congressional action before September 30, 2019.

H.R. 2822, introduced by Reps. Sherrill (D-NJ) and Upton (R-MI), extends funding at Family to Family Health Information Centers for five years at the current level of $6 million each year through FY 2024.

E. H.R. 2668, Special Diabetes Program Reauthorization Act of 2019, and H.R. 2680, Special Diabetes Programs for Indians Reauthorization Act of 2019

Created in 1997, the Special Diabetes Program (SDP) supports research on the prevention and cure for type 1 diabetes. The program is administered by the National Institute of Diabetes and Digestive and Kidney Diseases at the National Institutes of Health (NIH), along with other NIH institutes and the Centers for Disease Control and Prevention. The Special Diabetes Program for Indians (SDP-I) is a separate program to address the diabetes epidemic among American Indians and Alaska Natives. Coordinated by the Indian Health Service (IHS) Division of Diabetes, with guidance from the Tribal Leaders Diabetes Committee, SDP-I provides funds for diabetes treatment and prevention to IHS, Tribal, and Urban Indian Health programs. Both SDP and SDP-I were last extended in the BBA of 2018, funded at $150 million each year for FY 2018 and 2019.

H.R. 2668, introduced by Reps. DeGette (D-CO), Reed (R-NY), O'Halleran (D-AZ), and Mullin (R-OK), extends funding for SDP for five years at $200 million each year. This amount represents a $50 million increase over current levels.

H.R. 2680, introduced by Reps. O'Halleran, Mullin, DeGette, and Reed, extends funding for SDP-I for five years at $200 million each year. This amount represents a $50 million increase over current levels.

F. H.R. 3030, Patient-Centered Outcomes Research Extension Act of 2019

The Patient-Centered Outcomes Research Institute (PCORI) was authorized by Congress in 2010 as a private, non-profit funder of comparative clinical effectiveness research, which is a type of research that compares at least two alternative healthcare options. The purpose of PCORI is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of clinical evidence. PCORI also engages in dissemination and implementation efforts to facilitate uptake of research results in real-world clinical settings.

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[13] *Supra* note 6, at 215.

[14] *Id*.

[15] Pub. L. 115-123.

PCORI is funded by the Patient-Centered Outcomes Research Trust Fund. The fund currently receives an annual appropriation of $150 million, and additionally receives a per-covered-life assessment from the Medicare trust fund, commercial insurance plans, and self-insured plans. More than $2.4 billion in research grants have been awarded by PCORI's Board of Governors, which is made up of 21 members representing patients, clinicians, payers, manufacturers, researchers, and the directors of the Agency for Healthcare Research and Quality and NIH. The Patient-Centered Outcomes Research Trust Fund will expire September 30, 2019.

H.R. 3030, introduced by Reps. DeGette (D-CO) and Beyer (D-VA), extends funding for PCORI for ten years. The bill maintains PCORI's funding structure consisting of $150 million in annual appropriations, and a per-covered-life fee assessed on the Medicare trust fund, commercial insurance, and self-funded plans.

II. MEDICARE AND MEDICAID PROGRAMS

A. H.R. 3031, To amend title XVIII of the Social Security Act to extend funding for quality measure endorsement, input, and selection under the Medicare program

Section 183 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) directed the Secretary of Health and Human Services (HHS) to "contract with a consensus-based entity, such as the National Quality Forum" (NQF) to support activities related to quality measurement and performance improvement.[16] NQF reviews and endorses healthcare quality measures for use in private and public reporting and incentive payment programs, including annual guidance on measures that should be included in, or excluded from the Medicare and Medicaid programs.[17] The BBA of 2018 authorized $7.5 million in funding for FY 2018 and 2019 to support the above-mentioned contract between the Centers for Medicare & Medicaid Services (CMS) and NQF. This funding, supplemented by unobligated funds from previous years, allowed for approximately $30 million per year to support the contract (consistent with the $30 million in funding authorized for FY 2015 through 2017 under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)).

H.R. 3031, introduced by Reps. Chu (D-CA), Engel (D-NY), and Carter (R-GA) would authorize $30 million in annual funding for FY 2020 through 2024, to support HHS's contract with a consensus-based entity for quality measurement and performance improvement activities.

B. H.R. 3039, To provide for a 5-year extension of funding outreach and assistance for low-income programs

[16] 42 U.S.C. 1395aaa.

[17] Douglas Henley et al., *Making Measurement Count: The Importance of NQF*, Health Affairs (September 20, 2017) (www.healthaffairs.org/do/10.1377/hblog20170920.062052/full/).

Section 119 of MIPPA authorized funding for low-income Medicare beneficiary outreach, enrollment, and education activities through the following programs: State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the National Center for Benefits and Outreach and Enrollment. This funding was last reauthorized under the BBA of 2018 at $37.5 million for FY 2018 and 2019.

H.R. 3039, introduced by Reps. Gomez (D-CA) and Dingell (D-MI) would authorize $50 million in annual funding for FY 2020 through 2024, to support Medicare beneficiary outreach, enrollment, and education activities.

C. H.R. 3022, Patient Access Protection Act

Federal law requires states to provide Medicaid disproportionate share hospital (DSH) payments to hospitals to help offset uncompensated care costs attributable to patients who are uninsured or enrolled in Medicaid.[18] Hospitals often do not receive payment for services rendered to uninsured patients, and Medicaid provider payment rates are generally lower than the rates paid by Medicare and private insurance. Federal Medicaid DSH funding is capped at the state level, called the state's DSH allotment. All states except Tennessee receive an annual DSH allotment that is based on each state's prior year DSH allotments. Additionally, federal Medicaid DSH payments to a hospital cannot exceed the hospital's level of uncompensated care, known as the hospital-specific limit.[19] In FY 2017, Medicaid DSH payments totaled $18.1 billion, which includes $10.4 billion in federal funds and $7.7 billion in state funds.[20]

The ACA directed the Secretary of HHS to reduce federal Medicaid DSH allotments beginning in FY 2014. The ACA included these reductions expecting that the law's mandatory Medicaid expansion and expansion of private insurance coverage would lead to a decrease in hospital uncompensated care costs.[21] However, only 33 states and the District of Columbia have expanded Medicaid; and even in Medicaid expansion states, uncompensated care costs remain a challenge for many hospitals serving low-income individuals.[22] Congress delayed the Medicaid

[18] Section 1923 of the Social Security Act.

[19] MACPAC March 2019 Report to Congress (www.macpac.gov/wp-content/uploads/2019/03/March-2019-Report-to-Congress-on-Medicaid-and-CHIP.pdf).

[20] Medicaid and CHIP Payment and Access Commission, *Disproportionate Share Hospital Payments* (accessed: May 23, 2019) (www.macpac.gov/subtopic/disproportionate-share-hospital-payments).

[21] MACPAC March 2019 Report to Congress (www.macpac.gov/wp-content/uploads/2019/03/March-2019-Report-to-Congress-on-Medicaid-and-CHIP.pdf).

[22] MACPAC March 2019 Report to Congress (www.macpac.gov/wp-content/uploads/2019/03/March-2019-Report-to-Congress-on-Medicaid-and-CHIP.pdf).

DSH reductions, and increased the size of the cuts, on four occasions over 2013 to 2018.[23] The reductions are currently scheduled to begin in FY 2020. Under current law, DSH allotments will be reduced by $4 billion in FY 2020 and $8 billion in FY 2021 through2025, totaling $44 billion in cuts to hospitals over six years.[24]

Rep. Engel (D-NY) introduced H.R. 3022, which would permanently repeal the provision that imposes reductions to federal Medicaid DSH allotments.

D. H.R. 1767, Excellence in Mental Health and Addiction Treatment Expansion Act

Section 223 of the Protecting Access to Medicare Act of 2014 authorized the Secretary of HHS to select eight states to participate in a two-year demonstration program to establish Certified Community Behavioral Health Clinics (CCBHCs). CCBHCs are required to provide comprehensive mental health and substance use disorder services. CCBHCs must provide crisis management services available 24 hours a day, cannot reject patients based on ability to pay, and are required to coordinate care across a spectrum of settings. Furthermore, CCBHCs must provide at least nine types of services, including crisis mental health services; screening, assessment and diagnosis; patient-centered treatment planning; outpatient mental health and substance use services; primary care screening and monitoring; targeted case management; psychiatric rehabilitation services: peer support, counseling and family support services; and services for veterans. Under the demonstration, states must pay CCBHCs under a prospective payment system developed by CMS. States participating in the demonstration receive their enhanced CHIP federal medical assistance percentage (FMAP) for the costs associated with the demonstration.[25]

Federal law requires HHS to submit annual reports on the demonstration to Congress that includes an assessment of: access to mental health services in parts of the state covered by the demonstration compared to other areas of the state, the quality of services provided by CCBHCs, and the impact of the demonstration on federal and state costs. The law requires that the Secretary of HHS recommend to Congress whether the demonstration should be continued, expanded, modified, or terminated no later than December 31, 2021.

Reps. Matsui (D-CA) and Mullin (R-OK) introduced H.R. 1767, which would expand the demonstration in the existing eight states for two years and direct the Secretary to select an additional 11 states to participate in the demonstration for two years.

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[23] Medicaid and CHIP Payment and Access Commission, Disproportionate Share Hospital Payments (accessed: May 23, 2019) (www.macpac.gov/subtopic/disproportionate-share-hospital-payments).

[24] Section 1923(f) of the Social Security Act.

[25] Pub. L. 113-93.

E. H.R. 3029, To amend title XVIII of the Social Security Act to provide transitional coverage and retroactive Medicare part D coverage for certain low-income beneficiaries

In 2010, CMS began the Limited Income Newly Eligible Transition (LI NET) program as a demonstration to provide temporary Part D prescription drug coverage to low-income Medicare beneficiaries who are not already enrolled in a Medicare drug plan, including full benefit dual eligible and supplemental security income (SSI)-only beneficiaries on a retroactive basis, as well as uncovered low-income subsidy (LIS) eligible beneficiaries at the pharmacy counter. Enrollment in the LI NET program is temporary until CMS enrolls these individuals into a Part D plan, but ensures the beneficiary has drug coverage in the interim.

H.R. 3029, sponsored by Reps. Olson (R-TX), Barragan (D-CA), Marchant (R-TX), and Lewis (D-GA), would authorize the LI NET program to ensure these low-income beneficiaries could obtain transitional and retroactive Medicare Part D prescription drug coverage and would continue the current program that is underway.

III. WITNESSES

Panel One

Dean Germano
Chief Executive Officer
Shasta Community Health Center

Diana Autin
Executive Co-Director
SPAN Parent Advocacy Network

Aaron Kowalski
President and Chief Executive Officer
JDRF

Lisa Cooper
Professor of Medicine
Johns Hopkins University School of Medicine

Panel Two

Thomas Barker
Partner, Co-Chair, Healthcare Practice
Foley Hoag

Mary-Catherine Bohan
Vice President of Outpatient Services
Rutgers University Behavioral Health Care

Michael Waldrum
Chief Executive Officer
Vidant Health

Fred Riccardi
President
Medicare Rights Center