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INVESTING IN AMERICA'S HEALTH CARE

TUESDAY, JUNE 4, 2019

House of Representatives

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:01 a.m., in Room 2123 Rayburn House Office Building, Hon. Anna G. Eshoo [chairwoman of the subcommittee] presiding.

Members present: Representatives Eshoo, Engel, Butterfield, Matsui, Castor, Sarbanes, Lujan, Schrader, Kennedy, Cardenas, Welch, Ruiz, Dingell, Kuster, Kelly, Barragan, Blunt Rochester, Rush, Pallone (ex officio), Burgess, Upton, Shimkus, Guthrie, Griffith, Bilirakis, Long, Bucshon, Brooks, Carter, Gianforte, and Walden (ex officio).

Also present: Representatives Schakowsky, O'Halleran, Soto, Rodgers, and Olson.

Staff present: Joe Banez, Professional Staff Member; Jeff Carroll, Staff Director; Luis Domingues, Health Fellow; Waverly Gordon, Deputy Chief Counsel; Tiffany Guarascio, Deputy Staff Director; Stephen Holland, Health Counsel; Zach Kahan, Outreach and Member Service Coordinator; Josh Krantz, Policy Analyst; Una Lee, Senior Health Counsel; Aisling McDonough, Policy Coordinator; Meghan Mullon, Staff Assistant; Samantha Satchell, Professional Staff Member; Kimberlee Trzeciak, Senior Health Policy Advisor; Rick Van Buren, Health Counsel; C.J. Young, Press Secretary; S.K. Bowen, Press Assistant; Jordan Davis, Minority Senior Advisor; Margaret Tucker Fogarty, Minority Staff Assistant; Caleb Graff, Minority Professional Staff Member, Health; Ryan Long, Minority Deputy Staff Director; James Paluskiewicz, Minority Chief Counsel, Health; Brannon Rains, Minority Staff Assistant; and Kristen Shatynski, Minority Professional Staff Member, Health.

Ms. Eshoo. The Subcommittee on Health will now come to order. The chair now recognizes herself for five minutes for an opening statement.

Welcome to the witnesses. We are delighted to have you here and look forward to hearing from you.

Today, the subcommittee will consider 12 bills to extend critical public health programs and invest in Medicaid and Medicare services.

These are programs that Congress has previously authorized, but most will expire on September 30th. So Congress has to act now to ensure their ongoing benefits.

We are going to hear testimony about the bipartisan bills to extend and invest in the following programs, several that were authored by members of this subcommittee. This is a long list: community health centers, National Health Service Corps, teaching health centers for graduate medical education, the Special Diabetes Program and the Special Diabetes Program for Indians, Family to Family Health Information Centers, the Patient-Centered Outcomes Research Institute, state health insurance programs, Area Agencies on Aging, Aging and Disability Resource Centers, the National Center for Benefits and Outreach Enrollment, the National Quality Forum, Certified Community Behavioral Health Clinics, disproportionate share hospitals, and the Medicare

Limited Income NET Program.

Many of these programs are stuck in a biennial cycle where they may expire because of Congress's inaction. Can I just ask that the committee be in order? There is a low undertone here. I will finish as quickly as possible and then make sure that I am not talking when you are.

So today we are consider reauthorizing these programs for a longer time frame, giving them the certainty and the stability to conduct long-term planning to better serve patients and the American taxpayer.

I want to highlight a few of these important programs. First, we are considering expanding several types of health centers that serve our communities in very unique ways.

The Community Health Center Fund provides funding to nearly 12,000 health center locations across our country. That takes my breath away -- 12,000 health center locations.

These health centers provide primary care to one in 13 Americans, regardless of their ability to pay. Building on the Community Health Center model is the Excellence in Mental Health and Addiction Treatment Expansion Act, authored by Representatives Matsui and Mullin.

This important bill expands funding for certified community behavioral health clinics to 11 more states, and that is very,

very important.

As we face a mental health care shortage, we have to do more to expand access. In my state of California, Californians say their community does not have enough mental health providers to serve local needs.

Another center serving the community are the Family to Family Health Information Centers, or the F2F grant program. F2Fs assist families with children who have special health needs to make informed choices about health care.

F2Fs are staffed by family members who have firsthand experience in navigating special needs health care services. Community Health Centers, Certified Community Behavioral Health Clinics, and the F2F Health Information Centers provide unique services for the specific populations.

We are also considering other programs to improve access to vital primary care, including the Special Diabetes Program and funding for disproportionate share hospitals, which we all know goes to hospitals that serve lower-income Americans.

Other programs conduct needed research to make sure we are providing quality care. The Patient-Centered Outcomes Research Institute and the National Quality Forum help our nation's clinicians deliver quality care to more people at a lower price.

Finally, we are strengthening Medicare through stronger

enrollment support and help for low-income beneficiaries. Today's hearing is critically important to make sure millions of our fellow Americans receive quality health care.

I stand ready to work with every colleague to make sure these programs are expanded and extended.

So the chair now has the pleasure of recognizing Dr. Burgess, the ranking member of the Subcommittee on Health, for five minutes for his opening statement.

Mr. Burgess. I thank you for the recognition and once again today we are considering legislation to reauthorize vital public health programs, which expire in the coming months.

So this hearing is timely and, in fact, I am legitimately getting worried because that time between now and September 30th always goes by so fast.

We are out the month of August and there is always plenty of other competing things that are going on in the House of Representatives. So this is great that we are getting down to this.

Community health centers, teaching health centers, special diabetes programs, Family to Family Health Information Centers are the bipartisan programs that make a real impact in providing access to quality health care for Americans.

The community health center in my district, Health Services

of North Texas, conducted more than 50,000 patient visits for more than 14,000 patients in 2017.

Community health centers are the front lines for caring for some of the most vulnerable individuals in our communities and there is bipartisan support for extending this and other public health programs.

Reauthorizing these programs can take a substantial amount of time and I hope that we are able to accomplish these reauthorizations prior to the end of the fiscal year.

I do remain concerned that these bills have funding increases but no offsets. Additionally, the language in the community health center reauthorization bill does not include Hyde protections, which have long been bipartisan and were included in the Alexander-Murray Senate companion bill.

By not including these protections, the majority puts the effort to reauthorize these critical programs at risk and we do have to worry about the ability to move them forward if that position does not change.

Again, I hope we can work in a bipartisan manner to get these reauthorizations across the finish line in a timely manner. In an effort to do so, I introduced H.R. 2700, which would use the $5 billion in offsets from the drug pricing bills that passed through this subcommittee with unanimous support and use that

to pay for one year of public health extenders.

While one year is not a long enough extension, I thought it was important to show our commitment to reauthorizing these programs in a fiscally responsible way.

In fact, every Republican member of the Energy and Commerce Committee is a cosponsor of H.R. 2700.

The Patient-Centered Outcomes and Research Institute is another program up for reauthorization and I am interested in learning today from our witnesses what the return on investment has been and what we have learned from the comparative clinical effectiveness research.

Additionally, there are a number of Medicaid deadlines looming, the most significant of which is for the mandatory cuts to the disproportionate share hospitals.

The bill before us today, H.R. 3022, entirely eliminates the DSH cuts. So okay, I am supportive of delaying DSH for two years or repealing them for two years, as Representative Olson does in H.R. 3054.

However, eliminating the cuts entirely would prove a costly task and preclude us from making any valuable changes, changes that DSH payments desperately need if they are going to have a meaningful relationship to the level of uncompensated care that is actually being provided at the state level.

A two-year delay would provide Congress with ample time to revisit DSH and make any changes necessary to improve both the efficiency and the effectiveness.

MACPAC recently recommended three policy changes to improve the structure of these DSH allotment reductions and we should take the time to revisit this topic and engage with stakeholders to pave a smooth path forward.

Another Medicaid topic that is absent from today's discussion is reauthorizing Medicaid for Puerto Rico and our other territories. We must remember that the individuals reliant on Medicaid and the territories are American citizens and they are some of the most vulnerable.

Letting Medicaid funding for these individuals lapse would be disappointing and unfair to those living in the territories. And let us be clear, finding enough money to adequately fund the territories will be much more difficult if we are paying for a permanent elimination of the DSH cuts.

And I do have a letter from the Association of Hospitals of Puerto Rico, who dealt with the Medicaid cliff, the coming uncertainty it has created over the past decade -- this was before Hurricane Maria -- over the past decade has been a major contributing factor to the loss of doctors, specialists, and health professionals in country -- in the island of Puerto Rico.

Reauthorizing these public health programs and delaying the DSH cuts are important in maintaining access and quality for health care for Americans.

I do hope we will be able to work in a way that will ensure that we get the legislation to the president's desk prior to the end of the fiscal year.

I remain concerned that the total cost of these bills could exceed $50 billion with no offsets identified to pay for the policies.

So I thank you for having the hearing today and I will yield back the balance of my time.

Ms. Eshoo. The gentleman yields back.

We do plan to have a hearing on the issue of Medicaid in Puerto Rico, Dr. Burgess. And before I move on to Mr. Pallone, I want to point out that we have some very special guests here this morning with us and you see them with the bright blue ribbons on them.

They are representing foster children from across our country. So welcome to each one of you. We are thrilled that you are here.

[Applause.]

Ms. Eshoo. And as a former foster mom, an extra special welcome.

Now, I have the privilege of recognizing the chairman of the full committee, Mr. Pallone, for five minutes for his opening statement.

The Chairman. Thank you, Madam Chair.

Today we are examining 12 pieces of legislation that make critical investments in programs supporting Medicare, Medicaid, public health and our nation's health work force.

It is critical that we come to bipartisan agreement on these bills because without congressional action many of these programs will expire on September 30th.

On our first panel we will discuss several public health initiatives including three programs that play an essential role in America's health workforce, and these are the Community Health Center Fund, the National Health Service Corps, and the Teaching Health Center Graduate Medical Education Program.

A strong health workforce is the foundation of a strong health system. It is essential that we continue to invest in these programs that are working to train providers and place them in communities where they are needed the most.

And today, nearly 12,000 community health centers provide essential care to millions of patients across the country. I am grateful to my colleagues, Representatives Clyburn and O'Halleran, for their leadership in providing robust funding for

both community health centers and the National Health Service Corps, which offers loan forgiveness to health professionals who commit to provide service in medically underserved areas.

I would also like to thank Representative Ruiz for his leadership on legislation to reauthorize the Teaching Health Center Program, which trains primary care residents in community-based settings such as community health centers.

I am also proud to be a long-time advocate for the Family to Family Health Information Center Program and strongly support Representative Sherrill's legislation to reauthorize it

This program helps families of children with special health care needs get the information and support needed to provide the best care possible for their children.

On our second panel will examine proposals related to the Medicare and Medicaid programs. We will discuss a proposal led by Representative Engel that would permanently eliminate the cuts to hospital funding that Congress has been forced to delay over and over again every year.

Medicaid disproportionate share hospital funds, or DSH funds, provide critical financial support to hospitals that care for some of the most vulnerable.

Without action by Congress, DSH funding will be cut by $4 billion in October of this year. These cuts will place an

incredible strain on hospitals that are already struggling to provide care to children with complex medical needs, low-income Americans, and rural communities, and I commend Representative Engel for his efforts to permanently eliminate these harmful cuts.

We will also get an update on a demonstration in Medicaid to increase access to comprehensive mental health and substance use disorder treatments through certified community behavioral health clinics.

Every day 130 people in the U.S. die from an opioid overdose. As our country continues to struggle through this terrible epidemic, clinics in the states participating in this demonstration have had remarkable success at improving access to care including 24-hour crisis care, and I thank Representatives Matsui and Mullin for their work to extend and expand this important program.

So I just want you to know I am committed to working with all of my colleagues to advance all these important programs before the September 30th deadline.

It is also my hope that we can find a way to provide longer-term extensions so that those who operate or receive services from these programs have greater certainty.

And now I would like to yield the remainder of my time to Congressman O'Halleran. Oh, down there.

Mr. O'Halleran. Thank you, Chairman Pallone, Ranking Member Walden, Congresswoman Eshoo, and Ranking Member Burgess for allowing me to join the subcommittee hearing this morning on two very important pieces of legislation I am proud to have introduced.

First, the Community Health Investment Modernization and Excellence Act would reauthorize and provide moderate increases in funding for community health centers, the National Health Service Corps, over a period of five years.

These services are vital for rural and medically underserved areas including the 1st District of Arizona where 18 federally -- funded health community organizations provide care for nearly 200,000 patients.

Second, the Special Diabetes Program for Indians is an incredibly important program and has been successful in lowering rates of diabetes across Indian Country.

I have seen firsthand how these communities have long been disproportionately impacted by diabetes. Prior to the inception of this program, the prevalence of this disease was increasing among the American Indian and Alaska Native communities.

A lot of it is because of food also, not just exercise, but the fact that these are food deserts, for the most part, and 50, 100 miles round trip to get to food at all.

Unfortunately, rates of diabetes in these populations remain higher than any other group. We have more work to do. It is my hope that as we move forward that we realize that these programs are vital to Native Americans across our country.

And I yield back.

Ms. Eshoo. The gentleman yields back.

I would like to recognize a former member of Congress that's here with us today and was a member of the Energy and Commerce Committee, Phil Gingrey -- I am sorry. I wanted to pronounce it right. Dr. Phil, that's right. Another Dr. Phil. Welcome. It is great to see you.

[Applause.]

Ms. Eshoo. Okay. Now I would like to introduce the first panel of witnesses for today's hearing.

Mr. Walden. Madam Chair?

Ms. Eshoo. Yes. Oh, I am sorry. The gentleman from Oregon, the ranking member of the full committee. I am sorry. I apologize.

Mr. Walden. Thank you. We will move on. Not a problem at all.

Ms. Eshoo. I apologize. You have five minutes.

Mr. Walden. Not six?

Ms. Eshoo. Five wonderful minutes.

Mr. Walden. I have one --

Ms. Eshoo. Five and a half. How is that?

Mr. Walden. Okay. I will try --

Ms. Eshoo. For my blunder.

Mr. Walden. -- to knock this out faster than that.

Ms. Eshoo. Yes.

Mr. Walden. Good morning. Good morning to our panelists and everybody here.

This is a really important day and marks an important step for the committee's work to examine legislation that really strengthens our health care safety net by extending these critical programs.

These programs, which have long enjoyed, and I think you have heard this this morning, strong bipartisan support, include community health centers, teaching health centers, the National Health Service Corps, special diabetes programs, and more.

Each program plays a very significant role in our nation's safety net for millions of Americans, especially the medically underserved who face barriers to accessing care.

In my own district in Oregon we have 12 community health centers. They serve 240,000 people through 63 different locations. So we need to work together to both strengthen this program and the others that we are examining today.

In the last Congress, I helped lead the effort to provide record funding for our community health centers and reauthorize and fund these other programs.

We did it in a bipartisan way and we got it into law. We are also reviewing legislation that extends the Patient-Centered Outcomes Research Institute, the Excellence in Mental Health Demonstration Program, and legislation repeals part of the Affordable Care Act's requirement that DSH hospitals suffer these payment cuts.

I want to raise a couple of concerns at the beginning for my colleagues as we begin this reauthorization process. I am concerned that the language in the Teaching Health Center reauthorization bill may have some unintended consequences for the program and the legislation reauthorizing the community health centers does not include the Hyde language, as we have discussed previously, which Congress has consistently supported and renewed annually on a bipartisan basis multiple times and for decades.

In addition, I am concerned most of the bills we are reviewing significantly increase the authorization levels but don't identify pay-fors to keep the promise of higher funding levels.

And while we are the authorizing committee -- I understand that -- we also know it is a bit of a false promise to set a high

reauthorization level without also doing the heavy lift to figure out how to pay the bill because we are going to get called upon to do that.

A significant concern is H.R. 3022, the bill to eliminate DSH cuts, giving hospitals relief from the cuts that were called for under the Affordable Care Act.

Let me be clear. Republicans have never supported the DSH cuts and worked successfully to prevent them. But we should not surrender completely our ability to reform and modernize the program to ensure that funding is actually directed to those that it was intended to be used for.

In fact, in March of this year, MACPAC's own report states, and I quote, "The commission has long held that DSH payments should be better targeted to hospitals that serve a high share of Medicaid-enrolled and low-income uninsured patients and have higher levels of uncompensated care consistent with the original statutory intent of the law establish DSH payments," closed quote.

In other words, we should make sure the law is working as intended.

I am pleased to see the bipartisan commitment to continuing to fund the Excellence in Mental Health Demonstration. As one of the eight states to be awarded funding, Oregon has seen significant and positive results that truly helped my state's

residents.

In fact, recently I met with providers at a certified community behavioral health clinic in southern Oregon that's involved in this demonstration. The initial findings show they are achieving great results in the community. So count me as a fan.

The demonstrations are created to determine if new programs actually work and we need to get the results of this demonstration before we dramatically expand it, as the legislation we are viewing today would do by adding 11 states to the program.

My legislation, H.R. 3074 -- the Continuing Access to Mental and Behavioral Health Care Act -- would extend funding for the original eight states for an additional two years so we can complete the demonstration project and get the data that taxpayers really deserve.

I am disappointed, Madam Chair, that the committee did not include in this hearing H.R. 2700, the Lowering Prescription Drug Costs and Extending Community Health Centers and Other Public Health Priorities Act.

Republicans are serious about our commitment to responsibly extend these critical public health programs with bipartisan offsets, and I am not sure why our legislation was excluded from the discussions today.

We, obviously, will work together as we have to avoid unnecessary shutdown of these programs in September when their authorizations expire.

So we look forward to working with you and others on the committee. I look forward to hearing from our witnesses today.

And thank you, Madam Chair, and I yield back. I would say as a footnote I know several of us have the other hearing upstairs we have to get back and forth to.

But thank you for being here and thanks for the great work you and the people represented in this room do for our citizens back home.

I yield back.

Ms. Eshoo. The gentleman yields back.

Now I would like to introduce the first panel of witnesses for today's hearing. Mr. Dean Germano, chief executive officer of the Shasta Community Health Center. Welcome and thank you. Ms. Diana -- is it Autin? Autin. She's the executive co-director of SPAN, S-P-A-N, Parent Advocacy Network. Welcome, and thank you to you.

Dr. Aaron Kowalski, president and chief executive officer of JDRF -- marvelous organization that has chapters all over the country and they come on a regular basis to my Palo Alto district offices. I am sure they do to every member's office here. Dr.

Lisa Cooper, professor of medicine, Johns Hopkins University School of Medicine -- welcome to you and thank you.

Just a quick word about the lights. First it is green. When it turns yellow you have one minute, and red you stop. So it is only as complicated as that and I know that you will adhere to it.

So now I would like to recognize Mr. Germano for five minutes for you testimony. If you would like to summarize what you have written and submit it to us and do something other than what you submitted to us, you are all welcome to do that.

You are recognized, Mr. Germano. Thank you again.

STATEMENTS OF 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

STATEMENT OF MR. GERMANO

Mr. Germano. Chairwoman Eshoo, Ranking Member Burgess, distinguished members of the subcommittee, thank you for inviting me to testify about the Teaching Health Center Graduate Medical Education, community health centers, and the National Health Service Corps Programs.

I strongly encourage you to provide increased and stable funding for all three programs before they expire on September 30th. The success of these critical programs is at risk when funding for any one of them is jeopardized.

Shasta Community Health Center is based in Redding, California, in a predominantly rural and medically underserved region. Federally qualified health center since 1996, we care for over 40,000 patients annually.

Since 2014, we have been one of 56 teaching health centers, graduating eight residents, and we have employed 25 National Health Service Corps loan repayment recipients since 2000.

Our eight THCGME graduates -- of the eight, five work primarily in underserved populations in Redding and similar communities. Even using these programs my health center is four to five primary care physicians short and it can take up to 12 to 18 months to recruit a physician.

So growing our own through the THCGME program is a survival imperative. In 2018, Congress reauthorized the THC program through this September at a more sustainable level of $150,000 per resident.

Responding to the primary care physician shortage is incredibly timely because by 2030 we will need more than 120,000 physicians to meet this country's demands.

I am very grateful that Representatives Ruiz and McMorris Rodgers have introduced bipartisan legislation, H.R. 2815, to extend the THC program for five years.

We know that hospital-based training produces physicians whose skills and experiences don't always match the primary care needs of the community and who rarely choose to practice in rural or underserved areas.

By contrast, the THC model uses ambulatory health centers in underserved communities for training and the data proves that these graduates are three times more likely to practice in such settings after their residencies.

H.R. 2815 will help THCs restore some resident slots that were authorized by HRSA but not filled during the years of uncertainty and it would fund a very modest increase in resident allocation to help offset inflation.

Lastly, H.R. 2815 expands the program to meet pent-up demand. HRSA last approved a new THC in 2014 and many potential sponsors of such centers have expressed interest in becoming a teaching health center.

Our health center depends on the Section 330 grants which allow health centers to expand their facilities, open new sites, and to meet unmet needs in areas with limited access to care.

Section 330 grants leverage other funders because they confer status of high-quality health care provider. Broad bipartisan support for health centers has sustained 1,400 community health center organizations, caring for over 28 million patients and more than 11,000 rural, urban, and frontier communities nationally.

The September 30th expiration date threatens the very existence of the health center program. Over the last several years, Shasta and CHCs across this nation have experienced serious uncertainty due to funding disruptions.

Our doors are open to everyone regardless of ability to pay. Services are offered on a sliding fee scale basis and we locate

sites in medically underserved communities.

However, recent funding lapses threaten the notion of continuous access. We are grateful that Representatives O'Halleran and Stefanik introduced H.R. 2328 to provide five years of stable funding for the CHC fund including $200 million in annual growth and $15 million in annual growth for the National Service Corps.

Likewise, H.R. 1943, introduced by Representative Clyburn, provides five years of funding with 10 percent annual growth, an addition of $4.6 billion for health center capital funding, which would further -- and would further expand the Corps.

Shasta has benefitted greatly by the Corps. Over 50 years the Corps has effectively placed more than 50,000 people in the highest areas of need in our country so they can provide primary medical, dental, and/or mental and behavioral health services in underserved communities with more than 10,000 placements last year alone.

Our clinicians have come to Shasta with staggering student debt, enter the National Health Service Corps loan repayment program, and through their service many are debt free in just a matter of years.

Thankfully, Congress has extended the Corps through September and we are very concerned that another expiration of

funding would cause great damage to the program.

Additionally, currently funding only allows for awards of 40 percent of loan repayment applicants and a mere 10 percent of scholarships.

H.R. 2328 and 1943 would fund even more applicants for loans and awards and thus substantially increase access. As CEO of the community health center, a teaching health center, on behalf of all National Health Service Corps recipients, I urge Congress to provide increased and stable funding for these programs before they expire on September 30th.

Thank you.

[The prepared statement of Mr. Germano follows:]

**********INSERT 1**********

Ms. Castor. [Presiding.] Thank you.

Ms. Autin, you are recognized for five minutes.

STATEMENT OF MS. AUTIN

Ms. Autin. Good morning, Chairman Eshoo, Mr. Ranking Member, members of the subcommittee. I am Diana Autin, executive co-director of the SPAN Parent Advocacy Network, home of New Jersey's Family to Family Health Information Center, or F2F.

Today, I represent both SPAN and Family Voices, a national organization of and for families whose children and youth have special health care needs, which also provides support to the nation's F2Fs.

I am here today to support H.R. 2822, the Family to Family Reauthorization Act, which will extend funding for F2Fs for an additional five years at the current funding level of $6 million a year.

F2Fs help families with special health care needs navigate health care and other systems advocate effectively for their children and work as partners with providers.

Children and youth with special health care needs include those with autism, epilepsy, traumatic brain injury, cancer, schizophrenia, asthma, diabetes, or any other condition that requires health care services beyond that required by children generally.

Throughout the U.S. there are about 14 million children with

special health care needs, 19 percent of all children under 18 and more than one in five families with children.

Families struggle to find the right primary and specialty care providers to treat their children and to pay for their care. Even with insurance, out-of-pocket costs can be very high with co-payments and other costs that insurance may not cover at all.

It is difficult to navigate through the worlds of public and private insurance and other sources of care and financing that all have different eligibility criteria.

Children may miss getting needed services because their families are unaware of or don't know how to access or afford them. That's where F2Fs come in.

We are staffed by parents of children with special health care needs. Beyond their training, our staff have expertise and empathy, learn through personal experience.

We reach out to underserved communities and provide our services in a culturally and linguistically appropriate manner. We provide one-to-one assistance like helping a family appeal denial of coverage for needed services, get insurance coverage or find appropriate pediatric specialty care.

For example, in New Jersey, a father called our F2F about his 13-year-old son with Downs Syndrome, autism, major behavioral challenges. He was struggling to afford prescribed medications

which were making his son's behavior worse and making him gain weight.

Our F2F staff connected him to a nearby federally-qualified health center and helped him develop a behavior support plan for school and access additional services.

Within six months, his son was weaned off the medications and had lost 30 pounds, and his overall health and behavior had improved.

Some families face more than the usual challenges. Military families must relocate often, needing to find new providers, reapply for Medicaid, and negotiate for services in a new district.

In New Jersey, we help these families by embedding staff at and working closely with Joint Base McGuire-Dix-Lakehurst.

Special challenges also arise for families who aren't proficient in English or who come from diverse cultural backgrounds or urban low-income families who may need to take multiple busses to get to services, and for rural families who must travel long distances to get specialized care. Sometimes one parent may even have to relocate.

Families in the territories and Native American and Alaska Native families face linguistic and cultural barriers and the complications of remote locations, often compounded by extreme

poverty.

That's why we were so pleased when last year Congress expanded the F2F program to serve these families. There is now one F2F in each state, five territories, and three tribal organizations as well as D.C.

Each receives $96,750 a year. Despite our modest budgets, we provided information, training, and/or assistance to nearly 1 million families in 2018.

F2Fs provide a great value for taxpayers. We help families get the care and services their children need to survive and thrive and to avoid medical bankruptcy and we assist providers and policy makers to better serve children and youth with special health care needs.

Our efforts result in higher quality, more cost effective care and better outcomes.

The bill before you today would extend the F2F program for an additional five years, longer than ever before. Although modest, the F2F grant provides a foundation upon which other funding and activities can build.

Status as a federal grantee provides credibility that makes it easier to secure additional funds and partners. However, those other funding sources -- government agencies, foundations and individual donors, and community partner organizations don't

want to invest time or money in an entity that might not survive for more than a year.

Greater stability of F2F funding would be extremely valuable to our effectiveness. Since its creation over a decade ago by Senator Charles Grassley and the late Senator Ted Kennedy, the F2F program has enjoyed strong bipartisan support.

We thank Representatives Sherrill and Upton for continuing this bipartisan commitment to F2Fs so we can help families secure timely, high quality, and family-centered care for their children and youth.

On behalf of Family Voices and SPAN and as a parent myself, I thank the subcommittee for the opportunity to testify about the value of Family to Family Health Information Centers, and I am happy to answer any questions.

Thank you.

[The prepared statement of Ms. Autin follows:]

**********INSERT 2**********

Ms. Castor. Thank you very much.

Dr. Kowalski, you are recognized for five minutes.

STATEMENT OF MR. KOWALSKI

Mr. Kowalski. Ranking Member Burgess and members of the subcommittee, thank you for giving me the opportunity to testify before you today.

In 1977, my brother -- my younger brother, Steven, was diagnosed with type 1 diabetes, or T1D, at the age of three. In 1984, I too was diagnosed with T1D when I was 13 years old.

Because of that, I went on to get my doctorate in microbiology and molecular genetics, and then focused my career on the fight to cure this terrible disease and to help other people with diabetes stay healthy until then.

I've worked at JDRF, the world's largest charitable funder of type 1 diabetes research for 15 years, and just eight weeks ago I became its president and CEO.

I am here today with a simple message from our community. The Special Diabetes Program is making a tremendous difference in our lives and our hopes for the future.

We need you to continue to give it robust support. There is so much momentum that we can't afford to lose. We are grateful for the leadership of this committee on both sides of the aisle over the years and the broad bipartisan support in Congress for this Special Diabetes Program, or SDP.

By supporting the SDP, you have been the catalyst that has fundamentally changed diabetes management, diabetes care, and have brought us even closer to cures for diabetes.

In addition, lives are being transformed by the Special Diabetes Program for Indians, or SDPI, which funds prevention and treatment programs for those in American Indian and Alaska Native communities that are particularly affected by type 2 diabetes.

Approximately 30 million Americans have type 1 or type 2 diabetes and about a third of the Medicare budget is spent on people with diabetes.

Thanks to the funding provided by Congress, we have seen major progress in type 1 diabetes research that has led directly to improvements in the health and quality of life for people with diabetes and significantly reduced the risk for the terrible and costly complications of the disease.

This includes the first FDA-approved artificial pancreas, or AP system, which came on the market several years earlier than expected, thanks to research supported by SDP.

AP systems drive significantly better glucose levels, which reduce the risk for these terrible complications. For those who do have complications, we've seen incredible advances in drugs that preserve and even improve vision who have diabetic eye

disease, and other drugs that are being tested as we speak for those who are at risk for diabetic kidney disease.

And this is just the start. The SDP is currently funding multi-disciplinary and path-breaking research to understand the causes of type 1 diabetes and how it can be cured.

While the SDP research funding moves us closer to cures and improves the quality of care for those with type 1 diabetes, the SDP eye program that is run by the Indian Health Service has played a critical role in tackling type 2 diabetes among American Indians and Alaska Natives, a population that is disproportionately suffering from the disease.

These communities have a diabetes prevalence rate approximately two times the national average and the death rate 1.8 times higher than the general U.S. population due to diabetes.

Thanks to the SDPI, which funds evidence-based diabetes treatment and prevention programs that help over 700,000 people in 35 states, there have been marked improvements in average blood sugar levels and reductions in the incidence of cardiovascular eye and kidney disease.

As you can see, SDP and SDPI programs are making a real difference in the lives of people with type 1 and type 2 diabetes. That's why JDRF strongly supports House Bills 2668 and 2680, introduced by Representatives DeGette, Reed, O'Halleran, and

Mullin that will raise the amount of funding to $200 million a year for SDP and SDPI and fund them for five years.

All of us at JDRF are grateful that 378 representatives, including nearly all of the members on this subcommittee and the full committee signed a letter to leadership, led by Representatives DeGette and Reed, that recognizes the important contributions of this program -- these programs, and calls for the program's renewal.

We look forward to working with this broad group to get these bills passed and continue diabetes research advances and care.

Thank you, and I would be happy to take any questions.

[The prepared statement of Mr. Kowalski follows:]

**********INSERT 3**********

Ms. Eshoo. [Presiding.] Dr. Cooper, you are recognized for five minutes for your testimony.

Put your microphone on.

STATEMENT OF DR. COOPER

Dr. Cooper. Good morning, Chairwoman Eshoo.

Ms. Eshoo. We want to hear every word. We want to hear every word of your testimony.

Dr. Cooper. Thank you. Ranking Member Burgess and distinguished members of the subcommittee, thank you for inviting me to participate in today's hearing.

I am Dr. Lisa Cooper, a professor at the Johns Hopkins Schools of Medicine, Nursing, and Public Health, where I have served as faculty for 25 years.

As a board-certified general internist, I treat adult patients with a range of illnesses and unique health care needs. As a health services researcher, I have devoted my career to improving quality and addressing disparities in the U.S. health care system.

Over the past nine years, my colleagues and I at the Johns Hopkins Center for Health Equity, along with our health system and community partners, have completed three NIH-funded clinical trials improving hypertension control in African-American communities.

And now, with the support of PCORI, I am leading a new trial called Rich Life, launched in 2016 with 30 primary care practices

in Maryland and Pennsylvania.

Rich Life investigates whether system improvements and team-based care models can reduce disparities and cardiovascular risk factors, including hypertension, diabetes, and depression.

This study will help clinic directors and primary care doctors choose how to care for people who have high blood pressure and could be extremely impactful in communities that have high rates of this condition and limited access to care.

Throughout my experience as a practicing clinician and researcher, one theme is clear. Too often, patients do not have enough accessible or relevant information to make informed decisions about their care and too often we, as clinicians, must make decisions about our patients without knowing which option would best fit their unique needs and circumstances.

For all the advances we have made with new innovative clinical research, we sometimes still lack the information we need to help our patients make the best choices for themselves. That is why the Patient-Centered Outcomes Research Institute, or PCORI, is so important.

PCORI is the leading funder of comparative effectiveness research, which is research that compares how well different treatments and care approaches work so patients and doctors have the information they need to make decisions that are right for

them.

PCORI's research is unique and complementary to research funded or conducted by the NIH, which focuses on discovery, the AHRQ, which focuses on health services research, and FDA, which focuses on reviewing drugs, devices, and other products for safety and efficacy.

Patient-centered outcomes research is comparative effectiveness research that focuses not only on clinical outcomes but also on the needs, preferences, and outcomes most important to patients and those who care for them.

This research is helping patients choose the treatments best for them and focuses on many of the most pressing health concerns our country faces today such as heart disease, cancer, diabetes, and opioid dependence.

PCORI is the only research funder that ensures that everyone has a seat at the table who has a stake in health care improvement.

As a researcher who has received funding from both the NIH and PCORI, I have seen firsthand the values and differences of both institutions and what they both bring to the table.

To date, PCORI has funded more than 600 studies that address high-priority conditions, new and emerging approaches to care, as well as ways to improve doctor-patient communication and,

importantly, PCORI funds the dissemination of research findings as well as implementation of actionable results.

For example, PCORI funded a study that found that a simple decision aid can help people who go to the ER with chest pain better understand their risk of having a heart attack and therefore decrease unnecessary hospitalizations for testing.

Over five years this could benefit 9.4 million Americans and save $4.8 billion nationwide. Another example is a study in Washington State clinics that implemented an initiative focused on more cautious prescribing of opioid drugs, which led to reductions in high dose opioid prescribing while preserving patient pain control.

In both these examples, using a patient-centered approach not only improved health outcomes and patient quality of life, it also reduced utilization.

Simply put, results from PCORI-funded research are actionable, impactful, and have the potential to improve health outcomes for patients across the country and that is why it has strong support from more than 170 health care organizations.

But there is still much more to be done. Ensuring that PCORI has long-term and consistent funding is vital to their research funding mission. It also provides the stability that researchers need to conduct this work in training and support for the next

generation of researchers.

In closing, our health care system requires solutions that are both evidence based and patient centered to improve are and reduce health care spending. PCORI is uniquely set up to meet this challenge.

Therefore, I urge Congress to renew its investment in patient-centered outcomes research and enact a 10-year reauthorization of PCORI's charge and funding before it expires.

Thank you for your time and I look forward to our discussion.

[The prepared statement of Dr. Cooper follows:]

**********INSERT 4**********

Ms. Eshoo. Thank you, Dr. Cooper.

We have now concluded the opening statements of our witnesses. Our thanks to each one of you. We will now move to members questions. Each will have five minutes to question the witnesses and I will start by recognize myself for five minutes.

Mr. Germano, in your testimony you mentioned a grow your own -- grow your own strategy of training health care providers to address the primary care shortage, and we have that shortage in the country, and primary care physicians are the gateway to the entire health care system.

Can you tell us briefly how that strategy has actually worked? How has it benefited the community?

Mr. Germano. Well, our data through HRSA -- the teaching health center information -- really shows that we have three times the success rate of training and keeping our residents in our communities compared to other models of training.

So the data is pretty clear. It is --

Ms. Eshoo. But what makes it so?

Mr. Germano. Well, I think a big part of it is --

Ms. Eshoo. They love your community? I mean, what is it that keeps them glued there?

Mr. Germano. Well, I think part of it is that they see the mission. They're connected to the mission. Many of them come

from those communities or communities like it.

They have a heart for what we do and we really support them in their training and they have become confident in working with underserved populations, and they get connected rooted into our communities.

Ms. Eshoo. In California, thanks to the ACA, we've reduced our uninsured rate down to 6.8 percent, which is incredible when you think of the most populous state with the most diverse population, which is not the easiest to insure. That's down from 16 percent before the ACA was passed.

These are -- these are large increases in health care coverage. So if someone really doesn't know that much about community health centers and what they do, how would you respond to them and say this is why we are needed?

Mr. Germano. Well, we had that success in California. Our rates up in Shasta are higher than that. They were almost 25 percent before and now they're down to almost 6 and now have climbed back to 10 percent again.

We also have the situation of people with major medical and other costly front-end plans that make it difficult to afford primary care.

Our goal is primary prevention. We need a solid system. Any system in the world that has success in terms of caring for

their populations and keeping a lid on costs really have strong primary care systems and that's what the community health centers represent is a very strong primary care preventive health system.

That is the -- I think that is the key for every community across America and we have 84 million Americans that don't have the benefit of a community health center to do that for them.

Ms. Eshoo. Even though we have how many, 12,000 in the country?

Mr. Germano. Fourteen thousand.

Ms. Eshoo. Fourteen thousand. My staff wasn't right. Oh, my goodness. Mortal sin.

Dr. Cooper, in the studies that are done, can you just briefly describe how those studies develop legs and walk into a patient's life?

Studies are always important for what they reveal. But then how do they become real in people's lives?

Dr. Cooper. So I think what I would say is the way they become real in people's lives is that actually their patients involved in the design of these studies so they're actually involved from the very inception. Patients contribute --

Ms. Eshoo. But the larger population, though.

Dr. Cooper. So you mean afterwards? After the research

is done? I think this is a critical piece is that once we have results of the work, for example, if we know that there is a tool that helps patients to make decisions about whether or not to stay in the hospital for chest pain is actually getting that information out to doctors and patients so that when they're at the point of making that decision they are aware of the existence of that tool.

Ms. Eshoo. So have you measured this? I mean, just does that -- that as an example, patients with -- that go to the emergency room, they think they are having a heart attack -- your study says you should do A, F, and Z, what is the outcome?

Dr. Cooper. So that is not -- that is not my study. That is another study that was funded by PCORI where, basically once people used the tool they were able to determine whether or not they felt comfortable going home.

Ms. Eshoo. Well, how do you do that? Do you go through insurers?

Dr. Cooper. So what we do --

Ms. Eshoo. Do people line up at a clinic --

Dr. Cooper. Right.

Ms. Eshoo. -- to get the piece of paper that explains it?

Dr. Cooper. Right.

Ms. Eshoo. Tell us how it works.

Dr. Cooper. Yes. So the -- I think the process varies depending on where you are, right. So one of the reasons we have a lot of people involved in PCORI research is that we talk to insurers, we talk to front line providers, we talk to staff, and we talk to patients and families, and we find out what works in a particular system.

And so one size doesn't fit all. So we may learn from a particular health system that they have community health workers who are the ones who work with patients and who show them how to use the tool, and --

Ms. Eshoo. I think I know how it works. I want everyone else to hear it.

Dr. Cooper. Right. But, you know, in another health system --

Ms. Eshoo. -- always know the answer to your own question, right?

Dr. Cooper. Right. In another system it might be something different where they have pharmacists who are the ones who actually help people to work through their questions and their --

Ms. Eshoo. Well, my time is expired and I thank the witnesses. The chair now recognizes Dr. Burgess for his five minutes to question.

Mr. Burgess. Thank you for the recognition and I want to first start off by answering Mr. Germano's question that you asked of him -- how, when you grow your own, how does that work and for at least in the physician space -- I can't speak to other health care providers, but from a physician space we tend to settle where we train, and this is something we have -- I have studied this question for years and the Texas Medical Association has done an extensive research on this. Not so much where someone goes to medical school but where they do their training.

You typically marry during those years and, as a consequence, your spouse has a big say in where you spend your practice life. You become familiar and comfortable with the doctors to whom you refer or you know who to watch out for in the community.

So that information is very helpful to the young physician just starting out, trying to build a practice.

So when you gave that answer, I was reminded of all the work the AMA has done on this and it is -- it is a significant body of work.

It became really apparent to me after Hurricane Katrina and visiting with doctors down in the Louisiana-Mississippi gulf coast and the Dallas-Ft. Worth area where I am from was guilty of stealing a lot of physicians from that area at that time and quite successfully.

But one of the best predictors as to whether or not someone was going to stay in the -- in the area around New Orleans was if their spouse was from there -- not if they were from there but if their spouse was from there. That is a very -- that can be a very powerful anchor. And, again, we do tend to marry during our training years and that is, I think, part of the answer there.

Now, of course, Dr. Gingrey being in the audience, and I am reminded of the night we heard -- we marked up the -- well, it wasn't really the Affordable Care Act.

It was what went over to the Senate. But it came back and it was entirely different. I remember his insightful questions on the comparative effectiveness research that night.

Dr. Cooper, just so everyone understands, you get a direct appropriation under the Affordable Care Act of $150 million a year. Is that correct?

Dr. Cooper. So my understanding is that the funding is set through a separate funding stream for PCORI -- that there is a PCORI fund that is funded through a variety of different sources.

Mr. Burgess. Right. There is a trust fund. There is a charge for every insurance policy that is sold as well as there is a transfer from the Medicare trust fund, which makes up an aggregate of dollars that you have to spend.

Do we have anything that would give us sort of a return on

investment guide for the Patient-Centered Outcomes and Research Initiative?

Dr. Cooper. So we have a number of different studies that have shown that different approaches, when incorporating patients' preferences into decision making, that actually we do reduce utilization and could really save significant amounts of money.

So the example I gave you --

Mr. Burgess. But let me interrupt you for a second. Who would save significant amounts of money? Do we know? Do we have a good sense of -- we have spent, I think last year, $630 million on PCORI. What's the return on investment for that?

Dr. Cooper. So I would get back to you with the help of the PCORI staff on that because PCORI actually doesn't fund cost effectiveness research. It wasn't -- that wasn't part of --

Mr. Burgess. Comparative effective, just not cost effective.

Dr. Cooper. Yes.

Mr. Burgess. And I get that. And, you know, your specialty through the American Board of Internal Medicine several years ago came up with the Choosing Wisely program. Is that something you have looked at through PCORI, sort of look at those studies that we know we all do as physicians but the return on investment

is not that great?

And I think it was the -- again, your specialty society which said maybe we ought to think about what we are ordering.

Dr. Cooper. Absolutely. I know of one study that was funded by PCORI that specifically looked at monitoring of glucose levels in patients who are on oral treatment for diabetes and showed that actually doing glucose monitoring at home really didn't contribute anything important to the patient's health.

And so the study actually suggested that people on oral hypoglycemics do not need to engage in glucose monitoring. And so that kind of an outcome really shows that you can save money by eliminating all of those --

Mr. Burgess. I am just going to interrupt you for a second. My time is running out. Of course, it might affect your decision as to whether nor not to have that piece of coconut cream pie that's in the refrigerator.

But on the chest pain study that you did with the chest pain tool, is there any way that you can assess -- look, I am an OB/GYN doctor. I practice defensive medicine.

So I will tell you from my days in the ER, chest pain -- I mean, it is a problematic situation for the doc on the front line and you're always worried you're going to send someone out who then ends up having the big one in the parking lot and dies.

So is there a way you have dealt with the liability question?

Dr. Cooper. What I would say is that there is a clinical algorithm that was used with that tool, which included some risk prediction, and that people who answered questions in a certain way on that tool were able to be sent home safely.

And, in fact, those people who went home had lower uses of utilization and didn't have any worse complications. And so an estimation is that that would save considerable amounts of money if people were able to feel comfortable, both doctors and patients, based on a thorough assessment of the patient's profile that it was safe for them to go home.

Mr. Burgess. I will follow up with you about that in writing because it is -- it is an important concept. I will yield back.

Ms. Eshoo. The gentleman yields back.

The chair now recognizes the chairman of the full committee, Mr. Pallone, for five minutes for questions.

The Chairman. Thank you, Madam Chair.

I first wanted to ask the question of Mr. Germano. When the Community Health Center Fund was created in 2010 under the ACA, it was originally authorized to boost funding to community health centers for five years and we have reauthorized it twice in the four years since for periods of two years each time.

Since we first passed the Community Health Center Fund, we've

seen growth based on a record of success. Health centers have grown from serving 19.5 million patients and providing almost 77 million patient visits in 2010 to serving 27.2 million patients and 110 million patient visits in 2017.

For today's hearing, Chairwoman Eshoo has noticed two bills that both reauthorize community health centers and the National Health Service Corps for five years as well as the five-year extension of the Teaching Health Center Graduate Medical Education Program.

And I strongly believe that all these programs are very worthy of a long-term extension to bring stability to centers like your own that are providing community-based residency training and essential services to those who need it.

So, Mr. Germano, if I could ask you, can you tell us about the impact a long-term extension of funding would have on your health centers' ability to provide care to patients, manage a budget, recruit and retain members of the health care work force and can you compare that to the challenges that your health center would face with a short-term extension?

Mr. Germano. Thank you for that question, Congressman.

The running of a community health center tied to your community is a complex venture. Most of the things we do to impact our community are long-term orientation.

Think about building a new site, for example. I say it takes four to five years from thought to finish if you have all the means. When you -- when you're working on short term appropriations it has a paralysing effect on your ability to plan ahead and make those kinds of investments. It really does.

2018, when we went through the two-year -- the fiscal cliff piece -- I know of health centers that created layoffs. They did freezes of staff. They withdrew contracts for clinicians that they needed because they couldn't -- they didn't know they could -- they didn't have the confidence they could commit to meeting those obligations.

It really has a paralysing effect on the ability to think forward and plan. It has that same effect on your board of directors and it also sends a message to your community about how stable are you really if the rug can be pulled out from under you so easily, from their perspective.

So the long-term is really about planning and doing things efficiently and correctly. Short term is -- it makes it very difficult to think ahead and make those kinds of commitments.

The Chairman. Thank you. I appreciate that. And I would add too -- I have to go to the next question -- -but, you know, a lot of these are very small, too, and I think when you talk about small community health centers, which many are including

in my district -- it is even worse, I think.

But anyway, let me -- I have to go to Ms. Autin, and my question is about New Jersey's experience with Family to Family. I want to acknowledge that New Jersey has for a long time been a leader in the Family to Family program, which connects families of children and youth with special needs to the health care resources they need and I am glad my colleague from New Jersey, Representative Mikie Sherrill, has taken a leadership role introducing the bill to reauthorize this vital program.

So let me just ask you, can you talk about your organization's long history in New Jersey and how that helps you provide technical assistance to other states, the territories, and tribes that have sought to implement and improve their own programs, if you will.

Ms. Autin. So SPAN actually has been around for over 30 years and we were one of the very first F2Fs that was selected out of the legislation that was -- came from Senator Grassley and Senator Kennedy.

So that's been -- you know, being one of the first F2Fs that got started that gave us the opportunity to really learn on the ground and then be able to share that information with other F2Fs.

We also had the opportunity to do that because along with the two people from National Family Voices including Norah Wells, the executive director of Family Voices, I am one of the

co-directors of the national center that provides technical assistance to the F2Fs, and one of the ways in which we do that is by providing peer-to-peer support.

And so we connect F2Fs that have knowledge and expertise in one area to other F2Fs. Because we are in such a diverse state, because we've been around so long, because we have many other programs that can supplement and support our F2F and because of our really very positive relationship with our state department of health Title 5 program, I think we have a lot of lessons learned that we've been able to share with other F2Fs around the country and hosted them when they came to visit us for different issues around cultural responsiveness, et cetera. So --

The Chairman. All right. Thanks so much. Thank you.

Thank you, Madam Chair.

Ms. Eshoo. The gentleman yield back.

I now would -- let us see, who is -- who is next?

Oh, Mr. Upton. A pleasure to recognize former chairman of the full committee, Mr. Upton of Michigan.

Mr. Upton. Well, thank you, Madam Chair, and I appreciate the hearing. I know that we all do. And before I get to my questions I wanted to take this opportunity just for a moment to draw my colleagues' attention to a bill that I am co-sponsoring, which I think is an excellent complement to the programs being

discussed today.

H.R. 2075, which is the School-Based Health Centers Reauthorization Act of 2019, this is a bill that I strongly believe in. I have talked to many of my schools back home in Michigan. I look forward to working with the chair and the ranking member to advance this bill in the coming months.

It is bipartisan and it really does make a difference in a meaningful way. I guess I will start off with Dr. Kowalski. In your testimony you told us about the critical diabetes management -- how critical that diabetes management is and the role that SDP has played in bringing innovative new technologies to the market.

I have been involved with this issue for a long time and have seen wonderful advancements as I watch folks who started early with JDRF 20 some years ago and are still -- I mean, technology changes are amazing and really lifesaving.

How do these technologies prevent the complications from diabetes in terms of lowering health costs as we look to reauthorize this money?

Mr. Kowalski. Sure, and thank you for your leadership. I was just up at UM talking about a center that we are working on with the team there.

And both type 1 and type 2 diabetes complications are caused

by high blood sugar, and high blood sugar has a nefarious effect of driving changes in your body that affect your eyes, your kidneys, your heart, and your limbs.

The incredible advances that have happened in terms of the ability to monitor blood sugar, for example, SDP helped support the advancement of continuous glucose monitors.

I use a continuous glucose monitor. I have not poked my finger in over five months. It is absolutely incredible and we are seeing those advances be applied in type 1 and type 2 people to lower A1C measures, which is the measure of blood glucose levels.

Mr. Upton. Let me just interrupt you for a second. I don't -- so one of the manufacturers is, what, Dextrom, right? So if they moved Dextrom --

Mr. Kowalski. Dexcom.

Mr. Upton. -- monitor that so that they've got a new system now without having to poke and test that, literally, every day?

Mr. Kowalski. Yes. They do, as does another company, Abbott Diabetes, and from a JDRF perspective, we think competition is good. We want more options out there, and what we are seeing is competition driving more access, better glucose levels, less risk for complications.

Mr. Upton. Thank you.

Ms. Autin, H.R. 2822 -- it is a bill that I have co-sponsored along with Ms. Sherrill, reauthorizes the F2F program for five more years. You talked a little about it -- remarks about why this is so important and I know more than just New Jersey -- my colleague is not -- can you elaborate why it is -- why this is an important issue for us to move forward?

Ms. Autin. Thank you for that wonderful question, and it is important for all of the F2Fs. For one thing, it is very difficult to do planning, you know, as an organization when you don't know whether or not you're going to be around for more than another year.

I talked about partners and other funders. I mean, in our organization that F2F funding, you know, brings in lots more money to do that work and many other F2Fs the same thing is true. They want to know that there is going to be stability in that organization before they put their money there.

I think one of the most important things, though, is that we all are staffed by families of children with special health care needs.

Mr. Upton. And that is important.

Ms. Autin. That is so important. It is important because we are the people who know what the systems are like and how to really navigate them on the ground. But, of course, we also have

children that have special health care needs.

And so we -- it is even more important that we have stability of employment, stability of health insurance, being able to know and project that we are going to be able to have a job and keep our children covered under that same health insurance plan where we have already found the 10 specialists that are all covered by our, you know, health maintenance organization.

And, you know, I have had to have this experience multiple years where I have had to tell staff, I can't promise you that there is going to be a job here in the next six -- you know, after six months from now, and then those families have to make that very difficult decision to possibly leave a job that they love and that they are really great at and go someplace else where they have more stability, and that means we have more turnover.

That means we lose great staff and then that means there are more costs that are associated with trying to reach out to, you know, somebody else to come and fill that position.

So the -- you know, having the five years of funding is going to be one of the most important improvements in the F2F reauthorization that we have ever had.

Mr. Upton. I look forward to working with everybody to get that done. Yield back. Thank you.

Ms. Eshoo. The gentleman yields back.

The chair now recognizes Ms. Matsui of California, who is the sponsor of H.R. 1767, for five minutes of questioning.

Ms. Matsui. Thank you very much, Madam Chair, and I really appreciate all of you being here today and I would like to extend a special welcome to Mr. Germano from my home state of California.

Now, I appreciate your sharing with the committee how long-term sustainable health care funding is essential to supporting primary care and preventive services in Shasta and across California.

And as you may know, in 2014 I helped author the Excellence in Mental Health law that established certified community behavior health centers -- CCBHCs -- in eight states across the country.

Earlier this year I introduced H.R. 1767, a bill to expand Excellence's CCBHC's Medicaid demonstration with my colleague, Representative Markwayne Mullin from Oklahoma.

Now, in the Medicaid demonstration program we also know how important it is to have mental and physical health a holistic way of doing things. So we encourage partnerships in coordination with certified community behavior health centers and community health centers.

And I would like to get a better sense of how CHCs address

serious mental and addiction disorders, specifically, the level of access that patients with schizophrenia and opioid use disorders have to intensive community-based services in Shasta and the surrounding counties.

I know in my district in Sacramento are seven federally-funded health center organizations and 36 clinical delivery sites create a safety net infrastructure that provides primary and behavior health care needs in Sacramento.

Mr. Germano, what kind of partnerships has the Shasta community health center forged with community mental health providers in your service area?

Mr. Germano. Thank you for that question, and certainly, in rural areas of California and across this country the mental health gap is huge, and that is true also in our community.

Our health center has two -- played two major parts in this. One, we have created an integrated behavioral health component which really integrates the behavioralist, typically LCSWs -- licensed clinical social workers -- as well as marriage and family therapists within our primary care practice as team members with our primary care doctors and nurse practitioners and PAs so those warm hand-offs can happen.

That's important, and some screening can be done more effectively. We also employ psychiatrists on our staff --

because our county and our systems in California are mostly county-based for the seriously mentally ill, have really struggled in trying to keep that -- those services going.

So we have in fact gone off and hired psychiatrists and we work with the county as well because of in-patient services, and then there is advocacy groups, NAMI and others, that we work very closely with. We cannot do what we do effectively in underserved communities without an effective mental health delivery system.

Ms. Matsui. Right.

Mr. Germano. And it takes all those pieces, and it does take a village to provide those kinds of services. And I am happy to say we've been working hard at it on the addiction side. We have moved very heavily into medically-assisted therapies now.

We have -- we have redirected our resources into creating what we call MAT services. We are -- right now we have 200 patients on medically-assisted therapies and we are growing that program to try to meet that need -- the opioid abuse issues in our communities, and we are really pleased with the results so far.

Ms. Matsui. Well, that is wonderful. With the Excellence Act with the certified community behavioral health centers we have a federal definition. So it is just like we had to federally qualify health centers.

So, in a sense, they, working together, can really have an effect on the community. I will have to say that my co-sponsor, Markwayne Mullin, is not here today because of floods in his district.

But he has worked with many public safety groups in order to provide that type of service so that they feel very good because they don't have to waste hours and hours taking these people to ERs or trying to figure this out.

So anything that we can do, particularly in rural areas, I know will help the people there who don't have ready access to behavior health needs.

So anyway, I thank you very much and I yield back.

Ms. Eshoo. I thank the gentlewoman. She yields back.

I now would like to recognize the gentleman from Virginia, Mr. Griffith, for five minutes for his questions.

Mr. Griffith. Thank you very much, Madam Chair. I do appreciate it. I appreciate our witnesses being here.

What I like about having hearings like this is we learn a lot. This is not my field of expertise, although I have about 30 or 31 community health centers in my district.

It is a fairly large district. Probably have needs for a few more, in all fairness, but I do appreciate what you all do.

And I am now going to yield to Dr. Burgess.

Mr. Burgess. I thank my friend from Virginia for yield.

Mr. Germano, let me -- let me ask you. In your testimony you talked about the -- expanding or you mentioned that expanding the types of providers that would be eligible to participate in the National Health Service Corps is a zero-sum game. Can you -- can you further elaborate why this is?

Mr. Germano. Yes. As I stated in my testimony, only about 40 percent of current applicants actually get a loan repayment acknowledged. You know, they participate. They can go forward, and only 10 percent of scholars.

So if the fund isn't significantly increased -- significant -- adding more players to that field will just water down that benefit and I don't think it serves any of our purposes.

I happen to support the allied health professions who are looking to take advantage of this. But we need to greatly increase the scope of the National Service Corps -- their dollars -- in order to do that. It really is a zero-sum game right now.

Mr. Burgess. And Dr. Kowalski, if I could just ask you -- obviously, your organization of which you are now president -- so congratulations on the ascendency to that lofty position, or my condolences, one of the two -- so can you tell us how JDRF collaborates with the National Institute of Health on research priorities and particularly as it relates to the Special Diabetes

Program?

Mr. Kowalski. Yes, that is a great question. Thank you.

We work very, very closely with the NIH including with Dr. Griffin, who heads up NIDDK, and the program staffs who -- staff members who focus on various areas. We break up our research into curing type 1 diabetes, preventing type 1 diabetes, and better treating it, and each of those areas have embedded scientists who are experts at JDRF working hand in hand with the team at NIH.

For example, last week, NIH held a meeting where they were setting their program priorities and our team participated. So there is very close coordination on the research efforts of both organizations.

Mr. Burgess. So tell me this. I spoke to someone yesterday on the issue of islet cell transplant. What is the -- you talk about a cure for type 1 diabetes -- what is out there on the horizon as far as a cure is concerned?

Mr. Kowalski. So islet cell transplantation, for those who are not familiar, is the harvesting of the cells that make insulin from somebody who has passed away prematurely -- just like an organ transplant but just the cells.

And what we have seen in that procedure is you can cure people with diabetes. I was with one of the founders of that procedure

and he has people 17 years post-transplant off insulin.

The barriers are the cell source and the immunosuppression that is required. So both JDRF and NIH and SDP has really laid the foundation here of creating renewable cell sources so that we would not require transplant donors, and protecting the cells, and we have a variety of amazing programs going on both through materials or now with the gene editing CRISPR-Cas technology.

So I am incredibly optimistic. While we are making great progress on better treatments, those are band-aids. What we need is what we call disease-modifying therapies and I think cell therapy is incredibly promising.

Mr. Griffith. And, Dr. Burgess, if I might jump in real quick and reclaim my time --

Mr. Burgess. Yes, please.

Mr. Griffith. -- we have some folks working on genetically-modified pigs who are able to grow some of these cells. I think they're doing experiments with it, but they have eliminated the alpha-gal syndrome or the alpha-gal protein in these pigs and some other things to try to reduce the amount of suppression.

Yield back. Yield back to my friend.

Mr. Burgess. So there you have it. I knew I was asking that question for a reason.

Mr. Germano, you heard my earlier discussion about the liability issues and in community health centers you are under, if I recall correctly, a national --

Mr. Germano. Federal Tort Claims Act?

Mr. Burgess. Federal Tort Claims Act. So your costs for liability insurance are reduced so you're able to expand the amount that you're able to offer because you're not spending so much on that part of the overhead.

Is that true in the teaching health centers as well?

Mr. Germano. Unfortunately, there is gaps. Because of the way the FTCA has been interpreted for us, it essentially says that as long as the patients are our patients and the services are within our scope, it is covered.

But as you know, as a resident you go in the hospital, you're never sure who you're going to run into in the emergency room or surgery. So we have to buy alternative insurances to cover our residents because of that gap.

Mr. Burgess. I would like to help you with that.

Mr. Germano. I would love to have the help.

Mr. Burgess. All right. We will follow up after committee. Thank you.

Mr. Griffith. And I yield back.

Ms. Eshoo. The gentleman yields back.

It is a pleasure to recognize the gentleman from New York, Mr. Engel, for five minutes.

Mr. Engel. Thank you, Madam Chair. I appreciate your calling on me.

Let me say that there are six community health center networks in my district. I want to mention them, as they do a good job: Bronx Community Health Network, Hudson River Health Care, Morris Heights Health Center, Mount Vernon Neighborhood Health Center, New York City Health and Hospital Corporation, Open Door Family Medical Center, Incorporated.

Together, they deliver high-quality care to nearly half a million of my constituents. Now, I have heard from some of these clinics that two-year reauthorizations can hinder their ability to implement innovative care programs and retain experienced staff, and to that end I am pleased to co-sponsor the CHIME Act, a bipartisan measure which would provide five-year reauthorization to increase funding.

Let me ask Mr. Germano, could you please describe some of the consequences of short-term funding measures on a community health center's ability to implement care coordination programs?

Mr. Germano. Thank you for that question.

As was mentioned before, the biggest effect is the paralysing effect of not knowing what your future has in store. We are making

long-term commitments to really change the face of delivery in our communities, whether that be the hiring of clinicians, whether that be creating of points of access.

All those things take planning and investment, and when the dollars are -- can only go out so far, most boards -- most communities are going to say, we have to put -- we have to slow down or stop and in some cases we have health centers who ended up taking loans to meet payroll. We had others that rescinded contracts to providers who were coming because they couldn't guarantee they could afford them. It is a very -- it really has a very destabilizing effect having such a short window like that.

Mr. Engel. Thank you. I appreciate your testimony.

Let me also say that when we look at diabetes in my home state of New York, there are 2 million New Yorkers who have it. It costs the state an estimated $15 billion annually in direct medical expenses and, unfortunately, these figures are expected to rise as the diabetes epidemic worsens.

To help turn the tide in this epidemic, Congress created the Special Diabetes Program. The program funds cutting-edge research into diabetes treatments and technologies, and New York research institutions have been awarded $86 million in SDP grants.

Let me ask you, Mr. Kowalski, what are some innovative diabetes technologies that have been developed with SDP funds

and how are they improving diabetes care?

Mr. Kowalski. Thank you for the question, and first and foremost, I think what we've seen, as mentioned earlier, continuous glucose monitoring technology has played a pivotal role in driving better glucose control.

More recently, artificial pancreas technologies are coming to the market and the SDP program played a pivotal role in driving those into the American system much earlier than expected and I can tell you that my brother and I use those systems very successfully with much better results.

Ultimately, both in type 1 and type 2 people with diabetes these advances forestall the need for -- the development of diabetes complications and those costly expenses, both SDP and SDPI both playing a critical role in slowing and reducing those costs.

Mr. Engel. Thank you very much.

And Mr. Germano, let me -- let me ask you this. The United States has a growing shortage of primary care physicians, which is estimated to reach 50,000 by the year 2030.

The shortage disproportionately affects underserved communities and the Teaching Health Center program plays a vital role in addressing this gap.

So, Mr. Germano, can you please describe how a five-year

reauthorization will help Teaching Health Centers prepare the next generation of primary care physicians?

Mr. Germano. Thank you for that question. The five-year authorization goes to that issue of stability. When we take a class in, we are committing to three years.

So when we have one or two years' worth of funding, it is a real leap to guarantee to these young people that we are going to continue to support them.

The health centers that are in underserved communities -- Congressman, sorry -- Burgess -- Dr. Burgess mentioned that 70 percent -- the data shows 70 percent of those trained in -- well, in locations where they're trained land within a hundred miles of where they are trained.

So when we are training them in underserved communities we greatly increase the opportunity to keep them in our communities. Our data shows three times more success than other kinds of models.

So yes, we need teaching health centers in underserved communities. We need to keep them there to take care of our communities.

Mr. Engel. Thank you.

Madam Chair, thank you so much for this. This is really important stuff that I know we have both worked on.

Thank you.

Ms. Eshoo. I thank the gentleman and he yields back.

I now would like to recognize the gentleman from Missouri who is long on humour and friendship, Congressman Billy Long.

Mr. Long. Thank you. Appreciate being recognized.

Mr. Germano, the Teaching Health Center Graduate Medical Education Program plays an important role in bringing more primary care physicians to rural and underserved areas.

Shasta Community Health Center participates in this program so I am interested in your perspective on this. What are the training differences in a teaching health center residency versus a traditional hospital residency?

Mr. Germano. Thank you for that question.

There is quite a bit of overlap because we have accrediting requirements that we have to meet. It doesn't matter where you are trained -- you have to meet those requirements.

The difference is that we are looking for medical students, fourth year, wanting to get into our residency, for people who have a heart and understanding of our community and our mission -- serving our community.

We are looking for people with experiences that would demonstrate that they will be successful in our environment. We then surround them with support and faculty and all the other

resources we have to make sure they are successful in working in our communities.

We help them root in our communities to the best extent, and if they are not staying, we -- I have gone out and looked for similar communities where their spouse wants to move to and we connect them to a health center there.

So we span the gamut, and I would just finish by saying that what we are doing now is we are going now downstream to our high schools and saying to our own underserved communities, listen, have you thought about a career as a primary care doctor.

And this is how you get in and this is how we are going to help you get there, and we are going to get you into medical school and we are going to get you into our residency and you're going to serve your mother, your dad, your neighbors when you're done.

To me, that is the long term. That is what five years of commitment goes. It gives us that kind of support.

Mr. Long. How can teaching health centers help alleviate the primary care workforce shortages that we are facing?

Mr. Germano. Well, in H.R. 2815 there is a -- there is -- in fact, a number of the bills -- the important thing is we have to grow the program. The program is sort of stuck on 56 across the nation with the funding that we have.

So we need to grow it. In 2815 there is a provision to add eight new programs in 2021 and an additional eight in 2023, I believe, and it instructs HRSA and then there is other expansions of existing programs.

We have to greatly expand the number of people -- of residents that we train and that bill allows for, I believe, 250 more spots of training in our country.

Mr. Long. And how likely are residents to stay serving in the underserved areas after completing their residency at a teaching health center?

Mr. Germano. The data from HRSA shows that it is running about -- around 60 percent in the communities where they are trained. It doesn't mean -- and it is something like 82 percent stay in primary care.

And as I mentioned before, if they're not staying in your community, they are moving to another underserved community where they benefit.

One of my residents moved to rural Arkansas because that's where her hometown was and that is where they needed her, and she is helping to deliver babies down there right now. So --

Mr. Long. Let me -- let me ask you another question, kind of following up on what my friend, Mr. Engel, was asking.

You note that over the next decade the United States will

require nearly 50,000 primary care physicians but the number of graduates is now greater than the number of residency slots, which I know a lot of Americans would be shocked to find out that you can go completely through medical school and not be able to get a residency.

Mr. Germano. It is true.

Mr. Long. Not be able to become a doctor. What else can we do to ensure that graduates can get residency slots and be able to practice particularly in rural and underserved areas, which will face the deepest impact from these physician shortages?

Mr. Germano. Well, first and foremost, I think we need to create more teaching health centers in underserved communities. There is health centers around this country willing to be a sponsoring entity and I think we should make a deep investment in those health centers.

And I believe there are other community-based and other rural communities that could support a residency teaching program. But, for me, if you really want to target underserved communities, the community health center environment is where the investment should happen.

I think it can and it should.

Mr. Long. Okay. The National Health Service Corps will play a vital role in bringing more primary care physicians to

rural and underserved areas.

There are four programs within the NHSC -- the scholarship program, the loan repayment program, the state loan repayment program, and the students to service program.

However, four of the five programs' placements are within the loan repayment program. Could you talk about the role of the other three programs that are within NHSC and what we can do to enhance the placements within these programs?

Mr. Germano. Specifically, the scholarship program and the state loan repayment program? I want to be clear -- is that what you're referring to?

Mr. Long. The -- all but the loan -- yes, the repayment -- the state loan repayment program, student to service program, and the scholarship program.

Mr. Germano. Well, I would almost need to get back to you with more detail of what we can do.

Mr. Long. We are out of time anyway so that is a good plan. Let us do that. I yield back.

Ms. Eshoo. The gentleman yields back.

I now would like to recognize the gentlewoman from Florida and thank her for chairing while I ran off to another subcommittee upstairs. The gentlewoman from Florida, Ms. Castor.

Ms. Castor. Well, thank you very much, Madam Chair, and

thank you for organizing this hearing because it is very important that the committee examine health initiatives that are effectively helping families back home.

That certainly includes the Special Diabetes Program, everything the Family to Family Initiative does to ensure families with kids with special needs get the care they need. Patient-Centered Research is vitally important.

Thank you for your summary on Teaching Health Centers. I hope we can expand them and I want to salute Ms. Matsui for working for many years to expand our community behavioral health clinics. I think that has a lot of promise for families.

Probably the most impactful in my Tampa area district will be community health centers, and since the adoption of the Affordable Care Act with the community health center funding that provides grants, I have seen significant expansion.

It is so important to families in my community. Tampa family health centers currently leverages over $9 million in federal investments and serve well over 100,000 of my neighbors back home.

Now, community health centers they rely on a number of funding streams -- Medicare and Medicaid reimbursements, some private pay. But the grants that come from the community health centers fund are critical to expansion.

Mr. Germano, tell us how health centers across the country

are using the grants that come from specifically the community health center fund.

Mr. Germano. Well, our main purpose of the federal grants is really, I think, twofold. One is to make sure that we provide effective primary preventive care to our uninsured.

So every state, depending on how they dealt with the ACA, have a different number there.

Ms. Castor. And isn't that important in states that did not expand Medicaid, which, unfortunately, includes the state of Florida.

Mr. Germano. The 330 grant is truly a lifesaver for those states because the uninsured rates are much higher. The other places that it helps to support the infrastructure delivery of those services, not all those other funding sources cover a part of what's -- of what it costs but it is not the whole thing.

So we need all those funding sources, including the federal grant. The federal grant also provides for federal tort claims. People -- you know, that's the malpractice coverage that we lean on to help make it more affordable for us to deliver services.

It also allows us to work with our states on prospective payment under Medicaid. So Medicaid pays its fair share of what it costs to deliver services.

So the federal grant is fundamental as a foundational

building block for what we do.

Ms. Castor. And a couple of years ago, we were entirely frustrated because the community health centers fund was in need of reauthorization. I think you answered Chairman Pallone's question about the importance of continuity and on the longer term extension.

I know in my community the six-month delay in funding for community health centers, the National Health Service Corps, the Teaching Health Centers, among others, was particularly damaging.

We heard from folks back home that said this funding cliff is untenable. They said they had to freeze hiring, including physicians, and support personnel. They had to stop all construction expansion plans. That is not smart or financially wise.

They had -- even reducing the number of patients they saw and considered closing existing facilities. So you talked about the importance of continuity. But, boy, if -- give me a good example of how a funding lapse and additional delays affects patients' access to care and the workforce that we need to train.

Mr. Germano. Well, many of our health centers have been -- are at the maximum of their capacity. So the only way to take care of more people is to look at expansion. But to expand you have to plan. It just doesn't -- you just don't pitch a tent

and start delivering services in many cases.

So the continuity and being able to plan ahead to do that, I mentioned earlier, takes three to five years to plan a new site, you know, from thought to finish, and you have to have some certainty of your funding is going to be there.

The Teaching Health Centers, as I mentioned, every class is a three-year commitment. You have one or two years' worth of funding and a three-year commitment, it doesn't serve anybody very well.

It creates a lot of anxiety, and particularly in part of the residents, I might add, wondering if they're going to actually finish in the training program they started.

We did lose one health center during that period. Twenty-four residents lost their training program. We had to scramble and absorb them across the country. Not a good situation.

Ms. Castor. Well, I agree with you and I -- Madam Chair, I look forward to the committee marking up these bills with robust funding and extension and reauthorization.

Thank you, and yield back.

Ms. Eshoo. The gentlewoman yields back.

A pleasure to recognize the gentleman from Kentucky, Mr. Guthrie, for five minutes of questions.

Mr. Guthrie. Thank you, Madam Chair.

My first question is for Mr. Germano. I am a big supporter in community health centers. I think they do a fantastic job.

We just need to ensure that they are on a successful track and they are funded responsibly. One of the things that I have been driven by, being on this committee, is all the fantastic innovation coming in health care.

Now we can cure -- Dr. Francis Collins said we can use the cure word for sickle cell anemia. Just all this stuff that's coming forward.

So I just kind of -- what innovation do you see community health centers doing to be part of the great revolution or innovation revolution in health care and how they are innovating to better serve their communities?

Mr. Germano. Well, I think a lot of these technologies, these advancements, are moving into the ambulatory space. We've done -- we are doing less and less in the hospitals or at least less time, and now it is moving into the outpatient environment.

We have to make sure that the health centers have the resources to take advantage of those technologies and those therapies. I know that we look at best practices all the time in our practice -- what can we do, how can we influence, for example, our state Medicaid authority to make sure that these

technologies are somehow added to our scope -- are paid for under our scope of services.

We have to make sure that our uninsured aren't left out of those advancements, and that's what the 330 program does is help us do that.

We have to stay on top of it. We have patient-centered medical homes now. We wrap services around our patients. The mental health piece is very important in terms of behavioral health. It is not just the technologies; it is actually helping people maybe change behaviors to take advantage of these things.

Mr. Guthrie. Okay. Thanks. I just have a couple questions.

So, Dr. Kowalski, thanks for being here today as well. I am the ranking member on Oversight and we have been looking at insulin pricing and barriers to diabetes care.

Can you please describe how the diabetes -- Special Diabetes Program helps -- decreases these barriers and is innovating for individuals with diabetes?

Mr. Kowalski. Well, I testified a couple weeks ago on insulin pricing and we have an issue in the United States. Nobody should die or suffer for lack of insulin. I think what we talk about here is we have innovation happening through SDP that --

Mr. Guthrie. The artificial pancreas is something that is

now available --

Mr. Kowalski. The artificial pancreas and a variety of more coming down the pike when you talk about cures -- potential cures -- and we need to ensure they're accessible.

So we have been working with members of Congress and across NIH and, of course, with our team to look at policies that ensure that the advances that we are seeing that are faster than I have ever seen in all my time in science are accessible to anybody who will benefit.

Mr. Guthrie. It is happening at such a rapid, rapid pace, isn't it?

Mr. Kowalski. Absolutely.

Mr. Guthrie. It is amazing how -- and I have two nieces with diabetes and so that -- I keep a pretty close eye on that as well.

So, Dr. Cooper, can you please just speak to how PCORI-funded research is taken up in practices and are there any long-term measuring tools that PCORI uses to track impact of PCORI research?

Dr. Cooper. Certainly I can do some of that. So I can tell you that in the work that I am currently doing the practices that we work with are -- many of them are community health centers and they are eager to test different evidence-based approaches in their own settings and to try different ways of actually

implementing the things that we know from NIH discoveries should be used in practice but aren't because often those studies aren't done in the real world practices with the people who actually have to deliver those services and treatments.

So I think there is a lot of enthusiasm to be engaged in PCORI type research and to problem solve with researchers around how to get these new discoveries actually implemented with the realities of the resources and the staffing that exists in the settings.

Mr. Guthrie. Can you measure the implementation of your research? Do you have measures to see how that is moving forward?

Dr. Cooper. So some of the measures we have have to do with, first of all, the levels of engagement with different stakeholders and what contributions they each make to the overall process and how that actually changes the work from its inception to when it is complete and then later on looking at to what extent the intervention or the program is taken up.

So we look to see, for example, how many people are actually using the intervention that's being tested, how many people are being exposed to it, whether it is being used with fidelity, so is it being used like -- as it was intended or is it being adapted and used in a different way.

And then we look to see to what extent that uptake actually

leads to the outcomes that we look at.

Mr. Guthrie. Okay. Well, thank you, and my time has expired and I will yield back.

Ms. Eshoo. The gentleman yields back.

Now I would like to recognize the gentleman from New Mexico, Mr. Lujan, for five minutes of his questioning.

Mr. Lujan. Thank you, Madam Chair, and thank you all for being here today.

I want to address a disturbing health trend among Native American populations in the United States. Native Americans have the highest rates of type 2 diabetes in the United States. Native American adults are also 2.4 times as likely as white adults to have diabetes, and in 2013 Native American women were twice as likely to die from diabetes as white women.

The reality is that Native Americans are unnecessarily dying from diabetes. As we have heard today, the Special Diabetes Program and the Special Diabetes Program for Native Americans are both extremely successful and have meaningfully improved patients' lives.

For example, since the establishment of SDPI, the prevalence of diabetic eye disease and end-stage renal disease have been cut in half.

I believe it is our responsibility to ensure that these vital

programs have the funding necessary to continue but also to expand.

Mr. Kowalski, in your testimony you highlighted the groundbreaking research SDP and SDPI have funded since their creation. For Native American communities disproportionately affected by type 2 diabetes, how do these programs ensure that they receive the access and quality of care that they deserve?

Mr. Kowalski. Thank you for that question, and I think this is a tremendous example of how evidence-based medicine -- we have had a number of questions about evidence-based medicine, and the implementation -- can it be cost savings and deliver true impact.

And I think you point out quite rightly that SDPI is serving an underserved community who is suffering from a disease that is often stigmatized but is highly genetic and inherited -- type 2 diabetes -- and requires significantly more resources deployed against it.

We know that these interventions can make a difference and you point out statistics such as the higher than average diabetes rates and death rates.

The prevalence of type 2 diabetes has plateaued since SDPI has been implemented. We know that the rates of diabetes complications are being reined in and I think this investment has been shown to be cost saving.

The reduction in diabetic kidney disease, which is completely covered by CMS, is estimated to be saving over $500 million since the implementation of this program.

So I think there is much more to do and I think the reauthorization of this program is a hugely important next step.

Mr. Lujan. Well, and that's my follow up is what happens if this program is not reauthorized?

Mr. Kowalski. Well, we know that diabetes is growing, of course, in the Native population. But this is across our entire country. And if we don't intervene we are going to see increasing costs driven by diabetes complications and management.

These interventions work. There is no doubt. This program is not just research for research sake. This is implementation that is driving better outcomes and saving cost.

So I think that time is of the essence and we need to get this reauthorized as soon as possible.

Mr. Lujan. Well, I appreciate the emphasis not just on the fact that this investment is cost saving, but the second part of my question is not just the importance of this reauthorization but to expand the service.

What more can be done to get services in areas where they are still needed that they're not getting out there?

Mr. Kowalski. There is no doubt that here in the United

States we have a problem on kind of both ends of the spectrum, meaning that even people with the best tools still struggle.

Diabetes is a very hard disease to manage. So when you're in an underservedved environment it is tremendously difficult and the investment in these communities pay huge dividends.

One-third of the Medicare budget is driven by diabetes complications. More investment will reduce cost and, of course, this is a human disease. We are talking about costs but these are families who are suffering and we need to do better.

Mr. Lujan. I appreciate your response very much and highlighting the importance of reauthorizing this important program.

And with that, Madam Chair, I yield back.

Ms. Eshoo. The gentleman yields back.

That is a stunning figure that you just gave, Dr. Kowalski. Say it again.

Mr. Kowalski. One-third of the Medicare budget, and that is because Medicare is paying for all end-stage renal disease, and when we look at the advances in diabetes care and new kidney disease drugs we expect, we could significantly reduce those costs.

Ms. Eshoo. Thank you.

I now would like to recognize the gentleman from Indiana,

Dr. Bucshon, five minutes for questions.

Mr. Bucshon. Thank you very much, and thank you all for testifying.

The programs we are discussing today are all very important. I think that is pretty clear. And I think we all agree they should be funded, the more years the better, for the reasons that people have outlined.

But that said, I have strong concerns about some of the bills before us for consideration which do not include the Hyde Amendment protections -- pro-life protections that have been in funding bills, preventing government funding for abortions, and that has been in place since 1976 and has been supported by both parties for decades until about 2016 when many Democrats began supporting government funding of abortions.

It is just an unnecessary partisan discussion injected into what is a discussion over critical programs that we need to authorize and it makes it difficult for Republicans to be supportive of the legislation in their current form.

I mean, Dr. Burgess introduced H.R. 2700 to reauthorize the Community Health Centers and National Health Service Corps, the Teaching Health Centers GME, Special Diabetes Program, Family to Family Health Information, centers in sexual risk, avoidance, education, and personal responsibility education for one year

and his bill would have used the savings gained from the recently passed -- at least committee-passed bipartisan drug pricing bills to fund that extension, even though it is short, it had a pay-for.

Instead, unfortunately, last week we used the money to fund partisan Affordable Care Act provisions, which Republicans can't support.

So I think if we are really serious about preventing these program authorizations from expiring, I think we need bipartisan legislation -- that we need to come to a bipartisan agreement on how to pay for these priorities, which we have in the past, and I look forward to working with my colleagues on both sides of the aisle to advance these critical policies in a fiscally responsible way.

Mr. Germano, in your testimony you talk about the important ability to provide dental, mental health, and overall health services to the homeless, which is a growing problem in all of our districts.

Additionally, you mention that you use telemedicine extensively, and I have a very rural district and am a big supporter of telemedicine. It is important.

Can you talk more about how the federal funding helps support these and other important services that Shasta community health centers provide?

Mr. Germano. Thank you for that question, Congressman.

Oral health, historically, has been one of the forgotten services that are needed in communities of need. Oral health disease is the number-one pediatric disease, period, in America.

We made a commitment through federal 330 dollars a number of years ago to build an oral health infrastructure and we have actually helped get a school of hygiene open because of our association with the junior college and expanding that access throughout our community. So a lot of leveraging that went on there.

Telemedicine is a great advancement in a rural community. We are -- we have consults with -- a thousand miles away with specialists in major teaching facilities, access that our patients would never ever get, really, truthfully, otherwise.

However, it is expensive. Not so much the technology but you're working with major teaching hospitals and what have you. So the 330 grant helps to subsidize a lot of that cost to allow us to do that and to have our patients be seen effectively.

Mr. Bucshon. Yes. I mean, I think a lot of things that -- I was a cardiovascular surgeon before I was in Congress and we do overlook dental and oral health and, obviously, we are struggling to make sure we have parity in mental health services, which I support, obviously.

And things like telemedicine and other things that I think community health centers in rural areas can provide is really critically important, and I am hopeful that we can come to an agreement on how to make sure that we get all of these programs that I mentioned reauthorized hopefully for more than just a year or two years, but longer, because as I think you outlined, this certainty involved in that is really a critical piece to this puzzle.

With that, Madam Chairwoman, I yield back.

Ms. Eshoo. I thank the good doctor and he yields back.

Now I would like to recognize the gentleman from Maryland, Mr. Sarbanes.

Mr. Sarbanes. Thanks very much, Madam Chair. Thank you to our panel over here.

So, first of all, I want to thank the chairwoman for bringing all these bills before us and having us discuss the importance of the reauthorization. These are all critical programs and there is a lot of bipartisan support, as you gathered, from just the comments of my colleagues today.

Mr. Germano, I wanted to talk to you a little bit about the community health centers. You have given very powerful testimony today to why continuing to fund those at robust levels and provide those resources is so critical, going forward.

Those health centers, as you know -- and maybe you could speak to this -- serve children and young people significantly. So you have a sense of the degree to which that's the case? The kind of numbers we are looking at, percentages or anything like that?

Mr. Germano. Across -- I can't give you across the country but it is substantial. I would say at least 40 percent or more in the most --

Mr. Sarbanes. Yes. I think it is at least 30 and in some places it exceeds that in terms of patients that are served by health centers who are children under the age of 18.

And I certainly want to thank my colleagues who have introduced H.R. 2328 and H.R. 1943 for maintaining our strong commitment to community health centers which support the needs of children.

But it is children's stake in these programs and services that has led me to kind of carve out a niche commitment or perspective here on the committee and in Congress with respect to strengthening school-based health centers because I really feel like you have a captive audience.

You, obviously, have the young people there, and if you can deliver services right there on site and do it in a consistent way and a comprehensive way, it can make a dramatic difference,

not just for those individuals -- for those students, for their families, for the community, for the health of the school, et cetera. You can spot issues that may be arising.

I think having mental health services as a key component -- integral component -- of what is delivered by school-based health centers is something that we need to examine more deeply.

Can you speak to -- and I know that I think about 50 percent of the school-based health centers in the country have some linkage to community-based health centers and maybe you could talk a little bit to that relationship because through that lens you would know of or have a perspective on how important it is to deliver those services at the school level because I really -- I have introduced some legislation that would strengthen the support of school-based health centers but I have always viewed the community health centers and their health as fundamental, kind of foundational to building off of that the school-based health response. So if you could speak to that, it'd be terrific.

Mr. Germano. Thank you for that question.

I think the advantage of school-based health centers -- you have mentioned it -- is they are there. They are there with the kids. They are there with the families.

But in my judgment, they are an island unto themselves unless they are connected to a system and that is what the health centers

are -- a system.

So you are a nurse practitioner in a school, you come across kids who may have onset -- new onset diabetes or other indicators, you need a referral in to the services we provide, which would include maybe seeing the pediatrician at my health center.

Maybe needing the diabetic counselor. Maybe helping mom and dad with how to plan for their -- you know, buying food and those kinds of things. Getting them signed up for Medicaid if they're eligible.

So the connection to the network, to the system, is really important, I think, in terms of maximizing the value on the ground for those services in the schools.

Mr. Sarbanes. I appreciate that, and, again, I come back to this concept that it is a huge lost opportunity if you don't site some of these health services in the place where you have hundreds, thousands, potentially, of individuals that can take advantage of them.

So resourcing them is important. Examining best practices of these school-based health centers -- what it means to design a comprehensive school-based health center sort of covers the waterfront in terms of what you would want to see.

And then to your point, making sure that the linkages are there so that you can, you know, make the right kind of referrals,

you can step back, get a more holistic view of what that individual and their family needs, et cetera, and then provide other services as a result.

So we are going to continue to really lean on this effort around school-based health centers but make sure as we do it that we are connecting it to the community-based health centers, and so keeping them strong, which is what you are here to testify about today is, obviously, key.

And with that, I yield back my time.

Ms. Eshoo. The gentleman yields back.

Pleasure to recognize the gentleman from Illinois, Mr. Shimkus, for five minutes of his questions.

Mr. Shimkus. Thank you, Madam Chairman.

I would like to yield my time to Congressman Guthrie of Kentucky.

Mr. Guthrie. Okay. Thank you for yielding.

Dr. Cooper, the PCORI-funded study you are leading is comparing two ways to treat high blood pressure. Who will this research benefit and how do you envision the outcomes of this research changing the way care is delivered?

Dr. Cooper. Thank you. I think the research will benefit several different groups of people.

So, first of all, it will benefit patients who have high

blood pressure and who often have other chronic conditions as well -- because we are studying people who have more than one chronic condition -- and we are helping them to figure out whether working with a team that includes a nurse and a community health worker and also access virtually to specialists works better than simply going to a clinic where they get information in a brochure.

And so I think if we can show that that works, patients will be able to request to work with a nurse community health worker team to help them address their issues more comprehensively.

It'll also help clinics and health centers that are trying to decide how to staff to take care of patients with certain needs -- hypertension and other chronic conditions as well as social determinants of health, because we are working with underserved communities, and it'll help them figure out what resources they need, what staffing they need, and also provide them with ways to train and monitor that -- those programs.

So that is -- I am hoping that that will benefit patients as well as health systems and then also help providers to figure out what kinds of programs they can refer their patients to when they need extra support.

Mr. Guthrie. Okay. Thank you.

And, Mr. Germano, community health centers program's annual funding has more than tripled between fiscal year 2002 and 2018

due to increases in community health center fund.

The grants have been used for broad purposes and types of grant-supported program activities have expanded and changed over time. So since the establishment of the community health center fund in 2011, in general, how have these grant funds been used and how have the new investments changed over time?

Mr. Germano. I think -- thank you for that question.

The biggest increase is in new sites and new services. We have seen a tremendous expansion of the community health center model across the United States.

More and more underserved communities have created these community health centers. Existing health centers have expanded into new communities. Services mentioned earlier -- oral health, mental health, telemedicine, health care for the homeless, HIV care -- Ryan White.

So we have really reached out with those dollars and have more and more impact. We are now at 28 million Americans who are cared for by community health centers. I would like to see that doubled. We have 84 million people in America right now without a good primary care home and that is what we can represent is a good primary care home for them.

Mr. Guthrie. Okay. Thank you.

That is my questions. If anybody wants my time I will yield

back.

Mr. Butterfield. [Presiding.] The gentleman yields back.

The gentleman from Oregon, Mr. Schrader, is recognized for five minutes.

Mr. Schrader. Thank you very much, Mr. Chairman. I appreciate it.

Dr. Cooper, thanks for being here. As one of the original sponsors of the bipartisan bill that put PCORI into effect, the Comparative Effectiveness Research bill in 2009. So very interested in the work that you're doing and trying to bring it to fruition and implementation.

The main goal was to make the health care system work a little better, centered around the patient, best outcomes. Did some initial investment. You have indicated it has been paying off. You gave several different examples of, you know, cases where you came up with some pretty interesting things that you're trying to disseminate out there to the marketplace, to different clinics, hospitals, et cetera.

Things have changed a little bit in the intervening 10 or 15 years and particularly in the drug space. Things are becoming very expensive. Some lifesaving medications -- there has been the discussion on this panel about value-based reimbursement for some of these, you know, medications and what have you and the

cost of treatment, the co-pays, et cetera, are getting a little more attention for that upper middle class in the Affordable Care Act.

So would you agree that cost of treatment is part of a patient's consideration when deciding what -- where to go and what type of therapy to have?

Dr. Cooper. I certainly think that cost is part of the patient's consideration and people do need to often factor that into their decision making around what care or approaches they want to take and will be accessible and affordable to them.

Mr. Schrader. So given that and the problem we have that PCORI is expressly prohibited from considering cost effectiveness in its mission, should we be thinking about tinkering with that a little bit and include the cost of treatment as part of an impact so that the patient has the full understanding of what they're coming up against, given the fact there is so many great treatments out there?

Dr. Cooper. So I think it is up to you as the lawmakers to make that decision. I think that information is important and it should be studied somewhere and whether it comes through the way that PCORI is funded or authorized or through some other mechanism, I am sort of agnostic to that.

But I think we would all agree that it is important work

that needs to be done and coordinated with the work that's happening at PCORI, either coordinated or done there.

Mr. Schrader. All right. Thank you. Thank you.

A little concerned that CMS is not particularly implemented or at least from my understanding chosen to really adopt some of the great recommendations that are coming out of PCORI.

Is there a way we should be talking with them or trying to get them to perhaps use some of your recommendations a little bit more recent or a little more ongoing basis? The outcomes are good.

Dr. Cooper. Right. I definitely would encourage that. I think one of the things that PCORI does encourage is conversations among researchers and payers and insurers so that they are all at the table and they're involved in the design of the work and we are answering the questions that are relevant to them so that they can use that information in decisions about resource use and follow-ups.

But any other support that we can get in that realm I think would be very helpful.

Mr. Schrader. How about incentivizing CMS? You know, there are some great practices -- get a chance to use that again. We are talking about value-based reimbursement, getting good outcomes.

Dr. Cooper. I think incentivizing patient-centered outcomes is important and oftentimes we have been incentivizing, typically, clinically and biomedically-based outcomes and I think it is important to also incentivize health systems that pay attention to things that matter to patients and their families.

Mr. Schrader. I think particularly given CMS's clout and the influence they have it would be nice to get them behind some of these and help disseminate that information.

Mr. Germano, popular guy here today. We all love CHCs -- you know, critical to bringing health care to a lot of folks that can't afford -- that have no other access, actually.

But I am a little concerned that the alignment between some of the outcomes that HRSA uses to judge, you know, how the CHCs are doing don't align necessarily with the Medicaid outcomes.

For instance, if you're a health center, child immunizations have to be completed by age three. If you're a managed care organization, it is age two. You know, would it be smart to maybe try and sort of align both the CHC outcomes with the Medicaid outcomes too?

Mr. Germano. Please, can you make that happen?

[Laughter.]

Mr. Germano. It does drive my clinicians up the wall because

we have all these multiple standards and what are we held to and what are they held to.

So to the extent -- I mean, I think we are working on it with our Medicaid managed care plan or state, not so sure about HRSA but trying to get them all aligned to agree as to frequency and what the goals are so that we can work towards them.

It is maddening, in many respects, that we have to do -- deal with it.

Mr. Schrader. Thank you. Oregon, I know, is working on that, and I yield back, Mr. Chairman.

Mr. Butterfield. The gentleman yields back.

The gentlelady from Indiana, Mrs. Brooks, is recognized for five minutes.

Mrs. Brooks. Thank you, Mr. Chairman.

I am going to start with you, Mr. Germano, but I have several questions for the panel, and thank you all so very much for being here.

Can you further discuss the kind of treatments that community health centers are using combatting the opioid epidemic?

Mr. Germano. Thank you for that question.

Our primary mechanism is to use buprenorphine Suboxone -- medically-assisted therapies. We have created clinic systems around that. We have about 200 patients now in therapies right

now. Behavioral health is a big component of that; not just the drug, but the behavioral health and the follow-up.

So we are -- we have doubled that program in a year. We are probably going to double it again and we are going to add it to our maternity services as well.

Mrs. Brooks. And do you know is that a trend that you are seeing with other community health centers?

Mr. Germano. Very much so. I think we are gaining confidence as a system that it works, it is helpful, and if done correctly with behavioral health it can be very effective for our communities, yes.

Mrs. Brooks. One of the concerns that I have is the workforce shortage, and while we have talked about physician shortages, and I appreciate you talking about the issues with graduate medical education, I have introduced an Opioid Workforce Act because, as I understand, one of our biggest concerns in the treatment of opioids is the lack of a trained workforce.

In the teaching community health center model, are there any addiction medicine programs for residents that you're aware of and is that -- Representative Schneider and I from Illinois have introduced this Opioid Workforce Act to try to increase Medicare-funded residency slots for addiction medicine specifically. Are you familiar with any of those types of

programs?

Mr. Germano. I am not. But I will say this much. In our own residency program, we have made the MAT program a core part of their training. So when they are done, they are X waivered and they are ready to go when they finish training.

Mrs. Brooks. That is excellent. Do you know if that is something that other community health centers are doing as well?

Mr. Germano. I believe that many of them are doing that. I can't say all of them, but I am familiar with several that are.

Mrs. Brooks. Would additional funded residency programs make that more possible or do you think there is a need for any specific addiction medicine residencies?

Mr. Germano. I really can't answer that question. All I can say is in the teaching health center world, because our communities are suffering from the scourge of opioid abuse, they should be training their residents in this field. They should give them comfort.

Mrs. Brooks. And so you'd like to see all -- would you like to see all the primary care residency programs include your medication-assisted treatment training?

Mr. Germano. I think every community has to decide what is a priority. But from what I have seen across this country,

I would say yes.

Mrs. Brooks. Dr. Cooper, I would like to ask you about the PCORI program relative to opioid and pain management. You talked about it a little bit in your written testimony, and I am sorry, I had to go to another hearing and missed your testimony here. Can you talk a little bit about PCORI-funded programs relative to addressing the opioid epidemic?

Dr. Cooper. Sure. So I did mention the one where there was an initiative targeting providers and getting them to decrease prescribing of opioids.

There are other programs looking at team-based models of care for opioid addiction, different programs focusing on how to monitor medication used for patients, also looking at different approaches that combine medication such as Suboxone with cognitive and behavioral therapy included.

So a number of different programs comparing different strategies for addressing opioid addiction.

Mrs. Brooks. Thank you.

Shifting just for a moment, Dr. Kowalski, congratulations on your new role and I have been involved in the Special Diabetes Program reauthorization in the past and I know we have spent a fair amount of time asking about the funding and so forth.

What are the greatest challenges that are remaining as you

have taken on this new role and the obstacles? What are kind of the biggest obstacles in the disease that concern you the most and the greatest challenges that you face, and how can the Special Diabetes Program help overcome those?

Mr. Kowalski. I will echo what we have heard today. The lack of clarity on sustained funding is a big obstacle for us in diabetes as well. In your home state, we have IU doing some of the most innovative work in the immunobiology of type 1 diabetes, an autoimmune form of the disease.

TrialNet has played a pivotal role in our understanding of potential interventions to slow, prevent, and ultimately, we believe, cure the disease.

The NIH and the SDP play a pivotal role in driving that research forward. So a sustainability of funding at a moment where we are seeing science exploding, not only in type 1 diabetes; there is a lot of overlap in other autoimmunity that we are working -- MS, celiac, rheumatoid arthritis.

That progress needs to be sustained and we need to keep that momentum going.

Mrs. Brooks. Thank you. Thank you for your work, everyone.

I yield back.

Mr. Butterfield. I thank the gentlelady.

The gentleman from California, Dr. Ruiz, is recognized for

five minutes.

Mr. Ruiz. Thank you, Mr. Chairman.

First, I would like to thank Congresswoman McMorris Rodgers for co-introducing the Training of the Next Generation of Primary Care Doctors Act with me.

This bill will reauthorize the Teacher Health Centers Graduate Medical Education Program, which will soon end in September 2019 and it will add more primary care doctors in the communities that need them the most.

I know a little bit about this because I grew up in the very underserved community of Coachella -- farm worker family -- and when I came back after leaving home and coming back as a doctor I set to mission to really address the health care crisis that we have in the area.

And I did research with some of my students that I was mentoring -- pre-med students -- and we came up with the Coachella Valley Health Care Initiative and Health Care Access Report, and we counted that there was one full time equivalent doctor per 9,000 residents in large segments of the Coachella Valley.

And you usually think of Coachella Valley as lush country clubs, right. But there are a large portion that still struggle to get the care that they need. It is one of the reasons why I ran for Congress as well and it is the primary reason why I

set off to be a doctor.

The medically appropriate number -- recommended number is 1 to 2,000. So we are 1 to 9,000. To be determined as medically underserved it is 1 to 3,500. So we have a lot of work to do and the Teaching Health Center Graduate Medical Education Program was created under the ACA in the effort to get more doctors in medically underserved areas.

You see, we have a drastic physician shortage crisis everywhere in America in terms of absolute numbers. But the secondary crisis is that they are maldistributed, leaving large portions of our country very medically underserved without doctors.

And as we know, those of us who practice and study this that the two largest predictors of where a physician will eventually lay roots and practice are where they are from and where they last train.

So I built pipeline programs from the underserved communities through my physician -- Future Physician Leaders Program, getting them from high school, putting them through undergrad medical school with the USR School of Medicine and then training them in underserved areas, and that is the best way that you're going to address the physician shortage crisis in the underserved and rural areas.

So this program works. The Teaching Health Center Graduate Medical Education Programs work. In 2017, statistics show that 82 percent of Teaching Health Center graduates remain in primary care compared to 23 percent of traditional GME graduates.

Fifty-five percent of Teaching Health Centers' graduates practice in underserved communities, compared to only 26 percent of traditional GME graduates, and 20 percent of Teaching Health Center graduates practice in rural settings compared to only 8 percent of traditional GME graduates.

And I am working in my districts with Borrego Health and Neighborhood Health and Clinicas de Salud del Pueblo to really address this and bring in more residents into the underserved areas.

So Teaching Health Centers truly take a different approach to graduate medical education by placing residents directly in the communities most in need of care.

Dr. Germano, in your testimony you referred to it as "grow your own" strategy. Could you further explain how Teaching Health Centers training experience and outcome is different from traditional GMEs?

Mr. Germano. Thank you both for you commitment to the Teaching Health Center Program. And I am not a physician so --

Mr. Ruiz. I've got one minute, so I got too many questions.

Mr. Germano. But, really, it is about seeding programs in underserved communities and rural areas, in particular, have a tough time just as --

Mr. Ruiz. And is different from traditional GMEs how?

Mr. Germano. In that we identify young people with a commitment to serve in our community that come from our community and we train them, and that is how we do it.

Mr. Ruiz. Right. The other problem is that for these programs most of them have residencies that require three years, right. That's one of the minimum years for a family medicine residency program. But we have been reauthorizing them for two years. Why is that a problem?

Mr. Germano. Well, every class you take is a three-year commitment. When you have two years' worth of funding, it creates a lot of insecurity.

Mr. Ruiz. Exactly. So this is going to add funding for five years and, hopefully, will start to change that problem.

The other issue we have is the not only disparities in the diversity or lack of diversity in physician workforce but we also know that if you train more Latinos and African Americans, et cetera, they will go to -- more likely to go to Latino and African-American communities and they tend to be underserved as well.

So how does this help that?

Mr. Germano. Well, again, it is that pipeline from our own communities, from the faces of our community into the medical -- just like what you are doing down your way.

We are trying to do that across the country in teaching health centers, drawing from our community -- our own underserved populations, moving them through, looking like the patients that, you know, they are going to take care of.

Mr. Ruiz. And that is not just important in the overall idea of diversity is good, but when a patient understands the instructions and when the doctor understands the community in which they live in, they are better able to tailor the therapeutic recommendations and advice so that the patients can actually implement them.

And studies have shown that patients are more compliant, especially if they understand through the cultural nuances and language -- they are more compliant and they have better outcomes.

So it is actually -- when you want to measure value of public health, having physicians who are similar and can understand the life experience of their patients will lead to better health.

Mr. Germano. I agree.

Mr. Ruiz. I yield my time.

Mr. Butterfield. The gentleman's time has expired. The gentleman yields back.

The gentleman from Florida, Mr. Bilirakis, is recognized for five minutes.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it.

Mr. Germano, give Florida's traditionally higher senior and veteran populations, maintaining a skilled health care workforce is critical. It becomes even more of a challenge when student debt drives where residents choose to practice.

Often, it is our rural and traditionally underserved areas who suffer, unfortunately. According to HRSA, a family medicine resident physicians who train in health center settings are nearly three times as likely to practice in underserved settings after graduation, when compared to residents who did not, underscoring the value of the Teaching Health Center Graduate Medical Education Program.

That is why I recently joined my E&C colleagues introducing a fully paid for measure to extend this program -- H.R. 2700, the Lowering Prescription Drug Costs and Extending Community Health Centers and Other Public Health Priorities Act.

How often -- the question is, again, to Mr. Germano -- how often do medical professionals choose to stay in a medically underserved area once federal funding is no longer available?

Mr. Germano. Well, that -- gosh, it makes it hard, because they are making a commitment of their life, right. It is their practice and then their family, and they need to have some sense of security.

Mr. Bilirakis. Sure.

Mr. Germano. When they don't have that, they have choices. The marketplace -- there are so many opportunities that going to an underserved community isn't going to be high on their list if they don't feel security.

So we have to create a secure environment in order to attract and keep them.

Mr. Bilirakis. Yes. How do you propose we do that?

Mr. Germano. Well, I think stable funding is huge. The messaging that comes from that, that you're going to be here for the long run, that this is a commitment. We are stable as an organization and, obviously, we need them in our communities.

So they are wanted and needed and we can help support them in their lives.

Mr. Bilirakis. Okay. Next question. Can you describe how community health centers -- I am a huge proponent of community health centers, as co-chair of the caucus -- how are they -- and then also the community clinics -- how are they sustained?

Mr. Germano. We have multiple funding sources. The 330

is the building block which we all work from. We have -- Medicaid is another big piece of it. Medicare is another large piece of it.

I mentioned the 330 program. We have state resources, private -- we put it all together. We are not dependent on just one but you pull one of those cards out, particularly the 330 program, and sort of the whole thing falls apart.

So we pool our resources together to serve the greatest broadest scope of services to the biggest number of patients that we can reach. So all those -- it is a piece of everything, including 340(b) and others -- other income.

Mr. Bilirakis. What is your position on veterans having access to community health centers and actually the community health center would be reimbursed by the VA? And, you know, there aren't a lot of -- in some rural areas, you know, you don't have a lot of access. We don't have VA clinics in some areas, VA hospitals.

What is your position on that and can the community health center actually provide for those veterans? Is there room for that?

Mr. Germano. I think -- it think that is already happening in many places where the -- there the Veterans Administration has reached out to the community health centers, and I think they

are limited by capacity issues -- going back to workforce again.

But I think there isn't -- other than technical barriers in terms of, you know, how payment is made and those kinds of things -- contracts -- I think health centers would readily embrace doing more for their veterans.

Mr. Bilirakis. Yes. And, you know, we would like the veteran to have the choice to go.

Mr. Germano. Absolutely.

Mr. Bilirakis. Instead of the VA saying, you know, you can go into the community, the veteran should have the choice to go to the community health center because, again, the care is very good.

Mr. Germano. So we have a health care for the homeless program and probably a quarter of our homeless are veterans. And so we pull them into the system and help them.

Mr. Bilirakis. Well, thank you very much. Thanks for what you do.

I yield back, Mr. Chairman.

Mr. Butterfield. The gentleman yields back.

At this time the chair recognizes Mr. Gianforte from Montana.

Mr. Gianforte. Thank you, Mr. Chairman. I appreciate you having this important hearing. It is imperative that we find common ground on these very bipartisan programs so that there

is no lapses in funding.

Community health centers, National Health Service Corps, Teaching Health Centers, and Special Diabetes Program for Indians, and the mental health are all incredibly important to the state of Montana.

I fully support these programs and the work they do in our state. We need to ensure that they are funded. Robust public health programs lead to future savings and better health outcomes for all.

I am concerned, however, by our lack of ability to pay for increased funding levels for these programs. We need to ensure that we strike a balance between fiscal responsibility and guaranteeing that all have access to high-quality primary and mental health care.

So I thank the panel for being here today and I want to start with a question here for Dr. Kowalski, if I could. In your testimony, you mentioned the differences between type 1 and type 2 diabetes, and that the American Indian and Native Alaskan population have a disproportionately higher and are affected by type 2 diabetes, in particular.

Can you elaborate a little bit on the differences between type 1 and type 2 and also why the Native American population has such a high incidence?

Mr. Kowalski. Sure. So type 1 diabetes is a form of diabetes that is caused by an autoimmune response to the cells that make insulin, thus rendering people unable to make insulin and requiring replacement.

Type 2 diabetes is a metabolic disease where the body makes insulin but it doesn't work as well. And so why are some populations more susceptible?

That is a huge area of research but we do know it is very genetic. Again, earlier I said this is a disease that is stigmatized and I think tremendously unfairly because these are problems that are inherited and we see in Native populations across the globe a higher propensity.

So this investment in helping people who are underserved with type 2 diabetes, namely, in this case, our Native populations, pays huge dividends in terms of the quality of their lives, their reduction in risk for all of the types of damage that high blood sugar causes -- eye, kidney, and heart disease.

And we have seen the proof is in the pudding. The return on investment on this program has been very, very high.

Mr. Gianforte. So you would advocate for increased focus on type 2 diabetes in Native populations?

Mr. Kowalski. Both forms of diabetes are under funded by Congress. So we believe that both SDP and SDPI are really a tip

of the iceberg -- that there is an unmet need here that is significant.

Mr. Gianforte. Okay. Thank you.

Mr. Germano, unfortunately, Montana has the highest incident of suicide in the country. We also have a methamphetamine abuse epidemic.

What role do community health centers play in serving -- ensuring that patients have access to mental health?

Mr. Germano. Thank you for that question. Community health centers of today have really embraced what we call integrated behavioral health. There is a stigma tied to going to a mental health system for some people, and unfortunately so. But they'll go to their family doctor -- their community health center.

We have embedded behavioral mental health folks in our primary care practices. We introduce them to them. We connect them to those. We screen for those behaviors -- depression, anxiety. We connect them to resources. We work together with their family doctor, nurse practitioner, PA.

So it is a huge access point for people who could be, you know, subject to, you know, taking their lives, which unfortunately is also the case in my region, and that's why we have done a lot in this space.

The addiction piece is another growing element of the health centers. We have gotten into the medically-assisted therapies in a big way and in combination with also our behavioral health services because it takes not just the therapies but also the mental health support as well.

Mr. Gianforte. Yes. I recently held a round table on mental health and substance abuse, and I was surprised at how intertwined these two things are and very hard to diagnose between.

Can you talk about what the community health centers are doing, given how closely related mental health and substance abuse are?

Mr. Germano. Well, the first thing is we had to get over our own biases and understand, and I think we have, very quickly -- that there is definitely a behavioral health component to a lot of these situations and needs of our patients and working collaboratively, like I said, between our primary care clinicians and our behavioral health specialists and our psychiatrists, in some cases, who think about what's best for the patient and their families and their significant others. So that's it.

Mr. Gianforte. Okay. I want to thank the panel, and these are important programs. We need to make sure they continue.

With that, I yield back.

Mr. Butterfield. The gentleman yields back.

The gentleman from Illinois, Mr. Rush, is recognized for five minutes.

Mr. Rush. -- that are vital to my constituents and, importantly, it is absolutely critical, Mr. Chairman, that we do not allow the DSH payments to be cut now or in the future. The funding -- this funding is critical to my county -- Cook County's level one trauma centers and burn centers and emergency preparedness plans for my county, and if these cuts were to go into effect, not only these services but all health care services that serve those folks in need would be severely at risk and it would be -- this is totally unacceptable and I am glad to see this subcommittee taking an aggressive and upstanding posture as it relates to coming up with some solutions for this pending problem, and I am proud to be a part of this subcommittee under the leadership of the chairman.

I want to take a moment to discuss community health centers. You know, community health centers assure that health care is affordable and accessible for patients in my district and around the country. There are eight federally funded health centers in my district that serves almost 341,000 patients each and every year, and in my state two out of 10 patients are unserved and six out of 10 are Medicaid beneficiaries. Without community

health centers, we would be far worse off than we are right now.

And so I have a question I want to ask Mr. Germano. Mr. Germano, I am concerned about pharmaceutical deserts -- pharmaceutical deserts. Does your health center dispense prescriptions?

Mr. Germano. We have -- yes, we do. We do quite a bit, actually.

Mr. Rush. All right. There are many drug stores -- Walgreen's and CVS, CVS particularly -- that are closing down in underserved communities and putting at risk particularly the elderly who depend on these drug stores for their filling of their medication -- refilling of their medication.

With these closures, seniors, the poor, those who are risk, those who are ill, have to travel many miles in order to get their medication, and that is why we -- there have been some published articles around pharmaceutical -- what they call pharmaceutical deserts.

So my question, if given the authority do you believe that there is a role that community health centers can play in running free-standing pharmacies and would it be helpful if there were public-private partnerships between private pharmacies and community health centers?

Mr. Germano. Thank you for that question, Congressman.

Around me are a number of frontier health centers. They're out in communities where the local private pharmacist has retired or left, and you're right, there is no pharmacy in their community and they have to travel an hour or two, in many cases, to the small cities that they can get to.

It really is a problem with compliance. My health centers have worked really hard -- my colleagues out there in terms of things like mail order pharmacies to try to connect people that way.

There is telepharmacy that is being, you know, developed out there that can help as well. We keep stocks of medicines -- certain kinds of medicine -- to get people started until we can find a more stable source.

Health centers have pharmacies. Many of them do. Many of them run their own. In my case, it is a public-private partnership. We have a local pharmacy that actually is embedded in my health center. So we work together to deliver that service to our patients.

It really is about compliance and what's in the best interest of the patient.

Mr. Rush. Thank you, Mr. Chairman. I yield back.

Mr. Butterfield. I thank the gentleman.

The chair now recognizes himself for five minutes -- five

absolute minutes.

Mr. Germano, again, thank you. As the other colleagues have said, thank you for being here today.

Last week, I visited Lincoln Community Health Center in Durham, North Carolina, which is formerly Lincoln Hospital, which was named for the 16th president of the United States.

Lincoln is Durham County's main provider and primary health care for low-income, under insured, and uninsured patients.

The chief medical officer there and his team do remarkable work under very difficult circumstances. Seventy percent of the patients treated at Lincoln are uninsured or under insured.

Over 70 percent are living at or below the poverty rate. They epitomize the vital work being done in community health centers like yours and many others all across the country and I underscore why today's hearing is so important.

Sir, let me ask you. I wanted to talk with you about the National Health Service Corps. You mentioned that you have a number of them at your health center today.

I have long championed this program. Last Congress I introduced 3862, which is the National Health Service Corps Strengthening Act, and this year I led the NHSC Member Funding letter to the Appropriations Committee because I know it is a critical recruitment and retention program for health centers.

Like the Rural Group in my district, they have successfully used it recruit a number of providers over the years but ran into trouble last Congress when we let funding expire, at least for a time.

We were eventually able to get the funding extended but the Rural Health Group lost out on an OB/GYN that they were recruiting at the time. We must extend this valuable program before it expires once again in September.

You mentioned a bill that I am co-sponsoring, H.R. 1943 -- that's not the year I was born but it is pretty close -- introduced by my colleague and good friend, Congressman Clyburn, that would expand the NHSC.

Can you tell me what it would mean to the program if we were to enact the funding level proposed in that bill, if you are familiar with that bill?

Mr. Germano. Yes, thank you for that question. That bill would actually fund every applicant to the program. It would be successful -- almost every applicant obtaining a contract to serve in an underserved community.

Right now, only about 40 percent do. So that bill -- that funding bill would allow 100 percent of all applicants to be able to be contracted under the National Service Corps and serve their

communities.

Mr. Butterfield. Do you support the bill without reservation?

Mr. Germano. Absolutely. Sure.

Mr. Butterfield. Thank you. I yield back.

The gentlelady from Illinois, Ms. Schakowsky, is recognized for five minutes.

Ms. Schakowsky. Thank you so much, and I am always so grateful to be able to waive onto this subcommittee as these issues are so important to me.

By 2032, the United States may face shortages of over 100,000 physicians. But I actually would argue that we already have significant physician shortages today because of the fact that health care access is not equitable across race, socioeconomic status, and geographic location.

This status quo is unacceptable for our growing aging population, for our children, and for all vulnerable communities in our country.

In order to address the shortage and improve health care access, I am fully supportive of all of the bills that are in front of us in this subcommittee today, especially those that address inequalities.

It is clear that we have to reauthorize the National Health

Service Corps and the Teaching Health Center Graduate Medical Education Program for at least five years, if not longer, and increase funding levels to strengthen our workforce and increase access to care.

On May 17th, Ranking Member Burgess and I introduced H.R. 2783, the EMPOWER for Health Act -- a long acronym -- Education Medical Professional and Optimizing Workforce Education and Readiness Act -- that spells EMPOWER.

And the EMPOWER for Health Act is designed to increase access to health care in underserved areas and ensure that more diverse health care workers -- workforce is able to meet the needs of our entire population.

When we pass this bill, we will finally reauthorize critical Title 7 funding for -- that would ensure people around the country have access to skilled physician and medical professionals regardless of who they are or where they live.

Mr. Germano and Dr. Cooper, I wonder if each of you could discuss why it is so important that we not only support our physicians through the National Health Service Corps and the Teaching Health Center Graduate Medical Education Program but also ensure that we are building a diverse health care workforce as the aim of this legislation, the EMPOWER for Health Act. We can start with you, please.

Mr. Germano. Sure. Thank you for that question.

Debt is a huge issue for medical students. The average debt is $240,000 coming out of medical school, and much higher. I have had doctors, $300,000, $400,000. My son is a resident. He's going to have $400,000 worth of debt by the time he is done. It is untenable, and that is a factor in them choosing primary care practice as an option in residency because, unfortunately, there is a gap between what certain specialties make and what primary care clinicians make. So that's a problem.

You can even that gap out with things like the National Service Corps. You can take some of that pressure off and help them to -- make it easier for them to choose what they want to do, which is to work in primary care if they could.

So I think that is a huge issue. And in terms of the Teaching Health Centers, we are in the communities that are underserved. As was mentioned earlier, we look at pipeline. We look at residents -- medical students -- who have a heart and have a connection to our communities -- reflect our communities.

They are the ones who are going to be most effective and successful, and that is why we are such big supporters of it.

Ms. Schakowsky. Thank you.

Dr. Gordon? Cooper. Dr. Cooper. I am sorry.

Dr. Cooper. So --

Ms. Schakowsky. And if you could talk to about how diversity then is affected.

Dr. Cooper. So, you know, one of the areas in which I have spent most of my career is better understanding and addressing disparities in health care, and although there are a lot of different factors that contribute to those disparities, one significant one is the lack of diversity among health professionals. So some of the earlier work that I did actually did document that when there was ethnic and racial concordance and language concordance between patients and providers that patients had better experiences and in some instances actually better quality of care as well.

So we know that it is important, not necessarily that every patient has an ethnic or racially concordant provider, but we know that ethnic concordance and we know that diversity within the health professions actually contributes to better cultural competence among all physicians, right, because it changes the culture of the profession and it broadens cultural sensitivity and knowledge of different social determinants and those factors within the profession. So it is critically important.

And I also think that funding for agencies like PCORI that does address the needs of underserved populations and addresses disparities and care and health outcomes is an encouragement to

people from diverse backgrounds who want to pursue careers that are focussed on research. But if they feel that the research that they're interested in or that will benefit their communities is not being supported, that's also a discouragement.

So I think that, you know, all of these programs -- the funding for training in clinical care as well as in research -- are factors that will help to enhance the diversity of our profession.

Ms. Schakowsky. Thank you so much. I am way over time. I yield back. Thank you.

Ms. Eshoo. The gentlewoman yields back.

I now would like to recognize the gentleman from Oregon, Mr. Walden, for five minutes of his questions.

Mr. Walden. Thank you, Madam Chair, and again, thanks to all of you for being here and your testimony and answers to our questions.

Mr. Germano, health centers are oftentimes the only provider in our rural areas, and my district is just north of you. You're in Redding. I am across the border in Oregon.

So in addition to isolation and distance, what other challenges should we be aware of that you face? I kind of have an idea because I spend a lot of time with my health care -- health center folks.

But what do you run into? What do you hear from your colleagues?

Mr. Germano. Well, I think that transportation is a big problem and particularly sometimes it is tough even getting people into our little town of Redding, let alone if they need to go to a big teaching center like down in Sacramento or San Francisco.

So we run into that issue quite a lot, and there is also smaller groups of, like, for example, for Laotians and others. Language can be an issue if it is not common. But there is groups that need care and you have to try to wrap services around them that are effective, so interpretation --

Mr. Walden. What about broadband and telehealth? What do you run into there? Do you run into cross-state issues on medical licensure?

Mr. Germano. Yes.

Mr. Walden. You mentioned it takes 18 months or whatever to fill --

Mr. Germano. Recruit a physician, yes.

Mr. Walden. I mean, it seems to me -- I mean, I run into this and you're going across state lines. My district border is Washington, California, and Nevada --

Mr. Germano. Yes.

Mr. Walden. -- and the rest Oregon, and some of this

doesn't make sense anymore in today's telehealth world to have these --

Mr. Germano. Artificial barriers.

Mr. Walden. Thank you.

Mr. Germano. Yes.

Mr. Walden. Do you run into that?

Mr. Germano. Yes, we do. We have to pretty much stay to California when it comes to telemedicine for those various reasons. Whether it be liability, licensure, our state requirements, our Medicaid plan, it really limits us to our own region and it is problematic on the borders.

Mr. Walden. Right.

Mr. Germano. That is where you -- you know, you could have a great facility 10 miles north of you and you can't access it because you're in another state.

Mr. Walden. Mm-hmm. Yes, we face that a bit on the east side, going up against Boise or you might be -- now, the veterans -- I think Veterans Administration can go nationwide.

Mr. Germano. Yes, they figured it out. Yes.

Mr. Walden. And there should be a way we could -- it is something we ought to -- I don't know how we deal with this, your state's rights versus whatever. But, you know, come on. You might have the expert 10 miles away --

Mr. Germano. Exactly.

Mr. Walden. -- and you literally can't access them. So and then can you help me and the committee -- explain the differences between the Teaching Health Center GME program and other GME programs.

Mr. Germano. Very briefly, the graduate medical education Medicare CMS program is an entitlement program. They go by a whole separate set of rules. They have to follow the same accreditation requirements we do under the American Council of Graduate Medical Education. But their funding stream is hospital based, typically. That is where their funding comes from.

The Teaching Health Center Program is really about -- the funding runs through the community health centers or the consortia of partners, and then we are able to, within the scope of those accreditation requirements, tweak their training to reflect our reality.

Mr. Walden. Got it.

Mr. Germano. For example, we do a lot more in homeless health care with our residents. Our medically-assisted therapies is another, you know, core element of what we do, which is different than hospital-based training.

Mr. Walden. Yes, it is really important and I think we've got to figure out how to make sure we are staffing up -- that

you are able to staff up. I run into that as well, just the recruitment and the retention. What I have also found is if they come through one of these programs and practice in that area there is a higher likelihood they stay. Is that what you run into as well?

Mr. Germano. Well, the data shows that, you know, and we are a living example. I mean, I would like to keep more. I would like to keep more of our residents in our community.

But all of them stay in primary -- nearly all of them stay in primary care, key one, and two, almost all of them stay in working in underserved communities. So that's the other benefit. If not ours then their neighbors. So yes, the model does work.

Mr. Walden. Mm-hmm. Okay. That's, I think, all I have, Madam Chair, at this point. So I yield back.

Ms. Eshoo. I would like to work with you on this -- on the -- you know, on the licensure and all of the complications of not being able to go over state lines. It is not defensible anymore and there are so many communities that would benefit from our fixing that. So let us put that on the to-do list.

I know that Mrs. McMorris Rodgers is waiting. But we need to take the members and then you will waive on. So I will now recognize Mr. -- the gentleman from California, Mr. Cardenas, for five minutes of his questions.

Mr. Cardenas. Thank you very much, Madam Chairwoman, and also Ranking Member Burgess for having this important hearing.

It is great that we are talking about these programs and we need to keep focused on the Americans who are all trying to make sure that they get better service.

According to the nonpartisan Kaiser Family Foundation, those who visit health centers are far more likely to be low income and working poor, by the way, with more than half falling below the poverty line and are far more likely to come from a community of color.

Health centers are also far more likely to serve patients that speak only -- other than English, for example, when compared to other primary care settings. These are the primary care providers that these communities have come to rely on and where many families have received life-saving care we need to make sure that these centers actually are able to continue to serve.

Again, I just want to point out that far too often when people think of people getting care where there is little to no fee to the actual end user that it is somebody who is not working for a living.

I want to make it very clear that I know that in my district I have many, many working poor individuals who fit the results that the Kaiser Family Foundation research has exposed.

Mr. Germano -- in my district we would call you Germano -- I am sorry if I am saying it wrong -- so can you talk about some of the outreach activities that community health centers are able to do to reach these communities?

Mr. Germano. Our health centers in our region and across our state and our nation really is about outreach. We have a number of our staff who that is their job is to reach populations, people who won't normally connect with us whatever the situation.

So we work with churches. We work with social services agencies. We work with our police departments, law enforcement. They come in contact with folks or families or situations -- social services agencies.

So our goal is to make sure that we are connected to all these other resources and that we welcome everybody into our medical home.

Mr. Cardenas. Okay. Where would these communities go if they no longer had access to services provided by community health centers?

Mr. Germano. You know, I shudder to think. The default is the emergency room, right, and --

Mr. Cardenas. Or no care at all?

Mr. Germano. Pardon me?

Mr. Cardenas. Or no care at all.

Mr. Germano. Or they -- right. They defer until it becomes a critical issue, and that would be horrible for everybody.

Mr. Cardenas. I just had an unfortunate reality conveyed to me by a young woman who was explaining to me the horrors of her family's experience in this country when it came to health care.

She had two parents that were working poor. They had to rely on facilities like this to get their care. Her little brother was born with congenital conditions that they never could figure out exactly what it was, and he passed away.

And later on, her father became very, very ill -- the father of this little boy -- and he, apparently passed away as well. So two tragedies in one family.

And the actual tragedy to her little brother was actually a factor in why her father passed away way, way too young, because his exact words to her that she conveyed to me when she said, "Dad, you're really sick. You need to go to the doctor," and this is pre-Affordable Care Act, because I asked the question -- I said, but the Affordable Care Act.

She said my father passed away a month before the Affordable Care Act kicked in. He said, "I am sick and tired of seeing all these bills. I can't afford it."

So your -- the facilities that we are talking about today

are the facilities that will actually help individuals get access to health care and, secondly, not be afraid -- not be afraid of the financial burdens at least -- at least to see a doctor. At least to find out am I going to die or am I going to be okay.

Mr. Germano. You know, even today we see some of our uninsured patients come in with late onset diseases and you ask them, we've been here -- we've been -- why -- they have reasons, and we don't fully understand it.

But it is up to us to get the message out that this -- you can come here and you will see a doctor or a nurse practitioner or PA. We will help you to get medications. Anything we can do within our four walls we will try to do for you. It gets tougher once you get outside of our four walls. But we can do a lot within our four walls.

Mr. Cardenas. And what area of California do you serve?

Mr. Germano. Up in Redding, California.

Mr. Cardenas. Do you know a Dr. Lupercio? Have you ever met him? He works in a hospital. I was curious if you have come across each other.

Mr. Germano. I don't think so.

Mr. Cardenas. Pulmonary specialist, born in Mexico, got educated here. Serving the community. Amazing human being.

Mr. Germano. I will have to meet him.

Mr. Cardenas. Thank you, Madam Chair. I am sorry. I went over my time. Thank you so much.

Ms. Eshoo. I am a nice chair. I let people go over and finish their thoughts.

But we are winding down. Now, I would like to recognize the gentlewoman from New Hampshire, Ms. Annie Kuster of the famous Kuster family in her home state.

Ms. Kuster. Thank you, Chairman Eshoo, and thank you for this hearing and for all you for your patience today.

Many of the programs that we are talking about today are critical in my home state of New Hampshire where we are in the midst of a major opioid epidemic. 2017 we had 424 drug overdose deaths involving opioids and many of the programs that we are discussing are critical to combatting this epidemic.

I want to give a particular shout out to our community health centers serving some of the most vulnerable populations in our rural state. They have been instrumental in providing comprehensive care to those who need it, particularly, after Medicaid expansion under the Affordable Care Act.

And programs like PCORI have funded incredible research at Dartmouth Medical School in my district, studying treatment for pregnant women with opioid use disorder.

So I also appreciate that this collection of bills address

the workforce issues that we have been seeing. We are trying to encourage young people getting into career in technical education in our high schools, to get an LNA coming out of high school and then go to our community colleges and then go to our four-year colleges and working their way up to -- in the health care credentials.

I want to start, Mr. Germano -- you spoke of the difficulties in recruiting and retaining primary care physicians to underserved areas, and I am hoping that you could speak particularly with the community health center model and the workforce that stands up the community health centers are especially equipped to handle many of the public health challenges we face, and if you could elaborate on how these programs will make a difference for these workforce issues.

We have an unemployment rate of 2.4 percent, which is the envy of many of my colleagues. But it creates tremendous challenges in rural communities.

Mr. Germano. Definitely. The health centers more and more across this country have become, in my judgement, the de factor public health department now. They are the ones touching the lives of great swaths of our community.

No disrespect to public health. They have gone into more the monitoring and surveillance and those kinds of very necessary

things. So the primary care networks -- the community health centers have been the face of immunizations and sort of other surveillance and interventions.

So yes, we play a critical role as a safety net. That is our job. That is what we should -- one of our jobs -- that should be one of the things we do. Workforce with the lower -- I mean, it is a great thing we are seeing our unemployment rates drop but it creates some real challenges in terms of recruitment and retention.

Can we stay competitive, and not just about the doctors and the nurse practitioners but all our front line staff and what have you. So we are constantly chasing our tail, making sure that we are remaining competitive to keep our employees and sustain them.

So, again, ongoing sustainable funding is really critical in us to predict what we can afford.

Ms. Kuster. Great. Thank you, and thank you for appearing on behalf of the community health centers, a great asset to our community.

Dr. Cooper, I am going to turn to you about the PCORI funding -- that we have researchers at Dartmouth College examining the outcomes of prenatal care for women receiving medication-assisted treatment and the research is integral to understanding how to

-- prenatal, postpartum, how to support moms to have healthy babies. Could you discuss how a gap in appropriations will impact projects like these and the need for predictable and consistent funding?

And just while you are at it, in your opinion are there any other entity sources -- NIH or the Agency for Health Care Research and Quality -- that would be able to fill the gap or is this research that wouldn't continue?

Dr. Cooper. I think a gap in funding from PCORI would significantly threaten a project such as the one you described for a number of reasons.

One of them is that oftentimes when we do have results from such a project and they are positive results the promise that they hold is that we could then spread them to other settings or disseminate them more widely.

But without ongoing support from an institute like PCORI the ability to package the materials that have been developed and to use the learnings from that research to spread to other settings or to disseminate it would be limited significantly.

Additionally, you would have researchers who are conducting patient-centered outcomes research who may leave the field because of that uncertainty and either go back into clinical practice or do administrative work or something else.

They might also pursue research that is not patient-centered outcomes research and I don't think NIH and AHRQ would fill that gap completely. I think that there are some institutes at NIH that support similar work.

For the most part, they don't support the level of stakeholder engagement that PCORI does. It takes a long time to build partnerships with patient advocacy groups, family members, health insurers, health system leaders to conduct the research that ends up being very practical and sustainable over time, and we don't get that kind of funding.

Ms. Kuster. My time is up. I apologize. I would like to yield back. But thank you. Thank you.

Ms. Eshoo. The gentlewoman yields back.

I now would like to recognize the gentlewoman from Illinois, Ms. Kelly, for five minutes of questioning.

Ms. Kelly. Thank you, Madam Chair and Ranking Member, and thank you for your testimonies this morning.

I have heard from patients and providers that PCORI's approach to incorporating patients into research process makes the results more meaningful to people who will actually use it.

Dr. Cooper, you mentioned PCORI's unique governance structure with the emphasis on patient input and engagement. For the last couple of years I have been very involved with

legislation dealing with maternal mortality, and while no one knows exactly what happens and why there are the health care disparities -- I mean, some things we can guess -- do you see PCORI being helpful or instrumental in dealing with that health care disparity? Because there is a great one in this country.

Dr. Cooper. Most certainly I do see a strong potential for PCORI to contribute to research in the area of disparities in maternal mortality, one reason being that often women who come from underserved communities and African-American women in particular and American-Indian women who have higher rates of either maternal mortality or infant mortality are not represented in a lot of studies. So their perspective isn't given.

And so at PCORI they would have the opportunity to contribute to the research questions that would be answered and to contribute to the way that research should be conducted and the way the results should be shared with other patients and family members who would need the information in their decision making around there are.

Ms. Kelly. I know in these we had OB/GYNs in and I know in the state of Washington Native American women died eight times the rate of white women, and in my state of Illinois black women die six to one times rate, which is bigger than the national average.

And then you have been here a long time so is there anything we haven't asked you that you want us to know about PCORI?

Dr. Cooper. I think the only thing I would say is that I was so excited when PCORI was funded because it is the kind of work that I thought was needed for a long time -- that we have a lot of wonderful discoveries and therapies and drugs but they just weren't getting out to the people who need them, and people weren't able to make sense of a lot of the information that was coming at them.

And what PCORI allows us to do is actually to compare a lot of these different developments and discoveries and actually learn more about how each one of them works and applies to different people because they don't all work the same for everyone and it is really important to get everyone's perspective and to tailor those treatments and the appropriate concerns that people have and to the appropriate needs and resources within the context where they get health care.

Ms. Kelly. Thank you very much, and I will yield back.

Ms. Eshoo. The gentlewoman yields back.

Now I will recognize the gentlewoman from California, Ms. Barragan, for five minutes of questioning.

Ms. Barragan. Thank you. I wanted to first thank the panel for being here. There is so much to cover in so little time.

But before I do that, I wanted just to quickly talk about something that's going to happen on the second panel. I want to just spend a moment to discuss the Medicare limited income newly eligible transition program.

This demonstration program which began in 2010 provides temporary Part D prescription drug coverage for low-income Medicare beneficiaries not already in the Medicare drug plan.

This program has been incredibly successful in the past 10 years, saving $300 million and making sure beneficiaries get access to medication.

I was proud to introduce the Improving Low-Income Access to Prescription Drugs with my colleagues, Congressmen Olson, Marchant, and Lewis that would make the LI NET program permanent.

Far too many individuals across America already struggle to afford their prescription drugs. By making the LI NET program permanent, we can continue to provide transitional prescription drug coverage for those with low incomes.

I look forward to advancing our work to help all Americans get the medications they need.

Now, talking a little bit about community health centers, this past week in my district I held a round table with community health centers and other health care providers in my district, and in my district we work very closely with the Harbor Community

Clinic in San Pedro.

And I know there is already been a lot of discussion about what community health centers do and I also know some of this has been covered earlier.

But I think it is really critically important. Mr. Germano, if you could just tell us what the impact would be on communities of color if the fund is not reauthorized.

Mr. Germano. Health centers are very centered in communities of color around the country. They really are. They have a huge presence, and not enough, in my judgment.

And if funding becomes destabilized then I think you start losing those investments that have already been made and it prevents further investments in those communities because you can't plan ahead. It is that certainty again.

Ms. Barragan. So we've recently seen an outbreak of the measles --

Mr. Germano. Yes.

Ms. Barragan. -- and community health centers provides, as you mentioned, immunizations. Would that be at risk if this was not funded?

Mr. Germano. It goes back to that public health safety net role again. We had that situation in my own community where we became ground zero for detection as we had a couple cases in our

community, and public health rallied around us to be that face of prevention in our community.

Yes, it would be -- it would be a loss across this country and a danger.

Ms. Barragan. Thank you. My district is California's 44th. It is south L.A., it is Compton, it is Watts, it is the Port of L.A. It is a majority minority district. It is about almost 90 percent Latino/African American, and we have the highest diabetes rate than any other congressional district in the state of California.

It is also very personal. My mother has diabetes. Family members have type 1. And so Mr. Kowalski, what would be the impact on communities of color if this program were no longer funded -- the Special Diabetes Program?

Mr. Kowalski. So the Special Diabetes Program has delivered on a number of advances that will help anybody with diabetes. But, of course, in underserved communities you have a much higher incidence and prevalence rates.

We have tremendous momentum on many fronts via treatment, preventative therapies, and ultimately cures for diabetes, and it would be a tremendous shame to see us lose that momentum and what we would be doing is costing individuals time in their lives, literally, and ultimately our system millions and millions of

dollars.

So I urge the members, as you know, that this program is paying dividends and it will help all communities who are impacted by diabetes.

Ms. Barragan. All right. Thank you.

Dr. Cooper, I want to thank you for your work on the issue of racial health disparities. It was in 1999 when I was working at the NAACP that this issue became one near and dear to me.

Can you tell me how the Patient-Centered Outcomes Research Extension Act of 2019 plays a role in helping address racial health disparities?

Dr. Cooper. Yes, I would be happy to do that. One of PCORI's main focus areas is addressing disparities. So they also focus on several special populations which include racial and ethnic minorities, persons with low socioeconomic status as well as people who have many disabilities.

So I think because they have a special portfolio focused on addressing disparities a lot of that work actually does address issues that are critical to those communities and those populations.

For example, you might have a new drug or therapy for diabetes. But what we might not understand is how acceptable is that treatment to people who will have low income or people

who live in an ethnic minority community. Are there stigmas around certain kinds of therapies? What about the costs associated with getting those things or any other barriers to managing their condition that might get in the way of them benefiting from those therapies, and PCORI has the ability to address a lot of those with their research portfolio.

Ms. Eshoo. Does the gentlewoman yield? The gentlewoman yields.

I now would like to recognize the gentlewoman from Delaware, Ms. Blunt Rochester, for five minutes of questions.

Ms. Blunt Rochester. Thank you, Madam Chair, for the recognition and for turning the committee's attention to the critical public health programs that must be reauthorized this fall.

Just yesterday I introduced legislation to reauthorize another program set to expire in September -- the Personal Responsibility Education Program, or PREP -- and I look forward to working with my colleagues on the committee to ensure that this and other public health programs are reauthorized before the September deadline.

Delaware has three federally qualified community health centers, serve approximately 50,000 patients across the state each year. So in Delaware that's one in 19 Delawareans.

And I support both H.R. 1943 -- the Community Health Center and Primary Care Workforce Expansion Act -- and H.R. 2328 -- the Community Health Investment Modernization and Excellence -- CHIME Act, because community health centers need long-term sustained funding. I think that is a message that we have heard loud and clear here today.

Delaware has seen the impacts of this firsthand because Westside Family Health Center became the first community health center in the country to lose a location because of unstable federal funding, a closure that impacted about 2,800 patients who were disproportionately low income.

So I want to just kind of turn to the issue of planning -- short-term planning but, specifically, on the impact of recruiting and retaining particularly primary care physicians.

And I know, Mr. Germano, you talked about this. In Delaware, it has a huge impact. It is estimated that we have just 815 primary care physicians in Delaware, down 5.4 percent since 2013.

And so I just wanted to ask you, you talked a little bit about the impact but and you said -- you talked about the fact that wherever a person is trained they might tend to stay.

So if you could just reiterate that, and also just briefly talk about suggestions that you would have to incentivize people to continue to stay and work in those underserved communities.

Mr. Germano. Thank you for those questions. The data shows overall, I had mentioned, that 70 percent of residents stay within 100 miles of where they have trained, and the Teaching Health Centers go even further. We had more success because we have looked or providers who meet our mission, who are interested in our mission, and are many times tied to our communities in other ways, so have roots or will develop roots there.

So I think absolutely critical. That is the pipeline bringing them into our system and then getting them through and then helping them stay.

So I think those are -- those are the big ones. Those are the issues.

Ms. Blunt Rochester. No, that's helpful. That's helpful.

I am going to shift very quickly to Dr. Cooper. You talked about PCORI and, you know, one of the reasons why what you shared is so vital is because of the issue of health disparities and I was hoping that you could spend a little bit of time on that, the impact of addressing health disparities.

In Delaware, we have the Nemours child health system and health corps that are key stakeholders in receiving these funds and doing exciting work. But particularly as it relates to trust in clinical trials and how you get people to actually participate for their own -- the connection to the health care system.

Dr. Cooper. Thank you. Yes, so I will just mention briefly, I actually had a project that was funded that engaged with the Westside Health Center in Delaware many years ago.

It was not funded by PCORI. It was funded by AHRQ, and we were able to successfully engage health centers and African-American patients in a project that compared two different approaches to treating depression.

The difference between that project and my PCORI-funded work is that I did not have the benefit of the full year of planning to engage all the appropriate stakeholders and to get their input into the program.

And so when that project ended, even though we showed successful results, it wasn't actually sustained. But now, with the kind of funding that PCORI offers, there is actually a full year devoted to planning and to stakeholder engagement so that everyone sort of on board with the plan gives input to it and a lot of discussion takes place about how this program will be sustained if it is shown to be successful.

Ms. Blunt Rochester. Excellent. Thank you for sharing that.

Just one last point. Delaware had the sixth highest rate of overdose deaths in 2017, and so we know that the opioid crisis is having a huge impact, and one of our health centers, La Red,

actually has focused on this.

So I will submit some questions for the record surrounding the opioid addiction crisis as well. So thank you and I yield back.

Ms. Eshoo. The gentlewoman yields back.

Now it is a pleasure to recognize the gentleman from Georgia, Mr. Carter, and followed by the patient gentlewoman from Washington State, Ms. McMorris Rodgers.

So first, the gentleman from Georgia.

Mr. Carter. Thank you, Madam Chair. I thank all of you for being here. I know it is been a long day and you're almost there, so hang in there, okay?

Certainly important things we are talking about. There is no question about that. Mr. Germano, I wanted to ask you, do you happen to know how many health profession shortage areas there are in this country? Any idea?

Mr. Germano. I don't, but there is a lot.

Mr. Carter. There is a lot. Most of them in rural areas, I would assume, as opposed to urban. But I suspect we'd be surprised to find them in urban areas as well.

Mr. Germano. I think there is quite a few in urban areas as well.

Mr. Carter. Right. Right. Earlier, we -- earlier one of

my colleagues asked you about dental health and that is certainly important.

First of all, again, I am from Georgia, and remember there are two Georgias. There is Atlanta and there is everywhere else, and it is true. And I represent south Georgia. We got a lot of rural areas in south Georgia, a lot of health care needs.

Accessibility to health care is a big concern of ours and a big challenge and particularly oral health care as well, and I was just wondering if you could reiterate what you said earlier about oral health care and how important it is, particularly in our most needy areas like that.

Mr. Germano. Well, know that oral health disease is not just a cosmetic thing. It has the underlayment of causes other problems. Women who are pregnant with oral health disease could have bad outcomes with their babies, for example.

We know that we can prevent a lot of this. It is not just having a dental office. We have embedded dental hygienists in our pediatric practices now where they are going in after the -- after the visit, in many cases, and they are doing a little education and they are painting the teeth of children so to try to prevent, you know, cavities and other problems and educating as well.

Oral health disease -- number-one pediatric disease in

America is oral health disease.

Mr. Carter. Right.

Mr. Germano. And it is preventable. That's the thing. A lot of oral health disease is preventable.

Mr. Carter. You know, we talk a lot about making sure we have -- with good reason making sure we have doctors in underserved areas. But there are other health care professionals that we need to concentrate on also such as dentists.

Mr. Germano. Yes.

Mr. Carter. Any others that you can think of that really propose a glaring void there -- health care professionals that we just --

Mr. Germano. Well, I would love to see the role of the pharmacists be more --

Mr. Carter. Thank you very much. Oh, did I mention that I am currently the only pharmacist serving in Congress?

Ms. Eshoo. That was a good answer.

Mr. Carter. It was a good answer.

[Laughter.]

Mr. Germano. I do think there is a role for -- the problem is in the FQHC world, pharmacists are not recognized as billable providers; hence, it makes it difficult to put it together.

But it makes total sense. My clinicians clamour for that

-- you know, that kind of direct clinical pharmacy involvement, not just on the retail side but on the clinical side. It would make a world of difference.

Mr. Carter. Right. Thank you for that.

Let me switch now to a problem that, unfortunately, we are a leader of in the state of Georgia and that is maternal mortality. And, you know, it is -- it is embarrassing for me to say that and whereas I do question sometimes how we arrive at some of these figures because I want to make sure we are comparing apples to apples when we talk about maternal mortality. But we cannot deny the fact that it is a problem and particularly in the state of Georgia.

And I am just wondering, you know, one of the challenges that we face, as I mentioned before, is just a lack of providers, and what -- you mentioned earlier, and you are spot on because when I served in the Georgia state legislature one of the things that we discovered was that most of the physicians, as Dr. Burgess pointed out as well, most of the physicians stay where they practice -- where they do their residency -- and we learned that in Georgia.

That is why we increased the number of residencies in our state in order to try to attract physicians and try to get them to stay.

But any ideas on what we can do aside from that to increase the number of providers, particularly in the -- in the rural areas and particularly in the way of OB/GYNs where we need this for -- to address the situation of maternal mortality?

Mr. Germano. Well, most OB/GYN training programs are in big cities, so that you are running against it right away in terms of attracting OB/GYNs to rural communities. So that is tough.

But what we can do is to work with, like, our nurse practitioners.

Mr. Carter. There you go.

Mr. Germano. Early prenatal care, getting women in the first trimester, really critical. Getting them tucked into prenatal care and then we can help monitor and support them through their pregnancy. I think that can make a world of difference.

Mr. Carter. And, you know, scope of practice is pretty much a state issue. But at the same time, if we -- if we empower some of these other health care professionals to give them the opportunity to serve, I think they can help us to achieve what we are trying to achieve here.

Mr. Germano. I agree.

Mr. Carter. Very good. Again, thank all of you. This is extremely important and we certainly support what we are trying to do here. The question is how we are going to pay for all this.

But nevertheless, this is very important.

And thank you, Madam Chair, and I yield back.

Ms. Eshoo. The gentleman yields back.

And now the ever-patient gentlewoman from the state of Washington, Mrs. McMorris Rodgers, also the sponsor of H.R. 2818, which we thank you for. It is an important bill. You are recognized for five minutes.

Mrs. Rodgers. Thank you, Madam Chair, and just thank you everyone who has been a part of this, the witnesses, and your testimony today.

I am pleased that you are bringing this legislation forward today. Earlier, Representative Ruiz was talking about the Teaching Health Centers and how important they are.

I am proud in Spokane to represent one of the Teaching Health Centers that is making a big difference in our region. We are excited that Washington State University has built a medical school. The University of Washington and Gonzaga are partnering on a rural training track.

I represent an area that has a lot of rural communities and these -- this effort in Spokane is definitely part of the solution.

When you -- when I look at the partnership between the Teaching Health Center, the universities, the local hospitals,

and then our local VA, we need more doctors. We need more doctors throughout eastern Washington.

And I am also reminded that where the doctor does their residency they are more likely to practice. I met a guy, a doctor, not too long ago who had come from California to Spokane 30 years ago to do his residence and he is still there.

And it underscores how important it is, these residency programs. So I am a strong supporter of the Teaching Health Center Graduate Medical Education Program, that legislation that is before the committee today.

You know, it is estimated that nationwide we will have more than 23,000 shortage -- we will be short 23,000 doctors by 2025, and it is really unacceptable. And you see it further in the rural communities where the physician-to-patient ratio is especially stark.

Only 10 percent of physicians practice in these areas, even though a quarter of the population lives there. Compared to doctors who trained in the traditional Medicare program, those trained at Teaching Health Centers are 60 percent more likely to practice primary care and 30 percent more likely to work in a rural or underserved community.

I was proud to help lead this legislation in the last Congress where we doubled the funding, and I am excited and encouraged

that we are continued that effort in this Congress.

Representative Ruiz, Torres Small, Representative Roe and I have joined in introducing H.R. 2815. What it does is continue the support for this program by extending it for another five years and increasing the funding and providing more certainty, which we need across the country.

This legislation and this program is important -- meeting the needs of rural and underserved communities for a new generation of primary care medical professionals.

The Teaching Health Center has programs that are meeting important needs in psychiatry, OB/GYN, primary care, internal medicine -- you know, the very fields that we need more of our doctors to be pursuing.

So I have a few questions to Mr. Germano. I wanted to -- in your testimony you talked about the Shasta Community Health Center electing to become a Teaching Health Center as a means of addressing the ongoing physician shortage.

And I just wanted you to elaborate on that decision and just comment on how positively that may have impacted your effort to meet the needs in your community.

Mr. Germano. It is a big decision for a health center to be a sponsoring entity. You have to meet all the accrediting requirements. There is resources that go into it.

In the beginning it is tough because your best clinicians become your teachers, which means you take them out of the direct services and now you're teaching.

So the investment is more medium to long-term when you make that decision. But my job and my board's job is to look ahead and look at what's coming at us, and the shortage was very real then. It is even more so now.

So the Teaching Health Center Program is a huge investment in our future -- in our current and into our future, and we are seeing the paybacks now.

Mrs. Rodgers. Would you just address how your facility compares to other Teaching Health Centers across the country, and then also -- I am afraid I am going to run out of time -- the importance of the five-year reauthorization?

Mr. Germano. Well, each health center has their own sort of reality that they are -- the resources they have available to them. So we are all a little different in that respect. Some are urban. Some are rural. Some are frontier.

So, you know, we are very rural and, hence, I think we have a few more challenges we are starting to get our hands around. We are not having the same exact retention rates as some of the city programs but we are getting there. So I am really excited about that.

And, I am sorry -- the second question was?

Mrs. Rodgers. Well, the importance of a five-year reauthorization.

Mr. Germano. We have to -- we commit three years to every class. They have to know when we are recruiting. I can't have a medical student say to me, are you going to be around in two years if this program is going away? That is not a great recruitment tool into our program. We need to know -- we have to have certainty.

Mrs. Rodgers. All right. A two-year reauthorization for a three-year program just --

Mr. Germano. Doesn't make sense. Thank you.

Mrs. Rodgers. Doesn't make -- okay. I appreciate the chairwoman for allowing me to waive on today. Thank you.

Ms. Eshoo. Thank you for your patience and thank you for your important work on the -- on the legislation. I think that we have really very strong bipartisan support on this and which is really pleasing.

Now I am going to recognize the gentleman from Arizona, Mr. O'Halleran, who is one of the sponsors -- key sponsors -- of H.R. 2328, 2822, and 2680, five minutes of questioning.

And then I think after Mr. O'Halleran we'll be -- we'll ask the staff to ready the table for the next panel. But I want to

recognize the gentleman now and thank him for his patience, too.

Mr. O'Halleran. Thank you, Madam Chair.

A little perspective -- my district is larger than the state of Arizona -- I mean, Illinois -- 60 percent of Arizona. It goes from a few small urban areas to frontier -- a Navajo reservation, a Hopi reservation, 12 Native American tribes.

Economic conditions on the tribal lands anywhere from -- most of them 50 to 85 percent unemployment rate, getting worse. You can imagine the problems associated with that and the quality of life that people coming in to those areas have to address their lives to and the change.

You know, Mr. Germano, the National Health Service Corps provides vital scholarship and loan repayment programs that reduce workforce shortages in medically underserved areas and it has a successful retention program.

For instance, a 2012 study found that an amazing -- more than half of the participants in the National Health Service Corps stayed in a health shortage area 10 years after their participation in the program ended.

My anecdotal information in my district, that is not true. Not that it is not true nationwide, but the realities of this district are different, and thank God for community health centers.

What effects could we expect to see in rural and medically underserved areas if we -- in the longer authorized and increased funding for this program?

Mr. Germano. Well, I think if it is tough now, I can only imagine how tough it would be without that loan repayment. The cost of medical education has gone out of sight and these young people are making decisions about where they're going to practice and what they're going to practice.

And if they don't see the opportunity of loan repayment as an option, it is going to be very difficult for us as community health centers or any real provider in rural communities to be able to recruit them to our communities.

Mr. O'Halleran. Thank you.

Mr. Kowalski, thank you for your testimony here today. And as you are well aware, the Special Diabetes Program for Indians is tremendously important.

According to the Centers for Disease Control and Prevention, the American Indian and Alaska Native communities suffer from disproportionately high rates of diabetes.

This high prevalence, coupled with food deserts and limited access to health care facilities, can lead to more negative outcomes for these communities.

In addition, the high level of unemployment, tribes with

the inability to find jobs even if there was the ability to find the economic conditions under which those were to survive, will you please highlight how this program effectively supplements the Indian Health Care Services work in preventing diabetes and related complications among Native American populations?

Mr. Kowalski. Thank you, Representative, for that question and thank you for your leadership in introducing H.R. 2680, which would increase funding and extend funding for this incredibly important program.

As you point out, in your state we have tribes that have diabetes incidence rates of over 50 percent, some tribes upwards of 80 percent, and they are very underserved.

It is this program that has made significant differences. We talk about the importance of culturally tailored interventions and we have seen that in this program.

And I said earlier the proof is in the pudding. We have data-driven metrics in terms of the impact, in terms of glucose control levels being better, reducing the risk of complications.

For those complications, significant decreases, for example, in kidney disease and eye disease, which will save money. This is a critical program for underserved community -- the tribal communities in your state and across the country that deserves renewal and re-upping and I, again, thank you for your

leadership.

Mr. O'Halleran. Well, thank you. And another question for you is this program has remained flat since fiscal year 2004. It is amazing. At the same time, the population served by Indian Health Care Services increased.

Will you please explain what the effects would be if Congress simply reauthorized the program but did not increase its annual appropriations?

Mr. Kowalski. So since 2004, if you did just the simple math of inflation, we are talking about $150 million versus what would now be $230 million for a problem that has only grown.

So we are, again, under resourced for a problem that is hurting these communities and costing our economy. We need to do better and we are seeing results from the program, I think. The up side is huge here.

Mr. O'Halleran. Thank you, Madam Chair. Sorry for taking so much time, and I yield.

Ms. Eshoo. The gentleman yields back.

And that concludes our first panel. I want to thank each one of the witnesses. You have done a superb job. I know that this has been a long hearing. You haven't had a break.

But we are taking up 12 bills and these are all important to the American people. So you have given marvellous testimony.

You have underscored the need for stability and confidence in the -- in the program so that we -- in our reauthorizations that they have a longer pathway before reexamination by the Congress, and I think that that's a very prudent way to go.

But I just -- I couldn't help but think during the hearing what would we ever do without what each one of you testified about. All the people in our country that are being cared for as a result of your work and your leadership.

So every blessing on each one of you in your work. We thank you for being here, and we will ask the staff to prepare the table for the next panel of witnesses.

Thank you, everyone.

[Pause.]

Ms. Eshoo. We now will hear from the second panel of witnesses and we want to thank you for -- I think you were all waiting patiently. I think you have been here for the better part of the day and we thank you for that and what you are about to do.

Mr. Thomas Barker, partner and co-chair of Healthcare Practice at Foley Hoag; Ms. Mary-Catherine Bohan, vice president of outpatient services at Rutgers University Behavioral Health Care; Mr. Fred Riccardi, who is president of the Medicare Rights Center, and I want to call on our -- the vice chair of our committee

to introduce his constituent, Dr. Michael Waldrum.

Mr. Butterfield. Thank you very much, Madam Chair, and I realize the hour is late. It looks like we are going to have votes in just a few minutes.

But I would like to recognize and to join the subcommittee in receiving the chief executive officer of -- and distinguished professor of internal medicine and pulmonary and critical care at the Brody School of Medicine at East Carolina University.

Very briefly, my district consists of 14 counties and one of those counties is called Pitt County, and this university is a major economic engine in Pitt County.

And so I want to welcome Dr. Michael Waldrum to the subcommittee and look forward to his testimony. Thank you.

Ms. Eshoo. Thank you.

So we will -- at this time the chair recognizes Dr. Green for five minutes for your opening statement.

Mr. Barker. I am sorry.

STATEMENTS OF 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

STATEMENT OF MR. BARKER

Mr. Barker. Thank you, Madam Chair -- Chairwoman Eshoo, Dr. Burgess. Thank you very much for the opportunity to appear before the subcommittee today.

Thirty-eight years ago this week, I started my first job on Capitol Hill as an intern in this building, and when I walked through the Rayburn Horseshoe from the Capitol South Metro I never in a million years would have imagined that I would have had the honor of appearing before this subcommittee. So thank you very much for this opportunity.

I want to clarify at the outset, Madam Chair -- you mentioned my affiliation with my law firm. I want to clarify at the outset that although I was recently appointed the MACPAC, I am not appearing today on behalf of the Commission.

Rather, I am speaking to you as a health care lawyer with many years' experience representing both the government as the chief legal officer of CMS and HHS. I also represent health care

providers and payers in private practice and as a former professor of health care law and policy at George Washington University and Suffolk University School of Law.

My remarks today focus on the bill that was introduced by Mr. Engel that deals with the pending cuts in Medicaid DSH payments that were enacted as part of the Affordable Care Act and that had been deferred several times since then under current law.

As the members of the subcommittee know, the first round of DSH cuts will occur in fiscal year 2020. So my testimony, which I am not going to, obviously, repeat but my testimony focuses on those pending cuts and it gives a little bit of history of the DSH payment system, which I hope will be helpful to the subcommittee as it begins its deliberations on an extenders package.

I think it is important to understand that the DSH cuts of the ACA did not happen in isolation but, rather, as a part of a nearly 40-year history of Congress recognizing the special needs of disproportionate share hospitals.

In my testimony I went through the history of DSH, which actually started in 1981, probably in this room, when the House was beginning deliberations over the Omnibus Budget Reconciliation Act of '81, which was the first time that Congress

told the states to focus on the needs of DSH hospitals, and that statute was amended again in 1987, 1991, 1993, the BBA in 1997 and then again in 2010 when the ACA was enacted into law.

And my testimony concludes by referring the subcommittee to recommendations that MACPAC made to structure the DSH cuts differently by phasing them in over a longer period of time to allocate the cuts first to states that have unspent DSH allocations and then really -- and most importantly, in my view, to restructure the DSH allotments or the DSH caps to better align the state-specific DSH caps to the percentage of low-income non-elderly individuals in a state.

After all, that was the real original intent of DSH when it was enacted in 1981, which was an agreement by the Reagan administration, by the governors, and by the Congress over how Medicaid rates should be set by states.

So let me conclude by thank you for the opportunity to testify before the subcommittee this afternoon. I would be pleased to answer any questions that you have and I am happy to make myself available to the members of your staff if you have any questions about DSH.

Thank you.

[The prepared statement of Mr. Barker follows:]

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Ms. Eshoo. We thank you for that, Mr. Barker, and I love the history. We never know what paths in life -- where they are going to lead us and take us.

Mr. Barker. Well, Mr. Waxman was here then. Mr. Dingell was here then. I certainly remember working for them. Thank you.

Ms. Eshoo. Yes. It is a wonderful story. We stand on great shoulders.

Now I would like to recognize Ms. Bohan. You are recognized for your five minutes of testimony, and thank you.

STATEMENT OF MS. BOHAN

Ms. Bohan. Thank you for the opportunity to testify in support of the Excellence in Mental Health and Addiction Treatment Expansion Act, and to share with you how becoming a certified community behavioral health clinic -- CCBHC -- has impacted my organization and community.

I am honored to be there today on behalf of the National Council for Behavioral Health, a national association that represents 3,100 member organizations who, collectively, serve more than 10 million adults and children living with mental illness and addiction.

I am further honored to represent Rutgers University Behavioral Health Care, one of the seven CCBHCs participating in the two-year demonstration project in New Jersey.

Established in 1972, UBHC is one of the largest academic behavioral health care delivery systems in the nation and is the largest behavioral health provider in the state of New Jersey, serving over 18,000 individuals per year.

I have been vice president of outpatient services at UBHC since 2016. I am a clinical social worker by training and I have been a direct provider and administrator of mental health, addiction treatment, and community-based services for over 35

years in three different states.

I know only too well --

Ms. Eshoo. The ranking member is right. Pull your microphone closer so that we -- you have a soft beautiful voice.

Mrs. Bohan. Is that better?

Ms. Eshoo. But we want to hear every word.

Ms. Bohan. Okay. Thank you.

Ms. Eshoo. That's much better.

Ms. Bohan. I won't go back.

I know only too well how siloed mental health and addiction services can be. Historically, neither system assessed the physical well-being of their clients, often missing vital information that should be part of their care.

At Rutgers, CCBHCs have been the vehicle that has allowed us to finally offer integrated services and provide holistic care to those we serve.

I would like to take a moment to share what behavioral health services at Rutgers UBHC look like now as compared to before the CCBHC implementation.

The three outpatient clinics that were transitioned to CCBHC served about 3,300 individuals. In the first year of the program, we increased the number of people served to 5,000. In year two, we have treated 6,000 individuals and families.

We currently maintain 300 clients on medication-assisted treatment, or MAT, versus the 30 individuals that we treated the year prior to CCBHC.

Before the demonstration, the average wait time for first appointment was 21 days with a no-show rate of 50 percent. Individuals with behavioral health issues need immediate access to care and we were losing the opportunity to help people at the time that they identified their need.

Now we proudly offer same day/next day access. Our no-show rate is down to about 24 percent and continues to drop. When individuals were disengaged in treatment, outreach was limited to phone calls or letters. We now engage clients face to face in the community, person to person.

In one instance, a clinician was concerned about an adolescent who had missed an appointment and could not be reached by phone. The case manager did a wellness visit at her home and intervened with the client, who was in the middle of a self-harm episode.

The case manager contacted EMS, the family, and facilitated getting this client to the appropriate level of care. This type of intervention simply would not have been available to us prior to the CCBHC.

Two years into this program, Rutgers UBHC is just hitting

its stride. We are positioned to go further and do more for our community. But with the continued funding at risk, we have been unable to hire additional staff or pursue initiatives that would drive further innovation.

If the CCBHC demonstration project is not extended past June 30th, the impact on Rutgers UBHC is enormous. Case management and peer support services will be discontinued, which means our ability to engage individuals in the community will end.

Without case management and peer support, our same day/next day access model, which relies on a team approach to function, will be greatly impacted and I fear that wait times will again grow to be weeks long.

Health screens and subsequent linkage to primary care will be greatly reduced. The ambulatory withdrawal management program that treats individuals with opiate use disorder will likely close.

To be frank, if the program expires all of the success I shared with you today is at risk. We cannot go back to business as usual. Not Rutgers, not the other UBHCs, and most importantly, not our clients, because those are the ones who will lose out the most if this program ends.

So today I am asking for the committee's support in passing the Excellence in Mental Health and Addiction Treatment Expansion

Act so that the eight states who are currently operating CCBHC can continue this work and additional states can be afforded the opportunity to transform their behavioral health delivery systems.

On behalf of the individuals and families we serve, I would like to thank this committee for your focused attention on this issue and I would especially like to thank Congresswoman Doris Matsui and Congressman Markwayne Mullin for their leadership in sponsoring the Excellence Act expansion bill.

Thank you, and I look forward to your questions.

[The prepared statement of Ms. Bohan follows:]

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Ms. Eshoo. Thank you for your outstanding work. It is very hopeful, what you described to us. Thank you for your testimony. Powerful testimony.

Now I'd like to recognize Dr. Waldrum. You have five minutes for your testimony, sir. Thank you.

STATEMENT OF DR. WALDRUM

Dr. Waldrum. Thank you, and good afternoon.

And thank you, Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of this subcommittee for inviting Vidant Health to testify at today's hearing.

I am Michael Waldrum, chief executive officer of Vidant Health, a health system guided by its mission: to improve the health and well-being of the people of eastern North Carolina, a geographic region the size of Maryland that 1.5 million people call home, including the subcommittee's vice chair, Congressman Butterfield.

I am honored to speak to you today about the vital importance of Medicaid disproportionate share hospital, known as DSH, funding is for my health system and the people and communities we serve.

Vidant Health is a nine-hospital system and includes one of four academic medical centers in North Carolina, the Vidant Medical Center, which is a tertiary referral center and the only level one trauma center on the Eastern Seaboard between Norfolk, Virginia, and eastern -- and Charleston, South Carolina.

We employ more than 14,000 North Carolinians and contribute $3.5 billion to North Carolina's gross state product.

Vidant Health and the hundreds of essential hospitals like it across the country reach well beyond our walls to meet people where they live and help communities cope with social, economic, and environmental factors that affect their health.

We have ample experience with this. The majority of the counties we serve are among the most economically distressed areas in our state.

In the Vidant Medical Center primary service area, Pitt County, 60 percent of the public school students are enrolled in free or reduced lunch programs and the poverty rate is 24 percent.

Our providers work hard every day to combat obesity, chronic conditions, the infant and maternal mortality crisis, the opioid epidemic, and to support our communities where they live who are disproportionately burdened by these illnesses.

So we fund programs that empower community partners to overcome social economic factors that contribute to poor health, from chronic conditions support to food banks for school health programs and many other initiatives we are making a difference.

In fact, last year Vidant Health partnered with more than 159 different programs across eastern North Carolina, contributing almost $2 million in grant contributions to other social service organizations which serve more than half a million

of our neighbors.

Today's hearing is about investment in health care and these programs represent our investment in the health and productivity of our community.

We can do these things because Medicaid DSH helps us ease the financial pressure that comes with our commitment to meeting the health care needs of all of our people, including those faced with severe financial hardships.

That commitment to mission translates to more than $200 million in uncompensated care costs annually for Vidant Health. Medicaid DSH helps close that gap.

Our situation is not unique. The 300 hospitals in our national association, America's Essential Hospitals, alone provide nearly a quarter of all charity care nationally and more than nine times the amount of uncompensated care on average than other U.S. hospitals.

Vidant Health and the nation's other essential hospitals depend on Medicaid DSH to offset the financial losses we sustain caring for our nation's most vulnerable people who are often are the most complex and costliest patients.

This leaves essential hospitals with no financial cushion to absorb a cut the magnitude of this year's DSH reduction, $4 billion, or a total of a third of the DSH funding.

A cut this size would deeply change our ability to meet the needs of the individuals and families who depend on Vidant Health. These cuts will be felt even more so by the patients in states that have not expanded Medicaid, such as North Carolina.

DSH cuts would devastate the nation's safety net and jeopardize health care access and jobs in eastern North Carolina and the communities in the country with a particularly acute impact of rural America and including the rural environment that we serve.

Congress has wisely chosen to delay these cuts four times previously, each time with strong bipartisan votes. We greatly encourage -- we are greatly encouraged to see the same bipartisanship on this issue this year.

We thank Congressman Engel and Olson for organizing a letter to the House leaders calling for a further delay and we thank the 300 bipartisan House colleagues including the members of this subcommittee who signed that letter.

Thank you for allowing me to share Vidant's story.

[The prepared statement of Dr. Waldrum follows:]

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Ms. Eshoo. Thank you, Dr. Waldrum, very much.

Mr. Riccardi, you are recognized for five minutes for your testimony.

STATEMENT OF MR. RICCARDI

Mr. Riccardi. Good afternoon, and thank you.

Chairwoman Eshoo, Dr. Burgess, and members of the subcommittee, I am Fred Riccardi, president of the Medicare Rights Center.

Medicare Rights is a national nonprofit organization that works to ensure access to affordable health care for older adults and individuals with disabilities through counselling and advocacy, educational programs, and public policy initiatives.

Thank you for the opportunity to speak with you today about several bipartisan Medicare-related programs that we urge you to address in extenders legislation this year.

Specifically, there are three points I would like to share. I request that for permanent authorization for the low-income program outreach assistance, the Part D safety net program known as LI NET, and continue funding for the National Quality Forum.

Doing so will ensure that these initiatives continue to help improve the health and financial stability for people with Medicare.

Every day on our national consumer help line we hear from people who are struggling to cover health care and prescription

drug costs. For many, particularly those with low or fixed incomes, the program's premiums and cost-sharing amounts are just out of reach.

Already half of Medicare beneficiaries -- nearly 30 million people -- live on approximately $26,000 or less a year and a quarter of them live on approximately $15,000 or less a year, and health care costs are taking up larger and more disproportionate share of beneficiaries' very limited budgets.

Thankfully, assistance is available. The Medicare Part D extra help benefit helps beneficiaries access the prescription drug program by paying their premiums and lowering the cost of their co-payments.

Additionally, the Medicare savings program pays for Medicare Part B premiums. But people don't always know how to access these programs or how to apply for them and, as a result, they may not be getting the help or the care that they need, which can lead to worse health outcomes and higher costs.

The extra help in the Medicare savings program benefits increase affordability and access to care can truly be lifesaving, helping beneficiaries manage chronic conditions and better meet the needs of daily living.

At Medicare Rights, we have seen people access extra health benefit in the Medicare savings program and acquire transplants

and heart surgery and treatment for Parkinson's disease.

One such program encompasses outreach and enrollment efforts aimed at enrolling more people into the extra help and Medicare savings program benefit, authorized by the Medicare Improvements for Patients and Providers Act -- known as MIPPA -- of 2008.

This funding allows community-based organizations to connect beneficiaries with limited incomes to these programs, and since 2009 the program has helped nearly 3 million Medicare beneficiaries.

Additionally, the Limited Income Newly Eligible Transition program -- LI NET -- is a safety net program for people who are not currently enrolled in a prescription drug plan but are eligible for extra help or have Medicaid or supplemental security income.

We are pleased to endorse H.R. 3029, which would permanently authorize this critical program and we are grateful to Representatives Olson, Barragan, Marchant, and Lewis for championing this effort.

We also support continued funding for the National Quality Forum introduced by Representatives Chu, Engel, and Carter. H.R. 3031 would allow the National Quality Forum to build upon quality measurement, advancements already underway to create high-quality, high-impact, and more cost-efficient health care

system.

Finally, as you develop an extender's package or otherwise look for opportunities to improve the Medicare program, we respectfully ask that you prioritize the bipartisan bicameral BENES Act, championed in the House of Representatives by Representatives Ruiz, Walorski, Schneider, and Bilirakis.

The BENES Act would, in part, simplify the Part B enrollment process and better inform those approaching Medicare eligibility about the responsibilities.

Thank you for your time and consideration. Again, health care and prescription drug affordability are ongoing challenges.

Adequately funding and making permanent these programs I've discussed today will help ensure that older adults and people with disabilities can access and afford high-quality care.

[The prepared statement of Mr. Riccardi follows:]

**********INSERT 8**********

Ms. Eshoo. Thank you very much, Mr. Riccardi, and to each one of the witnesses.

We have now concluded your statements for this panel. But there are votes on the floor. So what we are going to do is recess for about 25 minutes to a half hour. Depends on how long the votes are. I think there are three of them.

Let us just say we'll resume in 30 minutes, and to ask our questions of you. So you have a little bit of a break, and we are going to run over to the Capitol and we will see you in a bit, okay?

Thank you. The committee is in recess.

[Recess.]

Mr. Butterfield. [Presiding.] All right. I guess we need to proceed, if we can. We will now move to member questions and I will recognize myself for five minutes.

Dr. Waldrum, thank you again for your testimony today and for the work that you do in eastern North Carolina, particularly for vulnerable populations. It has been very helpful to understand the potentially devastating impact onto Vidant Health if Medicaid DSH reductions were to take place this year.

The Affordable Care Act included DSH reductions with the expectation -- the expectation that Medicaid expansion would lead to a decrease in hospital uncompensated care costs.

However, only 33 states and the District of Columbia have expanded Medicaid.

Dr. Waldrum, North Carolina has yet to expand Medicaid. Is that correct?

Dr. Waldrum. Yes.

Mr. Butterfield. The majority of the counties that you serve are among the most economically distressed areas in our state. I can certainly say that for a fact.

Can you discuss the difficulties of being a safety net provider in a non-expansion state?

Dr. Waldrum. Thank you for the question.

Yes. So Medicaid expansion, clearly, is important to us and our region, and providing care in a distressed safety net organization and region is always a challenge.

As you know, we serve primarily a rural environment and North Carolina has the second largest rural population in the country and eastern North Carolina has 1.3 million citizens in rural environments.

And so we are always looking at how we provide care to those environments, and hospitals and providers in rural environments are challenged. You have had a lot of the discussion about that today as I listened to the deliberations this morning and we all know some of the issues.

There is a higher burden of disease in the citizens that live in rural environments with obesity, cancer, cardiovascular disease, and diabetes, as you have heard this morning, and the aging population in rural environments with a shrinking population.

And but people still live there, and in some services with some of the dialogue this morning, OB services, for instance, in a number of our hospitals we only have on average one baby a day. And so you have to have the infrastructure to provide services to those patients. But we do not get enough revenue to cover the cost for those services.

So that puts a burden on us. But if we didn't have those services, the mothers and babies would have to travel in some areas over an hour to have their baby.

Mr. Butterfield. So this is affecting your bottom line, to be sure.

Dr. Waldrum. For sure.

Mr. Butterfield. And when your bottom line is impacted, other things are impacted as well?

Dr. Waldrum. Well, it just compromises our mission to support our communities.

Mr. Butterfield. And you have a concentration in critical care. Can you discuss the impact that Medicaid expansion could

have on access to critical health care services for your patients?

Dr. Waldrum. Yes. I appreciate that.

So it would -- it would give coverage for many types of services and critical care services. With uncovered care, which is a very high-cost service, which is my specialty -- critical care -- having coverage for those services would really help our institution provide and cover those costs, obviously.

But there are other important services such as behavioral health and we know that having covered lives with Medicaid expansion helps us cover things like behavioral health, which helps with the opioid epidemic.

And so it really goes from ambulatory services like behavioral health all the way to critical care.

Mr. Butterfield. Now, the Census Bureau has identified 386 counties in the United States as persistent poverty counties, which means that a county has been in poverty 20 percent or better for the last 30 years.

That's a persistent poverty county -- 486 in the U.S. and 12 are North Carolina. Six are in the area covered by your hospital.

Can you speak to the impact that poverty and hunger and nutrition and safe housing have on a person's health?

Dr. Waldrum. I can speak to it because I've frequently

visited our communities and one of the communities I think you're referring to is Bertie County, which we have a hospital in, and travel, food insecurity, access to care or coverage, but just to drive to get access the distance -- so access to social services, I mean, you name it, it affects the people we serve.

Mr. Butterfield. Has your hospital or your association taken a position on Medicaid expansion in North Carolina?

Dr. Waldrum. Yes. We support it fully.

Mr. Butterfield. Okay. Thank you. I have some more, but I think I am going to yield back and pass it on to one of the other members.

All right. To the ranking member, Mr. Burgess.

Mr. Burgess. Thank you, Mr. Butterfield.

Mr. Barker, let me be a little bit provocative. Do we still need DSH?

Mr. Barker. I am sorry. Could you repeat?

Mr. Burgess. Do we still need the disproportionate share funding?

Mr. Barker. Oh, I think so.

Mr. Burgess. And given that context, what about just the proposed removal of the proposed cuts, just DSH funding goes forward with no structural reforms? Good idea? Bad idea? Neutral idea?

Mr. Barker. Well, I guess I would say, again, not speaking for MACPAC because I am not -- technically, I am not yet on MACPAC. I will be tomorrow. But I do think that MACPAC had a very thoughtful approach toward the -- ending DSH cuts.

I think that MACPAC was trying to be sensitive to the budgetary impact and that they were concerned that just flat out repeal of the DSH cuts would have a budgetary impact and so they proposed a more gradual implementation of the cuts combined with what I think is equally important and that is rebalancing the state DSH allocations with low income nonelderly population in a particular state.

The DSH caps were set at a time that -- were set over 20 years ago and they weren't based at the time on poverty levels in a state, and I think maybe it is time to revisit how they're allocated.

Mr. Burgess. So if the DSH cuts were wiped out in their entirety, the problems with the formula would still exist?

Mr. Barker. Yes.

Mr. Burgess. So -- and I think you make this point in your testimony, in your written testimony, certainly -- but maybe you can elaborate a little bit on the fact that historic spending in the disproportionate share funding may bear little or no relationship to the low income nonelderly population in a given

state today?

Mr. Barker. Yes, I think that is true because the way that the DSH caps were first established happened at a time when Congress and I think the -- it was the George H. W. Bush administration were very concerned about the explosion in DSH spending.

I pointed out in my testimony that DSH spending went from a little over a billion dollars in 1990 to $17 billion in 1992, and something was going on and they wanted to get a handle on it.

And so they imposed a cap, but the cap was just based on what states were spending in DSH at that particular time. It really didn't bear any relationship to the low income or the -- the low income rate or the poverty level in a state.

Mr. Burgess. So I am going to ask you something because I've always been a little sensitive about this as a physician. I mean, you look at hospitals who get disproportionate share funding but, of course, the physician workforce in that area may also be taking care of a very low income population or uninsured or under insured population.

There has never really been anything that balances what it costs providers to be in that area versus what it costs hospitals. As we heard, one delivery a day doesn't fund the entire labor

and delivery unit.

But it can also be very difficult for a provider to run a practice with that type of through put.

Mr. Barker. Yes, absolutely.

Mr. Burgess. And has there ever been anything looked at that would balance the equation for docs as well as hospitals?

Mr. Barker. I think that is why you are seeing a lot of hospital acquisition of physician practices just because -- that is one of the reasons that there has been a growth in hospital acquisition of physician practices because physicians can't manage it on their own.

Mr. Burgess. Which brings us then to what I consider the great conundrum. It is okay for hospitals to own physicians but physicians can't own hospitals, right?

Mr. Barker. That's -- I think that is correct.

Mr. Burgess. And we need to fix that. I wait for the judges' input and we will do that.

Do you think that a full repeal of the DSH cuts makes critical reforms of the program more or less likely?

Mr. Barker. I think it would make it less likely just because the -- there wouldn't be the political impetus.

Mr. Burgess. And, ultimately, then that is to the detriment of those populations that DSH was set up to serve in the first

place.

Mr. Barker. Yes.

Mr. Burgess. Is that -- is that a fair assumption?

Mr. Barker. Yes. Yes.

Mr. Burgess. Thank you, Mr. Chairman. Oh, that struck --

Mr. Butterfield. Thank you, Dr. Burgess. Thank you so very much.

Mr. Burgess. I had a hard time getting that out.

I will yield back.

Mr. Butterfield. Thank you.

At this time I will recognize the gentleman from New York, Mr. Engel.

Mr. Engel. Thank you, Mr. Chairman.

Medicaid DSH payments -- I want to talk about those -- they help hospitals and health systems, serve some of our nation's most vulnerable communities.

In fiscal year 2017, Medicaid DSH payments amounted to $18.1 billion, allowing safety net providers to deliver free or subsidized care to millions of Americans.

In October, these vital payments will be cut by $4 billion for the upcoming fiscal year and $8 billion for the following year. That is not a good thing to do.

Safety net hospitals regularly operate on thin or negative

margins. In fact, New York hospitals have some of the narrowest margins in the country. If Congress fails to delay Medicaid DSH cuts, some of our nation's safety net providers will be forced to close, leaving our constituents in communities without access to an important source of care.

Fortunately, there is broad bipartisan support for addressing these cuts. On May 13th, 300 members of the House joined Congressman Olson and me in pushing for a delay. I urge my colleagues to join me in helping preserve access to care for the most vulnerable among us.

Mr. Chairman, I also want to thank you and the committee for including legislation which would reauthorize funding for the National Quality Forum. I am pleased to sponsor this bipartisan legislation with Congresswoman Chu and Congressman Carter.

The National Quality Forum is one of the nation's leaders when it comes to developing tools for improving health care quality and outcomes.

Before asking questions of our witnesses, I ask unanimous consent to submit two letters of support into the record, the first from the American Hospitals Association in support of the Patient Access Protection Act, and the second from the Friends of NQF, supporting H.R. 3031.

Mr. Butterfield. Without objection on both of those requests.

[The information follows:]

**********COMMITTEE INSERT**********

Mr. Engel. Thank you, Mr. Chairman.

Let me ask Mr. Riccardi -- in recent years Medicare has made numerous efforts to move away from fee for service, instead toward a system that rewards value over volume. It is critical that we continue to find ways to measure and incentivize the highest quality of care.

So let me ask you, Mr. Riccardi, as we continue to pursue a health care system that pays for value instead of volume, what role do you see for the National Quality Forum's work?

Mr. Riccardi. An increasingly important one. NQF -- we need to ensure that they remain funded and sustainable for the direction of value-based care.

NQF has a membership of 450 organizations and the Medicare Rights Center is an active member of NQF. NQF facilitates dialogue across the private and the public sector, creating measures that operate throughout the Medicare program. In fact, hospital readmission rates have fallen by 8 percent and as states pursue value-based care arrangements and also focus on a variety of initiatives, these measures are key.

Increasingly, we are hearing beneficiaries calling our help line with questions about quality, and as CMS has improved tools for -- to evaluate and determine the quality of a variety of different facilities and settings, these measure are also key

in that in helping beneficiaries access valuable efficient care. Thank you.

Mr. Engel. Thank you. Hospitals use Medicaid DSH payments to support vital community health programs including initiatives to address opioid prescription abuse and improve maternal health.

Mr. Waldrum, could you please describe how your hospitals use Medicaid DSH payments to better care for your local community?

Dr. Waldrum. I would say I don't have time and we partner with our communities. But I will tell you to deal with all of those issues.

But we support a number of local initiatives and I will tell you one that happens in Conetoe, North Carolina, with Reverend Richard Joyner.

And so we have funded an initiative because the burden of the disease in those folks was very high, and so we helped him engage with the community to build a sustainable model where they educate children about healthy lifestyles and give them employment on a farm, and that has brought the parents in and they have a sustainable model to sell their product in our hospitals, and that has created a college fund and those kids are going to college and are breaking the cycle of poverty and ill health that they have been burdened with for decades.

And Ms. Bush, who is a 72-year-old woman in that community,

actually fought against it happening, and today, this morning, she was on that farm working and she's been working there for the last year and she is off 22 of her medicines because she has adopted the lifestyle and the habits that are being taught by that farm. So she is one example, and then these kids are the future of eastern North Carolina.

Mr. Engel. Well, thank you both. I think what you have said is very important and we all should heed it. Thank you.

Thank you, Mr. Chairman.

Mr. Butterfield. Thank you, Mr. Engel.

Richard Joyner is a dear friend of mine and I will let him know that you have acknowledged him today.

The chair now recognizes the gentlelady from California, Ms. Matsui.

Ms. Matsui. Thank you, Mr. Chairman.

Ms. Bohan, thank you for sharing with us how becoming a certified community behavioral health clinic has benefited your organization and community.

And we are hearing similar successes from clinics across the country where the demonstration has expanded treatment capacity and transformed their ability to meet the growing demands for community-based services.

Ninety-four percent of all CCBHCs have increased the number

of patients they treat for addiction and nearly two-thirds have been able to decrease wait times.

With the June 30th funding expiration looming, our CCBHC demonstration states are now stressing the extreme financial threat they face to sustain operations and provide vital continuous care.

I was glad to hear Ranking Member Walden express his support for extending the Excellence in Mental Health demonstration for additional two years.

Just this morning, I heard from a CCBHC in Oregon how a sustained investment in the program would allow its providers to reach into the community to further extend access to behavioral health services for individuals with serious mental illnesses.

In the midst of an opioid epidemic, we should be supporting innovative approaches like CCBHCs to provide integrative primary and behavioral health care. That is why expanding the Excellence in Mental Health demonstration as the support of interdepartmental serious mental illness coordinating committee of SAMHSA has been endorsed by Dr. Sally Satel of the American Enterprise Institute and has the support of 14 of my Republican colleagues.

People struggling with mental illness and substance use disorder across the country should be able to benefit the same

as patients in the eight states participating in the demo.

That is why I am fiercely advocating to extend this demonstration for the participating states and expand it to 11 more states in my bill with Representative Mullin, H.R. 1767.

In a new report entitled "Bridging the Treatment Gap," the National Council for Behavioral Health surveyed the CCBHCs and the results offer hope in our nation's battle against the opioid crisis.

The report showed, among other things, nearly universal adoption of medication-assisted treatment -- MAT -- and decreased patient wait times for these lifesaving interventions.

There is strong evidence that the program is leading to reduced overdose deaths in upstate New York, and I am also encouraged that CCBHCs in Oklahoma are reporting huge reductions in hospital emergency room utilization.

With that as background, Ms. Bohan, I would like to ask you a few questions. First, I understand that in New Jersey CCBHCs have opened new service lines like the 24-hour emergency psychiatric care and medication-assisted treatment while serving patients who have never received care before.

With the sustained funding including in my bill, how can your CCBHC further integrate and expand services for vulnerable patient populations?

Ms. Bohan. Thank you very much for your question and your support. Can you hear me? Yes. Okay.

So you are absolutely right. We have expanded service lines across the state of New Jersey. Twenty-four-hour mobile crisis services that did not exist previously in counties like Monmouth County are now really an integral part of the delivery there and they have quickly become the -- community resources have quickly become dependent on these services and being able to reach out directly to CCBHCs.

We are linked in with the Health Information Exchange so that community partners can really identify that someone belongs to a CCBHC and we are able to see if someone lands in an emergency room, and we can quickly get case management out and so forth to perhaps avoid a hospitalization and reengage them quickly.

Ms. Matsui. That is wonderful.

Ms. Bohan. And in terms of the opioid epidemic, many of the -- including Rutgers, the programs are looking at bridge programs from local emergency departments directly to CCBHCs so that individuals can be started on medication-assisted treatment and bridged directly over to the CCBHC where they could be maintained on this really lifesaving intervention.

Ms. Matsui. That's great. What risk would a lapse in demonstration funding have on your ability to provide holistic

services that address the ongoing opioid epidemic?

Ms. Bohan. It'll have a huge impact. As I said in my testimony, there are -- all of us have expanded our services, which also means expanding our workforce.

So we have individuals in place. We've expanded our ability to prescribe MAT. We have all established ambulatory withdrawal management programs so the individuals can come in and be inducted on MAT safely, and we are also able to deal with other medications as well in that setting.

So that is a program that is at great risk across the state.

Ms. Matsui. Well, thank you so much and I really appreciate your participation. Thank you so much, and I yield back.

Mr. Butterfield. The gentlelady yields back.

At this time, I will recognize the gentleman from Florida, my friend, Mr. Bilirakis.

Mr. Bilirakis. Thank you, my friend. Thank you, Mr. Chairman. I appreciate it.

Mr. Barker, the DSH program -- and I know that this has been covered but it is so very important to my state and other states as well, taking care of the indigent -- but the DSH program provides payments to hospitals, as you know, serving a disproportionate number of Medicaid patients and the uninsured.

ACA reduces this payment -- the payments by $14 billion from

2014 to 2019. Additionally, due to an arbitrary cap on DSH payments frozen since the early 1990s, Florida has been inequitably funded, and I know we are not the only state -- funded for DSH payments compared to other states with much lower uninsured populations, and this is a bipartisan issue.

So while I am supportive of delaying the cuts, certainly, I am concerned that simply repealing the cuts would not address the underlying issue.

The antiquated formula created in the early '90s that continues to negatively impact Florida and other good states, Florida's Medicaid patients and uninsured they are impacted by this and it is a real problem.

Should Congress update the DSH formula? Why or why not, sir?

Mr. Barker. Mr. Bilirakis, were you directing that question at --

Mr. Bilirakis. The question is for Mr. Barker.

Mr. Barker. Yes.

Mr. Bilirakis. Thank you.

Mr. Barker. So Dr. Burgess raised this issue --

Mr. Bilirakis. Yes.

Mr. Barker. -- when he was here before and I do think that repealing the DSH cuts in their entirety would remove the impetus

to reform the DSH formula. Yes, I agree with that statement.

Mr. Bilirakis. Okay. All right. Very good. Thanks for -- you know, and, again, this is a time to get it done. So how might Congress consider reforming the DSH formula to better reflect the current patient population in states like Florida and South Carolina, North Carolina, but all over the country -- New Jersey?

Mr. Barker. So the DSH caps that are in the statute right now were based on how much states were spending on DSH in 1991 or 1992.

Mr. Bilirakis. Right.

Mr. Barker. It doesn't bear any relationship to the number of low income or uninsured patients in the state whereas the whole purpose of DSH is to account for the situation of hospitals that treat a disproportionate number of low income individuals.

And so one idea would be that the DSH allocations be set based on a measure of low income nonelderly individuals in a state.

Mr. Bilirakis. Yes. I mean, again, it has affected so many states because things have changed since '91. So it is antiquated, and I appreciate -- thank you for the input and hopefully we can get something done about it.

Thank you, and I yield back, Mr. Chairman.

Mr. Butterfield. The gentleman yields back.

At this time I will recognize the gentleman from California, Dr. Ruiz.

Mr. Ruiz. Thank you, Mr. Chairman. There are many issues surrounding the outreach and enrollment for Medicare. So I would first like to thank my colleague and friend, Congresswoman Dingell, for her work on H.R. 3039, which provides the five-year extension of funding for Medicare outreach, enrollment in education for low income beneficiaries.

This funding will help connect those most in need with critical assistant programs. But we know that difficulties with Medicaid enrollment extend beyond this much-needed targeted specific funding which this funding will help. There are still many who fall through the cracks through the Medicare enrollment and suffer because of that.

In fact, most people that are newly eligible for Medicare are automatically enrolled in Part B because they are collecting Social Security retirement at the age of 65 and there is that communication so they automatically enroll.

But a growing number are not, as they are working later in life and deferring their Social Security benefits. Many of them are in under insured or uninsured or very little benefits to cover health insurance in those type of employments.

So unlike those who are auto enrolled in Part B, these

individuals make an active Medicare enrollment choice. So taking into consideration specific time lines and existing coverage.

Far too many seniors make honest mistakes when trying to understand and navigate this confusing enrollment system. The consequences of Part B enrollment mistakes are significant.

So if you are working, you are not automatically enrolled, you haven't enrolled, you don't have health insurance, you find out later that you don't have -- you're not enrolled in Medicare, you missed the deadline and that includes -- the penalties are late enrollment penalties, higher out-of-pocket health care costs, gas and coverage, and barriers to accessing needed services.

In 2018, an estimated 760,000 people -- 760,000 people with Medicare were paying a Part B late enrollment penalty with the average penalty amounting to a 28 percent increase in the monthly premium.

So I introduced a bill that will hopefully close this gap for seniors who are falling through and it is called the BENES Act, which will direct HHS to send enrollment notices to individuals approaching eligibility to educate them on how and when to enroll in Medicare Part B and close a coverage gap that currently exists for individuals that do not enroll at a specific time.

In other words, it gives these working seniors who deferred their Social Security a heads up proactively and giving them the opportunity to learn how and when to enroll so they don't miss that gap or fall through the cracks and miss the enrollment.

So, Mr. Riccardi, can you explain this underlying issue as well as the extent of the problem and what you are hearing from folks calling in to the Medicare Rights national help line?

Mr. Riccardi. Yes. And thank you, and thank you for championing the BENES Act and also Representative Bilirakis for sponsoring the bill also.

This trend emerged on our help line as confusion abounds. Medicare rules are complicated and, as you mentioned, a majority of individuals are automatically enrolled into Medicare if they're collecting Social Security.

But 20,000 people are turning 65 every day, people are working longer, and they are waiting to also collect their Social Security retirement benefits since the full retirement age for Social Security benefits is now age 66 and it is continuing to increase.

And so confusion is found from people of all backgrounds, of all incomes, and all educational backgrounds, and in particular we are seeing problems with individuals who may have some other type of coverage since our health care system and health insurance

is confusing, and HR specialists and employers are also confused about how to guide people through Medicare enrollment.

One barrier that could be easily addressed legislatively is to require that notice be sent to people before they're turning 65 to inform them about their eligibility for Medicare Part B and for Medicare.

And just remember, these individuals are entitled to the Medicare program but they are going without. This trend had emerged a few years ago on Medicare rights help line and to this day I still recall speaking to a client who had worked for a large company, and he had retiree coverage and he had worked for many years and contributed to Social Security and the Medicare program, but he was without Medicare Part B.

And for years, he had this retiree coverage. But it wasn't until he had stage four cancer that they no longer would pay for his cancer bills.

And so he was caught within this very catastrophic gap in coverage when you are waiting to enroll into Part B but you can't. And so he had to go, you know, close to 12 months, 14 months, without coverage and in his case, him and his wife had to take out a reverse mortgage.

And this was one of the first calls that we received on this issue, and every day we are hearing more and more from people

who are missing their enrollment period through no fault of their own.

And so the BENES Act would do, as you had mentioned, three really important things. First, it would inform people about their Medicare eligibility as they are turning 65.

It would simplify the enrollment periods. Generally, people are very confused about when to enroll into Part B and prescription drug coverage. It would simplify these enrollment periods.

And lastly, it would do away with this catastrophic gap in coverage that is in place. So thank you for your support.

Mr. Ruiz. Well, thank you for that information and I too want to thank my good friend, Representative Bilirakis. We join efforts on a multitude of bipartisan bills together and this is one, I think, that we are going to pass through the House and get signed by the president.

Thank you.

Ms. Eshoo. [Presiding.] Thank you.

I was on the floor to handle a bill. So excuse me for not being here for a good part of your testimony and thank you again for really essentially being here all day with us.

Let me just circle back, Mr. Riccardi. I got the tail end of this. At one time, Social Security would notify an individual

that they -- that they would become -- becoming eligible by whatever date and have an explanation, and I've always thought out of all the government agencies that Social Security materials are really understandable. They are written so clearly. It is not written in federalese and all of that.

So people are not notified anymore by Social Security that they are -- that they are about to become eligible for their benefits?

Mr. Riccardi. For individuals who are not collecting Social Security benefits there is no information or separate notice that is provided to individuals to inform them that they are turning 65 and that they're within the window of time to enroll into Medicare.

So, currently, that is not happening.

Ms. Eshoo. Maybe I am confusing Social Security with AARP because when you are 55 they start telling you that you are going to turn 65 in 10 years.

Thank you for that. And your legislation addresses this; it closes the gap. So they will get a notice?

I am sorry. You need to -- he can't hear you.

Mr. Ruiz. So yes, correct. So for those who aren't drawing Social Security and retiring, they either continue to work and don't have health coverage or enough health coverage, then they

don't get a notice.

So my bill will send -- be proactive and let them know about their enrolling.

Ms. Eshoo. Let me ask this. Is there still going to be anyone left out, without a notice?

Mr. Riccardi. The notice -- the notice will improve people's -- the information that they can access around enrolling, and with that information people should be able to make a more informed decision.

Going back to my earlier point, there are a number of beneficiaries who are living on very limited incomes. As I had mentioned, a quarter of people are living under, you know, $15,000 a year. So the cost of Medicare and the Part B premiums can still be prohibitive to some.

So that's why we encourage enrollment into the Medicare savings program because there are some reasons why somebody may not be enrolled in Medicare because they can't afford it.

Ms. Eshoo. We had -- Mr. Barker, you have -- I heard your testimony on disproportionate share of hospitals.

Mr. Barker. Yes.

Ms. Eshoo. Yes. I would like to know if you know the following. And I don't recall exactly how many states decided not to participate in the expansion of Medicaid with the ACA.

Were there 22 or something like that?

Mr. Barker. I think 33 states have expanded Medicaid so --

Ms. Eshoo. Thirty-three states. Thirty-three states left -- the expansion, right? And they left a great deal of money on the table. But, to me, the worst of it all was that the people that they represented in their states didn't have the opportunity to enroll.

Having said that, do you know of -- in those states how those disproportionate share hospitals have fared? Has their population -- the people that they serve gone up and, if so, exponentially? Do you have any information on that?

I can't help but think that there is a nexus between the two. Do you know?

Mr. Barker. I don't know. I actually think that Dr. Waldrum --

Ms. Eshoo. Does anyone on the panel know?

Mr. Barker. -- might know more than I do because he --

Ms. Eshoo. Dr. Waldrum?

Mr. Barker. -- his hospital is in a state that has not expanded Medicaid.

Dr. Waldrum. Yes, I very much appreciate the question and I think it is a very valid point. The states that did not expand

Medicaid the fact are pretty clear that we have had more rural hospital closures in those states than we have in states that expanded.

And so the burden that it has placed because of the issues, primarily rural non-expansion states, that is where the hospitals are closing and there is literature to support that it has to do with the lack of --

Ms. Eshoo. Do you think that you could get that information to us?

Dr. Waldrum. Yes, we would be happy to.

Ms. Eshoo. You know, around here rural is a big issue on -- no matter what we do, whether it is telecommunications, technology, the digital divide, the homework divide, health care, transportation, you name it, rural areas in our country are affected and I that this is another one.

And when you say that a hospital has closed, that is a very big deal in Anyplace, USA, much less in a rural area. So I would really appreciate getting that information and my own sense is, understanding pretty well -- very well -- how DSH works that without another appropriation of those funds, what will happen to these places?

Dr. Waldrum. I am certain that more --

Ms. Eshoo. What will happen to the people in these places?

Dr. Waldrum. More hospitals will close. There will be reduction in services and we know that what happens is that services are curtailed initially. One that we mentioned earlier, OB services -- so in a lot of rural hospitals they have gotten out of OB services because of the low volume and that limits access and that is contributing to the maternal and fetal -- I mean, infant mortality crisis in rural America, and actually there is data that shows that when that happens the next thing is that the hospital closes and then the town, the community, suffers and in some cases actually goes away.

Ms. Eshoo. Wow. What a description. That doesn't belong in America. Thank you very, very much.

I now would like to recognize the gentleman from Oregon, Mr. Schrader, for his five minutes of questions.

Oh, I am sorry. Should I go to Mr. Guthrie then?

Okay. Mr. Guthrie?

Mr. Guthrie. Thanks. Thank you very much. Appreciate it.

Ms. Eshoo. The gentleman from Kentucky. We need to introduce you appropriately. The gentleman from Kentucky, Mr. Guthrie.

Mr. Guthrie. Well, thank you. I appreciate that very much.

Thank you very much.

So, Mr. Barker, the -- I know in one of the opening statements

about the responsibility to stop the DSH cuts -- the DSH cuts were implemented by -- what legislation brought forth the DSH cuts? Do you know?

Mr. Barker. The ACA.

Mr. Guthrie. And the concept -- and I understand the question of my friend from California who was asking about states that didn't expand.

I am from Kentucky and we did expand Medicaid. We also set up exchanges that Kentucky fully embraced and I know our current governor has made some changes but still essentially fully embraced the Affordable Care Act with -- given some changes, going from state marketplaces to the federal exchange, but still there.

And my hospitals still -- well, first of all, to the hospitals you described closing the DSH cuts have never taken place. There has been no cuts in DSH is my understanding. Is that correct, I think, Dr. Waldrum?

Dr. Waldrum. I believe that is correct.

Mr. Guthrie. It is correct. So this is --

Dr. Waldrum. It is the lack -- it is the lack of the covered lives by expansion.

Mr. Guthrie. Well, Kentucky is having similar issues and we have the same -- we did expand. Do you know -- Dr. Barker -- Mr. Barker, so the concept was that you wouldn't have to have

DSH because everybody is going to be covered if they expand and created the exchanges.

Kentucky expanded and created the exchanges, and our hospitals they'll have to close if they -- some hospitals if they didn't have DSH. We are seeing consolidation.

Do you know why the premise of the Affordable Care Act in terms of DSH hasn't worked?

Mr. Barker. My understanding was exactly what you said, which is that the thinking was that as the number of uninsured individuals declined, there would be less need for DSH -- both Medicare DSH and Medicaid DSH.

Mr. Guthrie. Right. But so that didn't happen, did it? I mean, Kentucky expanded Medicaid. Kentucky created exchanges and still rely on DSH heavily.

So it seems like that didn't work. Whatever the concept was didn't work. Do you know why it didn't work? I understand the premise what was supposed to happen, but it didn't work.

Mr. Barker. I can't comment on why it didn't work.

Mr. Guthrie. Okay. So the second thing -- so Mr. Waldrum, about DSH -- it is something that, you know, I support. We are going to have to maintain because of what the effects on hospitals, particularly rural areas.

But let us see if we had a hypothetical to your delay and

then Congress should update the formula to better align the relationship between DSH allotments in a state and the number of low income nonelderly individuals.

So my question, Dr. Waldrum, would your state -- would your hospital -- how would -- if we realigned that formula, would your hospital be affected positively and would all of you commit to working with us to find a long-term solution that can steer DSH funding to where it should do the most good?

So would you like to see a change in the formula? I mean --

Dr. Waldrum. So I am not an expert in the complex calculations and how those are passed down to the states and then how that would be allocated locally. I am really --

Mr. Guthrie. It is to the hospitals. It would be the hospitals.

Dr. Waldrum. To the local hospitals, correct. And so how that would flow I am not an expert from a technical perspective. I am a provider, a physician, and a hospital administrator that tries to provide services to these communities and cuts promulgated on, as you described, very fragile communities and how we serve those folks.

We wouldn't want and would oppose those cuts. And so I am not here to address the technicalities and I am not an expert

in that area.

Mr. Guthrie. Any comment on that, Mr. Barker, on the formula of DSH and how DSH is allocated?

Mr. Barker. On the Medicaid side, that's a state by state determination. So the federal statute --

Mr. Guthrie. Right.

Mr. Barker. -- sets a minimum threshold for classes of hospitals that have to be designated as DSH but then it is up to a state to decide within those parameters.

Mr. Guthrie. But there is a federal formula that allots that money, correct? Like Tennessee doesn't get much DSH --

Mr. Barker. Oh, you mean the overall DSH?

[Simultaneous speaking.]

Mr. Barker. I am sorry, Congressman. I didn't understand your question. Yes, you are right. There is a statutory DSH cap.

Mr. Guthrie. Right.

Mr. Barker. Tennessee was not getting any DSH funds back in 1992. But that DSH cap was set on the level of DSH spending in a state in 1991 or 1992, and the reason Tennessee doesn't have one is because they weren't using any DSH funding back --

Mr. Guthrie. Do you think that should be -- I think that might have been when they had TennCare. I am not sure. I don't

know if there are some Tennesseans who -- so do you think that formula should be -- to be fair, to other states, that it be reallocated instead of based on a 1991-92 number?

Mr. Barker. I do think -- Dr. Burgess raised this issue earlier. Yes, I do --

Mr. Guthrie. Sorry. I was in another meeting.

Mr. Barker. No. No. No. No. I think that it would be a good idea to revisit the DSH allocations.

Mr. Guthrie. Okay. Thanks. I appreciate that. With my last 10 seconds, you know, that DSH was a big pay for the Affordable Care Act and here we are, and we are going to need to do it. I am not saying we don't need to do it. But now reallocating money that has already been allocated to make sure that hospitals don't close.

So I appreciate the time, Madam Chair, and I yield back.

Ms. Eshoo. The gentleman -- let us see. I now would like to recognize the gentleman, and he is a gentleman, from Oregon, Mr. Schrader, for his five minutes of questioning.

Mr. Schrader. Thank you again, Madam Chair. I appreciate it.

I will follow up a little bit on the line of concern that Congressman Guthrie and Congressman Burgess -- Dr. Burgess -- had talked about because it sounds like from what we have heard

today that the DSH payment thinking with the ACA didn't work out quite as well as we had thought.

Charity care has decreased. That is a good thing. Medicaid care has increased and, as we all know, Medicaid doesn't pay full freight. So I think some of the hospitals, perhaps in Mr. Guthrie's district, are still having some trouble balancing the commercial rates, obviously, with the increase in Medicaid population.

But I think it gets to the central point that, you know, big proponent of making sure, you know, we make sure these hospitals and rural hospitals in particular stay in place. You know, prefigure, recontour this formula that is 20-plus, maybe 30-plus years old at this point in time makes sense.

I would put in though, as a person whose state actually did to the Medicaid expansion that whenever if we redo this formula we should take into account the fact that those states that stepped up and actually provided health care for our low income people there ought to be no penalty at least for them having done so.

The original Senate language, you know, that was finally implemented when this was all done many years ago, talked about low income and I think that should still be the major guiding force for how we approach these payments.

To me, you know, based on what we have heard today, the MACPAC stuff will be a great starting point in terms of how we deal with any gradual elimination or reduction -- probably not elimination but reduction in the DSH payments with some tweaks to make sure that we take into account what's actually happened, you know, over the last 20 years and particularly since the ACA has put into effect.

Mr. Riccardi, just chat a little bit if you don't mind and follow up -- I talked about this a little bit and it has been talked about with the previous panel, you know, how important the FQHCs and the CHCs are for delivering health care for a lot of folks that are uninsured or don't have access to health care, basically.

In trying to incentivize aligning the quality metrics, Oregon has gone a long way in trying to match up managed care metrics, you know, with those for FQHCs and trying to make all your guys' lives hopefully a little bit easier. You have enough widgets to count. Be nice just to count, you know, one widget for -- one metric, if you will, for each of those widgets.

So while the states are starting to do some stuff -- and I have some folks in my state rather it just be a state function. I don't know if that is the best way to go.

Would you support aligning these, you know, quality metrics

between managed care, Medicaid basically, in the FQHCs and CHCs?

Mr. Riccardi. Yes. In New York there is an example. I am a member of a work group where we are partnering with the public and the private sector, looking at, you know, a variety of quality metrics in determining, you know, what makes the most sense for patients and also for providers and other health care professionals to ensure that that information is readily understandable by the health care workforce and also the patients who need that information.

So I do see that collaboration happening. But I think there is, you know, more that can be done and that's something that we are supportive of.

Mr. Schrader. So I wonder if it is the role of the federal government to help provide an opportunity or incentivize that and then let the states, depending on their own culture, figure out what outcomes are most important to them to align themselves with and hopefully run through CMS, at the end of the day.

Mr. Riccardi. Yes, and I think that's why it is so important that an organization like National Quality Forum is supportive because they are able to assist, you know, every state with these measures. And so agreed.

Mr. Schrader. Good. Well, that's all the questions that I had, Madam Chair. Thank you much and I will yield back.

Ms. Eshoo. The gentleman yields.

And I recognize the gentleman from Georgia, the only pharmacist in the Congress, Mr. Carter. How is that?

Mr. Carter. That is very good. Thank you.

Ms. Eshoo. I know that. What was my first clue?

[Laughter.]

Mr. Carter. Thank you, Madam Chair, and thank all of you for being here. This is certainly important and we appreciate your being here and helping us with this.

I wanted to start by saying that, you know, I am very honored to be the Republican lead on H.R. 3031, working with Representative Chu and Engel on the National Quality Forum.

I think it is very important. It is very important because it is a valuable resource for making sure that we have and that we achieve cost-efficient and high-quality and value-based health care that ensures that all Americans will have quality health care, and we certainly need to continue this program and that is why I am proud to be a part of that.

I will start with you, Mr. Riccardi, and just ask you, you mentioned it in your testimony and I wanted to ask you if you could just expand a little bit more on the value of the National Quality Forum, particularly as it relates to Medicare recipients.

Mr. Riccardi. Thank you for that question, and to add, you

know, the saying goes that it is important that an individual gets the right care at the right time at the right setting. You may want to add also at the right cost.

And the National Quality Forum has created the highest level of quality standards that are available to states and agencies and both, as I mentioned, the private the public sector.

And, in particular, with the Medicare program with the preventable readmissions program, we have seen some success and decrease in those admissions, and I know from my background I also am a lecturer at the Columbia School of Social Work, and a number of my students have been involved in some of those demonstration programs, helping prevent readmissions.

And the accessibility and the use of those quality measures have been key to ensure that people are receiving the right care at the right time in the right setting.

Mr. Carter. I can't help but remember -- I was a consultant pharmacist in long-term care for many years and we used to have the seven rights of drug administration -- the right drug for the right patient in the right dose at the right time, the right administration, so on and so on.

So you are exactly right and I appreciate you reiterating that.

Mr. Barker, I want to change gears real quick and talk about

DSH payments. I have got a very rural district in Georgia and south Georgia particularly -- very rural area -- and my district, certainly to the western portion of my district is very rural, and DSH payments are extremely important to our rural hospitals.

And some of them are totally reliant on this. So I understand that there are some hospitals or some states that aren't using their full DSH allotment and I find that hard to believe, and just wondered if you can -- if you can explain how that can happen and what's going on there.

Mr. Barker. So my understanding is that there are three states -- if I am not mistaken, there are three states that are not using their full DSH allotments, and I assume that that is because that there is, as well as a state-specific cap in DSH there is also a hospital-specific cap.

Medicaid DSH payments cannot exceed the amount of uncompensated care that a hospital has. And so the only thing that I can think of is in those three states those hospitals are being paid at least the cost of their uncompensated care.

Mr. Carter. MACPAC had made some recommendations that -- on potential reforms, and I think you may have mentioned some of these. Do you have any other ideas or any other suggestions on what we can do in Congress to make sure that this program is being utilized like it is supposed to be?

Mr. Barker. Thank you for that question.

You are right, I did mention the MACPAC recommendations and one of them addresses exactly the issue that you mentioned, which is applying the DSH reductions to those states that have not expended their full allotment, which is -- would sort of hold for at least a portion of the DSH cuts hold everyone harmless.

Another recommendation that MACPAC made is to rethink the way that the DSH caps are allocated right now because they don't really bear any relationship to low income or uninsured patients.

Mr. Carter. That is important. Thank you for bringing that up because we do need to look at that, and if there is reform needed we need to address it.

Mr. Barker. Thank you, sir.

Mr. Carter. Well, again, thank all of you for being here. This is extremely important. We all understand that. I am concerned about how we are going to pay for all this.

But at the same time, there is no question that these are quality programs that need to be continuing on and, certainly, whereas we need to look at some reforms on certain programs like the DSH payment system, you know, I want to make sure that particularly the rural hospitals understand that we understand how important it is to them for their survival.

So thank you, Madam Chair, and I yield back.

Ms. Eshoo. The gentleman yields back, and I want to thank each one of the witnesses. I think you have given really high-value testimony today. I know that I have learned from you and, Ms. Bohan, the numbers in your program are really stunning -- really stunning -- and I think when the time comes that the secretary has to review your pilot I want to be able to lean in at that time because when you talk about those wait times being brought down and reaching out to people, it is exactly what we need in our country.

And while I am not going to say something to each one of your individually, I could -- thank you. Congress is so dependent upon the experts that come here to answer our questions and I am proud of the members of the entire subcommittee because their questions were all serious and well directed, and you gave us answers and we can build on that foundation as we move forward to reauthorize.

So all of our thanks for your participation. I also would like to submit the following statements or letters for the record. There are several of them:

A statement from the American Osteopathic Association in support of H.R. 2815; a letter from American Federation of State, County, and Municipal Employees regarding certified community behavioral health clinics; a letter from Oregon AFSME in support

of H.R. 1767; a letter from AFSME 1199(j) and Care Plus New Jersey regarding CCBHCs; a letter from the American Hospital Association in support of 1767; a letter from AHA in support of 3022; a statement from the Endocrine Society regarding the Special Diabetes Program; a letter from Representatives DeGette and Reed regarding the Special Diabetes Program; a letter from Friends of NQF in support of 3031; a letter from Healthcare Leadership Council regarding NQF and PCORI; a letter from the American Academy of Family Physicians regarding THCGME and CHCs; a letter from the Alliance of Community Health Plans regarding the Patient-Centered Outcomes Research Institute; a letter from the National Kidney Foundation regarding PCORI; a letter from Friends of PCORI Reauthorization regarding PCORI; a statement from the PCORI Board of Governors regarding PCORI; a letter from the Council of Academic Family Medicine in support of 2815; a letter from the Leadership Council of Aging Organizations regarding outreach and enrollment to low income Medicare beneficiaries; a letter from the Children's Hospital Association regarding DSH; a letter from Representatives Engel and Olson regarding DSH; a letter from America's Essential Hospitals in support of 3022; a letter from Texas Parent to Parent in support of 2822; letters from Family to Family Health Information Centers regarding 2822; a letter from the Catholic Health Association in support of 3022.

So are there any objections to these letters and documents being placed in the record?

If not, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

Ms. Eshoo. And I think with that, remind members -- there are only two of us here, but staffers are still here -- that pursuant to committee rules they have 10 business days to submit additional questions for the record to be answered by the witness who has appeared.

We know that you will be highly cooperative and full answers in a straightforward way in a short period of time. How is that? Everyone agree to that?

I think so. So with that, yes, Dr. Burgess?

Mr. Burgess. If I may --

Ms. Eshoo. Yes.

Mr. Burgess. This afternoon marked the passage finally of the Pandemic All-Hazard Preparedness Act on the 100-year anniversary of the Spanish flu. So you are to be congratulated for this entire subcommittee that worked so hard on this for the past three years and we have now gotten it across the finish line.

So I will be looking forward to seeing you at the signing ceremony down at the White House.

Ms. Eshoo. That will be wonderful, Mr. Burgess.

And huge, huge kudos to Representative Susan Brooks, who was and is, I think, just the best partner I could ever have on a bipartisan basis, and to the -- certainly to the -- to you, Dr. Burgess, to the chairman of the full committee, and to the

ranking member of the full committee.

They say it takes a village. It takes a team here and --

Mr. Burgess. And your staff.

Ms. Eshoo. I haven't finished. I haven't finished. You always want to correct me.

Certainly, to the staff, too. Catherine -- is it Catherine Wallens or Willins -- on Representative Brooks' staff, and Rachel Fybel on mine. They work late into many nights with the bouncy ball going over on what was taking place in the Senate.

But it is about our national security and public health and response to whatever God has in store for us. So kudos, and thank you for raising it.

So I don't think that there is anything else to come before the committee. It is quarter to 4:00 in the afternoon and at this time the Health Subcommittee is adjourned.

Thank you, everyone.

[Whereupon, at 3:45 p.m., the committee was adjourned.]