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HIF109140

EXAMINING EXISTING FEDERAL PROGRAMS TO BUILD A STRONGER HEALTH WORKFORCE AND IMPROVE PRIMARY CARE

WEDNESDAY, APRIL 19, 2023

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. Brett Guthrie [chairman of the subcommittee] presiding.

Present: Representatives Guthrie, Burgess, Latta, Griffith, Bilirakis, Johnson, Bucshon, Hudson, Carter, Pence, Crenshaw, Joyce, Harshbarger, Miller-Meeks, Rodgers (ex officio); Eshoo, Sarbanes, Cardenas, Ruiz, Kuster, Kelly,

Barragan, Blunt Rochester, Craig, Schrier, and Pallone (ex officio).

Staff Present: Kate Arey, Digital Director; Jolie Brochin, Clerk, Health; Sarah Burke, Deputy Staff Director; Kristin Flukey, Professional Staff Member, Health; Grace Graham, Chief Counsel, Health; Sydney Greene, Director of Operations; Nate Hodson, Staff Director; Tara Hupman, Chief Counsel; Peter Kielty, General Counsel; Emily King, Member Services Director; Molly Lolli, Counsel, Health; Emma Schultheis, Staff Assistant; Michael Taggart, Policy Director; Lydia Abma, Minority Policy Analyst; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Tiffany Guarascio, Minority Staff Director; Una Lee, Minority Chief Health Counsel; Juan Negrete, Minority Professional Staff Member; and Rick Van Buren, Minority Senior Health Counsel.

*Mr. Guthrie. The subcommittee will come to order.

The chair recognizes himself for an opening statement.

Today the health care subcommittee is taking an important step in reauthorizing critical programs within the Health Resources and Services Administration. The policies before us today each play a unique role in providing greater access to care for millions of Americans, particularly those in rural and underserved communities. Many of these programs expire on September 30th. By taking early action, we are providing reassurance that they can continue without disruption.

Early action also provides subcommittee members with the chance to review the impact of -- the policies are currently having, and ensure all future funds are directed in the most effective and appropriate way possible. It also gives us time to work together and find bipartisan offsets for mandatory spending in future years.

The first bill, the Strengthening Community Care Act of 2023, would extend the Community Health Care [sic] Fund and the National Health Service Corps through 2028. Both programs allow millions of Americans across the country in

medically underserved communities to receive access to high-quality primary care services, including pharmacy, mental health, substance use disorder, and dental care services.

Across Kentucky, HRSA's Uniform Data System data shows that 25 health systems received grant funding in 2021. Nearly 600,000 patients were served, many of which were served by providers who participated in the National Health Service Corps.

I want to thank Dr. Joyce for leading on this important issue, especially at a time in which we are facing primary care provider shortages across the nation.

I am hopeful we can come to a bipartisan agreement on a path forward to extend funding and -- on the necessary offsets for the Teaching Health Care Center Graduate Medical Education program. I am committed to working with my colleagues to continue these essential programs. However, I do think we do not make -- should not make these programs permanent at this time.

We are examining the National Nursing Workforce Center Act, led by Representatives Kim and Blunt Rochester. This bill is designed to help bolster our nursing workforce, and

would specifically require HRSA to work with state nursing workforce centers to help streamline their nursing workforce programs. This would ultimately provide more targeted investments that reflect the need of local communities.

I thank my colleagues for working on this bipartisan bill.

I also would like to thank Representative Blunt Rochester for working with me on one of my nursing workforce priorities, the Building America's Health Care Workforce Act. This would address very serious nursing workforce shortages in the long-term care community. I will continue my push to advance legislation like this that cuts red tape, especially as we near the expiration of the COVID-19 public health emergency on May the 11th.

We will also consider proposals to provide continued access to key programs for chronic conditions such as diabetes. The Special Diabetes Program Reauthorization Act of 2023 and the Special Diabetes Program for Indians Reauthorization Act will provide continued funding for both programs through 2028. Over 1.6 million Americans living with Type 1 diabetes -- these programs will allow patients to

continue receiving comprehensive diabetes care, and will lead to a higher quality of life and lower health care costs for patients.

I thank Representatives Bilirakis and Cole for leading on these issues.

We are also considering legislation that will promote more transparency and greater access to care for over 100,000 individuals in need of an organ transplant. Dr. Bucshon's Securing the U.S. Organ Procurement and Transplantation Network Act would ensure the nation's organ procurement system is operating more efficiently, which will ultimately lead to greater access to organ transplants for vulnerable populations.

Lastly, we are examining a proposal to increase transparency within the Covered Countermeasures Injury Compensation program to help ensure claimants are receiving adequate information in a timely manner.

I look forward to today's discussion. I thank the witnesses for being here, for being with us today.

[The prepared statement of Mr. Guthrie follows:]

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*Mr. Guthrie. And I yield back. The chair now recognizes my good friend from California, the ranking member of the subcommittee, Ranking Member Eshoo, for five minutes for an opening statement.

*Ms. Eshoo. Thank you, Mr. Chairman.

And good morning, Administrator Johnson. Welcome back to the Health Subcommittee, and thank you for your superb leadership at the helm of the Health Resources and Services Administration, overseeing more than 90 programs that improve the health and well-being of all Americans. You head up the agency with grant-making, and it is the dispersal of those funds in HHS that really make the policies dance. So thank you.

Today our subcommittee is considering eight bills to extend critical public health programs, bolster the health workforce, and address the broken organ transplant system. We are going to hear testimony about five health programs that expire on September 30th; Community Health Centers that are really core, you know, operations in our congressional districts; the National Health Service Corps; the Teaching Health Center Graduate Medical Education program; the Special

Diabetes Program; and the Special Diabetes Program for Indians.

First we are considering a bipartisan bill to extend mandatory funding for Community Health Centers and the National Health Service Corps for five years. The Community Health Center Fund provides support to nearly 14,000 health center locations across our country. These health centers provide primary care to 1 in every 11 Americans. We cannot do without them -- including 1 in 5 Californians, regardless of their ability to pay.

A Community Health Center in my district, the Asian Americans for Community Involvement, provides a full spectrum of care through a multilingual team of doctors, nurses, and patient navigators. They have earned a superb reputation for the care that they give to people in the community. And at this health center the team can speak more than 40 languages to ensure their services are responsive to cultural beliefs, to practices, and preferred languages.

The National Health Service Corps is a highly effective program that has been connecting providers to patients in need for over five decades. I am disappointed that funding

for these programs is not adjusted for inflation, despite the clear need. But I support the bipartisan reauthorization.

We are also considering programs to improve access to primary care. We have to stay on this, because that is the entrance to the entire health care system in our country, including the Teaching Health Center GME Program and the Special Diabetes Programs. They support viable primary care workforce for low-income communities by providing residency -- and we spoke about this on the phone -- residency training at Federally Qualified Health Centers.

The Affordable Care Act enabled the teaching health centers -- can we not talk in the background here? It is distracting. Please.

The Affordable Care Act enabled Teaching Health Centers to train residents. Thirteen years later, these centers have proven they can successfully train residents who will build their practices in rural and underserved urban communities. This is -- you know, a giant bravo on this, because it really is working. But funding for this program remains elusive and inconsistent, preventing it from reaching its potential. I support the legislation we are considering today to

permanently authorize the THC GME program and fund new training sites to increase resident physician spots. And I believe that this subcommittee can get to a bipartisan agreement on this reauthorization.

The other expiring programs include Special Diabetes and the Special Diabetes Program for Indians, which provide critical investments in research and care for those living with diabetes.

I have more to say, and I will say it as we move through our hearing today because my time is almost up. But I want to thank you for your leadership, and I want to thank you also for sending out to each one of us -- HRSA -- in our congressional districts, because this really brings it home about what HRSA is doing, the grant-making, and the difference that it is making in the lives of our constituents.

[The prepared statement of Ms. Eshoo follows:]

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*Ms. Eshoo. So with that, Mr. Chairman, thank you for holding the hearing, and I yield back.

*Mr. Guthrie. Thank you --

*Ms. Eshoo. And welcome to the chairwoman's daughters. Are they still here? Right here.

*Mr. Guthrie. Oh --

*Ms. Eshoo. Oh, yes, yes.

*The Chair. She outed you.

[Laughter.]

*Ms. Eshoo. Yes, yes.

[Applause.]

*Ms. Eshoo. Future women Members of the Congress.

*Mr. Guthrie. Absolutely.

*Ms. Eshoo. Yes.

*Mr. Guthrie. We do welcome you here today, and I thank the gentlelady for yielding back, and the chair now recognizes the chair of the full committee, Chair Rodgers, for five minutes for an opening statement.

*The Chair. Thank you, Mr. Chairman. And I too would like to welcome my two daughters, two most important advisors, Brynn, Brynn Rodgers and Grace Rodgers, who are on

spring break. It is great to have them in D.C. today.

Yes, so welcome to the Energy and Commerce Committee. Yes, it is great to have you.

And also welcome to Carole Johnson, the administrator for the Health Services and -- Health Resources and Services Administration, known as HRSA. And I too want to say thanks for the detailed district analysis that you have given each one of us, and also coming to Spokane and spending some time in my district.

Today we will discuss several existing Federal programs and proposed legislation related to health care workforce, primary care services, organ procurement, competition, countermeasure injury compensation transparency, and diabetes research and treatment.

The health care workforce shortage is leaving people without the primary care they need, which is why we are considering the Strengthening Community Care Act of 2023, led by Representative Joyce. This legislation will reauthorize the Community Health Center Fund and the National Health Services Corps that will help support both primary care services and the health care workforce.

I am especially proud of the work Community Health Centers in my district are doing to expand services and increase job opportunities. New Health currently offers a medical assistant pre-apprenticeship program in partnership with local high schools. They are also working with a local school district to develop workforce a training center, where rural high school students can gain access to clinical and non-clinical internships.

Additionally, CHAS Health in Spokane is giving high school students the opportunity to participate in training sessions where they can learn about the different aspects of the health clinic and related professions. I am hopeful that these efforts will help bring more health care workers into our community.

Next we will discuss proposals to continue the Teaching Health Center Graduate Medical Education Program funding. I am a long-time supporter of this program, which helps to bring more primary care doctors, OB-GYNs, mental health providers, and others to rural areas. Spokane, Washington has recognized this, and is a national leader on recruiting the next generation of health care workers. The mandatory

funding for this program runs out September 30th, and I am committed to working to extend it. I hope that we can come to a bipartisan agreement and find the offsets needed.

We will also consider the National Nursing Workforce Center Act of 2023, led by Representative Young Kim. This bill will help enhance existing state-based nursing workforce centers, so that we can better access workforce challenges and address any gaps.

I am thankful for Representative Bucshon's leadership on the Securing of the U.S. Organ Procurement and Transplantation Network Act. It will allow for HRSA to make the Organ Procurement and Transplantation Network process more competitive, with the ultimate goal of making organs available to more people in need: one area where more work needs to be done.

We will also consider a proposal to increase transparency within the Countermeasures Injury Compensation Program. This is administered by HRSA, and provides compensation for covered injuries or deaths that occur as a direct result of using certain countermeasures used to treat ailments from a public health emergency or security threat.

Lastly, we will discuss two programs critical to improve the lives of people with diabetes, including Representative Bilirakis's Special Diabetes Program Reauthorization Act of 2023 and Representative Cole's Special Diabetes Program for Indians Reauthorization Act of 2023.

[The prepared statement of The Chair follows:]

**********COMMITTEE INSERT**********

*The Chair. With that I am looking forward to today's discussion, and I yield back.

*Mr. Guthrie. I thank the gentlelady; the chair yields back.

The chair now recognizes the ranking member of the full committee, the gentleman from New Jersey, Mr. Pallone, for five minutes for an opening statement.

*Mr. Pallone. Thank you, Mr. Chairman. Today the committee continues its critical work of strengthening our health care systems by building a stronger health care workforce and improving access to primary care.

I am delighted that we will be considering my bill, the DOC Act, which permanently authorizes and increases funding for the Teaching Health Center Graduate Medical Education Program. And this program supports the training of primary care medical and dental residents in high-need communities. It is the only Federal program that invests in this training of future physicians in a community-based setting, rather than a hospital setting. And this is important for a number of reasons.

We know that physicians often choose to practice close

to their training sites. By moving primary care training into the community, Teaching Health Centers help to address the workforce shortages in underserved areas, and increase access to primary care.

This program has been incredibly successful since it was established by the Affordable Care Act. Today there are 72 Teaching Health Center programs in 24 states, with 969 medical residents handling more than 1 million patient visits annually in rural and urban communities. It is because of this success that the program has been reauthorized several times with strong bipartisan support.

Reauthorization is critical, but often times these reauthorizations have often been short-term, leaving the program in a state of uncertainty. The threat of expiration makes it difficult for Teaching Health Centers to plan and recruit for their residency programs. Low funding levels also jeopardize the sustainability of programs and their ability to address primary care workforce shortages in underserved areas.

Unfortunately, unlike the Medicare Graduate Medical Education GME program, which funds GME slots and teaching

hospitals at over $16 billion a year, the Teaching Health Centers program is not permanently authorized or funded, and my bill provides the long-needed security that these programs have asked for. It will create a reliable stream of doctors for high-need communities with funding for 48 new programs across the country, and creating an estimated 1,060 new residency slots. It is still a tiny fraction of the GME slots that we fund in teaching hospitals, but this kind of investment is exactly what we need to increase access to primary care in underserved areas.

We will also discuss legislation that will extend funding for Community Health Centers, which provides primary care to more than 30 million people across the country, including many living in poverty and in rural areas. While I am disappointed the funding included in this legislation today does not reflect increases in the costs of providing care, it is critical that we do not allow this funding to lapse. So I am pleased that the legislation we are discussing today provides for long-term, stable funding for these centers.

We will also examine legislation that will reauthorize

other expiring public health programs, including the Special Diabetes Program and the Special Diabetes Program for Indians. Both of these programs provide critical research and care. And particularly the Special Diabetes Program for Indians funds critical treatment and prevention efforts for American Indians and Alaska Natives, who have the highest prevalence of diabetes in this country.

I am also pleased that we will be considering legislation introduced by Representative Blunt Rochester to address shortages and bolster the nursing workforce by expanding state-based nursing workforce centers and establishing a national nursing-focused research center.

We will also discuss legislation that seeks to improve existing programs at the Health Resources and Services Administration, HRSA, including the Organ Procurement and Transplantation Network, or OPTN. More than 6,000 Americans die each year while waiting for organ transplants, and this problem is even more pronounced for people of color and people in rural communities. HRSA has undertaken a number of efforts to modernize the OPTN, and the legislation before us today seeks to complement those efforts. It would make OPTN

contracts more competitive in order to increase oversight and enhance the performance of the program.

So I look forward to continuing work with my colleagues on these important pieces of legislation, but I would like to once again request that the committee immediately schedule a hearing to examine the very real health impacts of all Americans by these extremist right-wing judges who are attacking the Federal drug approval process by the FDA.

Today we expect a decision from the Supreme Court, but the decisions to date challenging FDA's decade-old approval of the drug mifepristone are not grounded in science or in law. We should hold a hearing on the detrimental impacts these decisions could have on the drug approval process, so we can ensure Americans continue to have access to FDA-approved medication.

There is no time to wait, and that is why every Democrat on this committee has requested the Republican majority schedule a hearing immediately. We must examine the very real impacts that these dangerous court decisions could have on the American people.

[The prepared statement of Mr. Pallone follows:]

This is an unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker.

**********COMMITTEE INSERT**********

*Mr. Pallone. And with that, Mr. Chairman, I thank you, and I yield back.

*Mr. Guthrie. I thank the gentleman for yielding back, and I will -- the chair will move into witness testimony, and our witness today is Carole Johnson, administrator of the Health Resources and Services Administration at the Department of Health and Human Services.

We appreciate you being here today, and look forward to discussing these bills before us with you. But you are now recognized for five minutes for your opening statement.

STATEMENT OF CAROLE JOHNSON, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

*Ms. Johnson. Thank you so much, Mr. Chairman.

Chair McMorris Rodgers, Ranking Member Pallone, Chair Guthrie, Vice Chair Bucshon, Ranking Member Eshoo, and members of the subcommittee, thank you for the opportunity to speak with you today about improving primary care and the health care workforce. I am Carole Johnson, administrator of the Health Resources and Services Administration, the agency of the Department of Health and Human Services that supports delivering health care in the nation's highest-need communities, building the health care workforce, improving maternal and child health, supporting individuals with HIV, and meeting the health care needs of rural America.

I would like to begin by thanking the subcommittee for your longstanding bipartisan support for HRSA's programs. With your help we have made significant gains in expanding access to health care services, particularly in communities that have struggled for far too long to recruit and retain

health care providers and access high-quality care. Yet we know there is much more work to do.

I particularly appreciate the opportunity to focus today on three vital programs HRSA -- three vital HRSA programs that are designed to help meet these needs. Mandatory funding for each of these programs is expiring at the end of this fiscal year.

First, the Community Health Center program, which provides high-quality, cost-effective care to 30 million people through 1,400 local health care centers, operating nearly 15,000 sites that see patients regardless of their ability to pay. Health centers are a vital source of care for individuals and families who are uninsured, people who live in rural areas, folks who are enrolled in Medicaid, and others who find it hard to find a doctor or pay for the cost of care.

Second, the National Health Service Corps program, through which we provide scholarships and loan repayment to students and clinicians in return for them practicing in health professional shortage areas. Last year, at a time of critical workforce challenges across the country, we reached

a historic high of 20,000 National Health Service Corps clinicians practicing in underserved and rural areas, thanks to this program, as well as about 3,000 medical students currently receiving National Health Service Corps scholarships in return for their service commitment to practice in high-need communities.

And third and finally, the Teaching Health Center Graduate Medical Education program, which funds medical and dental residency programs in settings like health centers, recognizing that most primary care takes place in community settings, not acute care hospitals. This fiscal year -- by the end of this fiscal year we will have close to 1,100 primary care medical and dental residents in training in these community settings, with recruitment of new residents for a Resident Match Day 2024 beginning as early as this fall.

The President's fiscal year 2024 budget includes 3 years of mandatory funding for each of these critical programs. Multi-year funding will help to prevent disruptions in care or training for millions of patients and thousands of students and clinicians, while also giving health centers,

medical residents, and students predictability and confidence in the sustainability of these programs as they grow.

With respect to health centers, the proposed budget includes funding to sustain current services and reach more people in need through longer hours and additional sites. Importantly, the budget also recognizes the overwhelming need to better integrate mental health and substance use disorder services into primary care by both funding and requiring behavioral health as a health center service.

With respect to the National Health Service Corps, the budget would allow us to maintain the historic level of 20,000 providers currently practicing in health professional shortage areas.

And for teaching health centers, the budget would ensure no disruption for current residents, allow teaching health centers to take on new residents as current cohorts complete their training, and help programs with planning grants to -- programs that currently have planning grants to begin to come online.

I would like to emphasize the key point that clinicians who are trained through these two programs tend to stay and

practice in rural and underserved communities, yielding a valuable long-term return on the Federal Government's investment in these programs.

I have recently had the opportunity to visit a host of health care centers, including those that serve individuals experiencing homelessness, school-based health center clinics, health centers that are partners in our HIV work, in our Cancer Moonshot work, and others that demonstrate how much health centers are reflective of and trusted by the communities they serve.

I have also had the opportunity to meet with National Health Service Corps members who, to a person, report that Health -- the National Service Corps [sic] has helped enable them to practice in the community where they want to serve, often a rural community. And often, without National Health Service Corps money, they would have had to make a different choice about their practice.

In addition, I have had the good fortune to visit a couple of teaching health centers, both with Chair McMorris Rodgers, and a planning grant awardee with Ranking Member Pallone to see up close and in person how important this

program is to the next generation of the health care workforce, and really building primary care in the communities where we want people to serve.

These are just a few examples of the exciting and important work happening in communities across the country as a result of these critical programs. And I look forward to working closely with the subcommittee to sustain and build on this work.

Thank you, and I look forward to your questions.

[The prepared statement of Ms. Johnson follows:]

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*Mr. Guthrie. I thank the witness for her statement, and we will now move to member questions, and I will begin questioning and recognizing myself for five minutes.

So Administrator Johnson, HRSA operates workforce programing both in scholarship programs and loan repayment programs, as we have discussed just recently -- thanks for the meeting -- in exchange for individuals working in medically underserved communities. So my -- what I want to kind of explore is staying in medical-served [sic] communities, as we talked about before.

So can you explain how HRSA measures success within these programs?

And for providers practicing in health care provider shortage areas, do you have long-term data on how many of those providers stay within the communities in which they are practicing, or practice in other health care provider shortage areas?

*Ms. Johnson. I thank you so much for that question, Mr. Chairman. It is really important to us that we are tracking as well as we can continued participation, continued practice in the communities where we are encouraging people

to serve.

So we, as a matter of practice, we know how long people are practicing as part of their service commitment. That is part of their contract with us through the National Health Service Corps. And in some instances we are able to offer people continuations that keep them in a community longer if they continue to have eligible medical debt.

But we also are tracking whether people stay in underserved and rural communities. We do that most directly through our two-year survey tracking, which shows our rate of people continuing to practice two years out from when they have completed their service agreement, not when they start practicing in the community, but when they have completed their service with us, and so they are no longer under contract with us. And that retention rate is 86 percent.

And then what we are working to do, and what we have been doing is building the capacity to continue to monitor and be informed by where people choose to practice beyond that. And we are working closely with CMS on national practitioner identifier data, so that we can continue to monitor that over time.

*Mr. Guthrie. Okay, thank you. And also, I know that we want to get people out into these areas through the programs that we just discussed, and hopefully remain in the areas.

The other way that we like to do it is in Teaching Health Center Graduate Medical Education, if they are in those same kind of areas. So I guess my question is how many residents practice within the same area or community within a health care provider shortage area, especially in rural communities?

*Ms. Johnson. Yes --

*Mr. Guthrie. So how does that get people out into the -- how does the Graduate Medical Education get people out into --

*Ms. Johnson. I appreciate the question, sir. The Teaching Health Center Graduate Medical Education program doesn't have the same kind of service commitment tied to it that the National Health Service Corps does.

*Mr. Guthrie. Right.

*Ms. Johnson. In the National Health Service Corps you get our resources in return for practicing. And so then you

are obligated to do that. In the Teaching Health Center program our model is to try to make sure that we are training people in the communities where we hope that they will continue to serve by having people have direct experience of working in rural areas, in underserved communities.

And we find, you know, our -- after our residencies are completed -- now, you know, as Mr. Pallone mentioned, we are -- we still -- we have about 1,400 people who have completed the training. You know, more than half of them are still in their communities. And we are continuing to work to ensure that we are doing everything we can to keep people in rural and underserved communities.

*Mr. Guthrie. So how would you define the success of those programs?

And I know that you measure, and you had 86 percent staying for it. So I guess an anecdotal -- or how would you define success in these?

*Ms. Johnson. I think that, from the strict requirements of the law, our success is the overwhelming demand we have for people who come to these programs, and the reports we get from people who come to these programs that

they would have made a different choice about where they had to practice if not for these programs giving them the support to pay down their medical debt, to let them go to communities that are underserved or rural, that allow them to do that work which we all -- which is our shared goal, and why these programs have been in place for so long, and we have all worked to continue to grow them.

I think it is also an added benefit of these programs that we see people continue to stay in those communities long after their obligation to us, and that is part and parcel of what I suspect the clinicians on this panel would say, which is what we see, which is that people tend to stay in the environments and communities where they train, or where they have mentors, or where they start their practice. And so we get that benefit from the programs, as well.

*Mr. Guthrie. Well, and it is important to have these graduate medical programs outside of the bigger city, in the rural areas, because, you know, a lot of southern states, in particular, like Alabama, the universities are in Tuscaloosa and Auburn, but the teaching hospital, the medical centers in Birmingham and Mississippi, the same way Oxford is where

their main school -- and Starkville, which are small towns. And then there are medical centers in Jackson, Tennessee, Memphis versus -- Knoxville is not a small town, but it is important.

And I am going to close, because -- and without responding -- because I am out of time. But it is important that we get outside of those major health centers and get people in the community, so they will hopefully put down their -- as we talked the other day, their -- you are graduating from medical school and residency, you are almost at the time you are putting down roots and picking where you are going to be.

*Ms. Johnson. That is right.

*Mr. Guthrie. And it is a good opportunity to be exposed to rural areas if they haven't before. So thanks for that. I appreciate that.

I now recognize the ranking member of the subcommittee, Ms. Eshoo, for five minutes for questions.

*Ms. Eshoo. Thank you, Mr. Chairman.

In 1997 this subcommittee held a joint hearing with the Senate Labor Committee to review our nation's system for

organ transplant. I was at that hearing, and I have long remembered it and how the witnesses from the United Network for Organ Sharing seem to resent any questions being asked of them. That is what stands out to me from that hearing, amongst other things. But I recall that very well.

Now, 26 years later, that organization continues to have a stranglehold on the Organ Procurement and Transplantation Network, OPTN, which has been plagued by inefficiencies, oversights, and errors along the way.

I know a key part of your plan to modernize the transplant system is to establish a competitive and open bidding process for the next OPTN contract. Why don't you tell us, in your words, why you think this is necessary?

*Ms. Johnson. Well, thank you so much for the question, Ranking Member.

You know, if you are an individual, or your family member is in need of an organ transplant, this is the absolute most critical system that you depend on to make sure that the system is fair, and treats everyone the same, and gives everyone equal access, and that it is run well. And my responsibility in this seat is that it is run well.

And as you point out, there has been -- you know, the statute is 40 years old, and there have been limited opportunities, limited work in the past to modernize that, which is why we are so excited to work with the subcommittee on modernizing the system.

We think that we need best-in-class contractors, rather than having all functions of the Organ Procurement and Transplant Network tied up in one single competitive bid. We think there is the opportunity for competition here, which will allow --

*Ms. Eshoo. Let me ask you -- because I only have 2 minutes and 43 seconds left -- in fiscal year 2024, the budget proposal, the President requested congressional authority to update tools governing the OPTN. Do you think that the legislation that we are considering today fulfills this request?

*Ms. Johnson. I think we are continuing to provide TA to the committee on the particulars of the legislation.

*Ms. Eshoo. Okay.

*Ms. Johnson. But we are very pleased to be able to work with you on this --

*Ms. Eshoo. Good.

*Ms. Johnson. -- going forward.

*Ms. Eshoo. Great. When the Community Health Center Fund lapsed for five months in 2017, how were the community centers, health centers, impacted, and what would happen, very importantly, if this Congress allowed the Community Health Centers authorization to lapse again?

*Ms. Johnson. Yes, thank you for the question. I mean, nothing is more important, particularly at this moment in health care delivery, than predictability and stability of funding, particularly as health care facilities are trying to recruit new workers, trying to hold on to their current workforce.

You know, workforce is a big challenge in the field right now --

*Ms. Eshoo. It is.

*Ms. Johnson. -- and instability in funding, or fear of not being able to maintain their capacity, it not only creates disruption in their day-to-day services, but it really creates challenges with stability of the health care workforce. And everybody is competing for their workforce.

*Ms. Eshoo. Okay. As of April 1st, certain states have begun removing Medicaid recipients who are no longer eligible for the program, and more than 40 states will begin this process in the coming months. How are the Community Health Centers preparing for this change?

*Ms. Johnson. Oh, thank you for raising this question. This is an incredibly important moment for the people that health centers serve, and it is important that we ensure that people who remain eligible get re-determined and maintain their Medicaid eligibility; those who aren't can get to affordable marketplace coverage. And we are using our sisters at health centers to be able to do that. We are providing a little bit of extra funding to our state primary care offices to coordinate that.

But if people who otherwise would be eligible lose coverage, health centers will still need to see them, which puts an even greater burden on health centers at a time when we have the -- we are approaching this issue with respect to continuing funding.

*Ms. Eshoo. Terrific. Thank you for your leadership.

And I would like to point out that our former chairman

of this committee, Congressman Greg Walden, is here.

It is great to see you, Greg. You can come and sit behind me, if you would like.

[Laughter.]

*Ms. Eshoo. It is wonderful to see you, a friend to all of us, really great to see you.

I yield back, Mr. Chairman.

*Mr. Guthrie. The gentlelady yields back. He would like to sit behind you, but he couldn't admire his picture from sitting there.

[Laughter.]

*Mr. Guthrie. Or portrait, I should say, not a picture.

The chair now recognizes Dr. Burgess from Texas for five minutes for questions.

*Mr. Burgess. Thank you, Mr. Chairman.

Good to see you again, Mr. Chairman. Always welcome in this hearing room.

I do have a number of questions, Ms. Johnson, on the 340B program. I may run out of time, and I may need to submit those for the record.

I do need to ask -- the Sickle Cell Disease Partnership

had asked that their statement for the record -- be made part of the record, and I would ask unanimous consent to --

*Mr. Guthrie. Seeing no objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Burgess. So, of course, I do get to meet with doctors all across the country. They come in and they talk to me about all kinds of issues. And you can imagine after the physicians fee schedule and reimbursement, the number-one issue -- the number-two issue is always workforce.

So we have just been through this bad pandemic, put a lot of stress on our health care system, a lot of stress on our doctors. Now we have got inflation that has reared its ugly head, in combination with low reimbursement. And the consequence of that is doctors are leaving practice.

Last Congress -- and I can't believe I am going to say this out loud, but last Congress Mr. Sarbanes had a very good idea about physician re-entry. I don't know if he is going to reintroduce the bill this year. We were never quite able to get to a place where we could actually partner on the bill. But the concept is one that I think is worthy of some discussion to create a training program for -- in his version it was for primary care doctors who would like to return to clinical practice, to un-retire, if you will.

So there is no question about it, we are at a time in this Congress we have got to be so diligent with all our

spending. But would something like a physician re-entry program work if Federal dollars were used strictly for offsetting the costs of training and re-credentialing re-entering physicians?

*Ms. Johnson. Well, thank you for the question, sir, and for your attention to this really important issue. I would love to talk to you about the particulars of it, but conceptually, you know, getting physicians who have the ability or the capacity to come back into the workforce is a great goal that I would love to work with you on, and love to think about how we can work together to achieve that. I think that is true of nurses, it is true of the workforce writ large.

And, you know, I recruit physicians to come to work in the Federal Government for some time, and I see them having to make choices about what credentials they retain. And I think it is really important for us to think about how to make sure we get people back into the workforce when they are able to.

*Mr. Burgess. Sure. After you have left the bedside, it can -- for any number of years or months, it can be very

difficult to then re-emerge on that path.

Do you -- I assume that one of your principal tasks is assuming -- assembling data information available on the effectiveness of the current health care workforce programs.

*Ms. Johnson. That is right. We collect a lot of data on both the -- who participates, and the outcomes associated with it.

*Mr. Burgess. So would it be possible to consolidate or re-imagine some of these programs to be more effective with Federal spending? Broad question, I get it, but could you do a better job?

*Ms. Johnson. Well, sir, we are constantly looking at the programs, both for -- from a couple of ways. One, from the front end, to make sure everyone who can be competitive is competitive, because sometimes it is hard to apply for Federal grants, and we are trying to make our entry door easier. Two, from ensuring that we are getting the best outcome data, and we are not having people collect data for data's sake. And then three, constantly looking at where can we get efficiencies in the design and implementation of our programs.

*Mr. Burgess. So recently, Optum disclosed they employ 70,000 physicians, 7 percent of the total workforce. They acquire new health systems, literally, every month. And they want to add 10,000 physicians a year to their growing base.

Does HRSA collect data on whether the National Health Service Corps physicians -- or any physicians, for that matter -- stay independent, or do they join these large practices?

*Ms. Johnson. We collect data on our National Health Service Corps members when they are fulfilling their service obligation. And then we do our two-year outlook. And we are continually working to build to figure out where they are going in -- beyond that. And so, you know, we, obviously, are looking for where they are billing from in the future.

*Mr. Burgess. Sure. Well, I mean, it leads up to -- one of my pet peeves is -- in this country, because of the Affordable Care Act, it is legal for hospitals and health systems to own doctors, but doctors can't own hospitals, and we are in the best position to understand the allocation of those resources. I hope this committee will work on the concept of physician ownership of hospitals. It is one that

remains, I -- should remain at the forefront of our minds.

And Mr. Chairman, I yield back.

*Mr. Guthrie. The gentleman yields back. The chair now recognizes Mr. Sarbanes from Maryland for five minutes for questions.

*Mr. Sarbanes. Thanks very much, Mr. Chairman, and let me thank our witness today for your good work. It is so important.

And let me thank Rep. Burgess, as well, for saying such kind things a moment ago -- apparently, against all of his impulses. But I appreciate that.

[Laughter.]

*Mr. Sarbanes. And I look forward to continuing to work on the Physician Reentry Initiative. And I appreciate the conversations that we have been having over the last couple of years about -- or really, I guess, over the last six months. I think there is good opportunity there to collaborate and think about an innovative design that can encourage that cohort to come back into the practice of medicine, particularly in those areas of shortage.

And we would certainly look forward to input from you,

Ms. Johnson, about how that can be designed, and what sort of resources could be brought to bear to assist with this because we understand -- and you certainly understand -- that the shortages across the country in just about every category of the health workforce, if not, frankly, every category of the entire workforce in the country, those shortages are significant and need to be addressed. And I thank you for all of the work that you are doing.

I do also want to commend my colleague, Representative Blunt Rochester, for the work that she has been doing. And we have been collaborating on this, as well, in terms of advocating for funding for HRSA's efforts to collect and analyze, disseminate information about health care workforce dynamics through the National Center on Health Workforce Analysis, which is a very important resource for your agency and, frankly, for the country in terms of understanding what these dynamics are, and making sure we are, again, being creative in addressing them. We need to enact policies that will lead to a stronger, more diverse workforce, one that can address the current and projected provider shortages that we face.

In addition, there is the National Nursing Workforce Center Act, which is another bill that Representative Blunt Rochester has been working on. And I again thank her for those efforts. It will be interesting to understand a little bit better what you envision the design of that could be, if you get authority around it.

I know that the Biden Administration has made clear, including through its proposed Health Care Workforce Innovation Program, that it definitely understands the need to comprehensively and innovatively approach health care workforce issues, particularly now. And there is, I think, bipartisan focus on this as we continue to confront a mental and behavioral health care crisis that seems to be growing by the day, and as we are serving an aging population. So these innovative approaches have to span provider types, geographics, and other things in order to be effective. And no solution is too small to make a difference.

I do know, as well, that there is workforce programs that provide educational, other financial assistance. You have mentioned that in terms of the Corps, and this idea of exchanging for service, that support in exchange for service

at the Community Health Centers and other critical access points.

Can you speak just briefly -- I have about a minute left, but I would be interested to hear you speak again or emphasize what it would mean to increase our commitments to the National Health Services Core, other service-based programs like a kind of reentry program that was mentioned earlier by Congressman Burgess, but these efforts to help us recruit, train, retain a diverse and community-focused -- and I think this is very important -- workforce that can meet our current and projected demand.

*Ms. Johnson. Thank you so much for the question, Congressman.

There is -- I suspect this is true for your experience, as well -- there is nowhere that I go, to any of our grantees, to anyone in the community-based health workforce, where workforce isn't the first, second, and third list on their priorities of the issues that they are facing right now, which is why we think it is so critically important to sustain the level that we are at when it comes to what we have been able to do with the National Health Service Corps,

and be able to help place clinicians in the communities that need them most in return for loan repayments and scholarships, that that service commitment is so critical.

We also think -- outside the scope of the hearing today, but we also think the other investments we are making in our budget, as you pointed to, our new innovation program that would help -- really help bubble up good, community-based ideas for how we more effectively train and more efficiently train in the health care workforce is a vital pillar of how we kind of move the process forward. Our new investments in training more mental health providers, our new investments in breaking some of the bottlenecks that make it harder to move more people into nurse training, we really think that, comprehensively, the budget is focused on workforce as a priority.

*Mr. Sarbanes. Thank you very much.

I yield back, Mr. Chairman. I appreciate it.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair now recognizes Chairwoman McMorris Rodgers for five minutes for questions.

*The Chair. Thank you, Mr. Chairman.

In a report published in December of 2015, GAO reported that HHS has 72 workforce programs that were funded in fiscal year 2014. In that report, GAO looked at the 12 programs with the highest obligations. Seven of those were at HRSA, including the National Health Service Corps. How many workforce programs does HRSA currently administer?

*Ms. Johnson. I believe our workforce number now is about 50.

*The Chair. Okay. Well, how many --

*Ms. Johnson. And that is considered the individual --

*The Chair. -- workforce programs --

*Ms. Johnson. -- programs.

*The Chair. So 50 different workforce programs?

*Ms. Johnson. Different funding opportunities.

*The Chair. Okay. And then would you speak to how you measure performance outcomes of these programs?

*Ms. Johnson. Yes. Thank you for the question.

Performance outcomes is a weighted factor in awarding our grants. We make sure that we are collecting outcomes associated with the grant. That will factor into future funding for the potential awardee, it factors into decisions

about the current award, and then we collect performance metrics in detail about the participants in the program and the outcomes associated with the programs.

*The Chair. Okay. Would -- could you provide the committee with an updated list of the programs, including basic funding and performance --

*Ms. Johnson. Absolutely.

*The Chair. Okay, thank you. As I mentioned in my opening statement, I have been a long-time supporter of the Teaching Health Center GME program. I have led its authorization -- reauthorization, not authorization -- reauthorization of the program during several congresses. And I understand HRSA plans to use resources from the American Rescue Plan to expand to new residency programs.

How will this impact existing Teaching Health Centers like the Spokane Teaching Health Center in my district?

*Ms. Johnson. Thank you so much for the question, and thank you for your leadership on this issue, Madam Chairwoman. It has been incredibly helpful to have the impact of your vision here, and what it means for residents on the ground, and so inspiring to hear the residents we

talked to in Spokane about how they intend to continue to work in rural communities.

The President's budget is actually built so that we can both take advantage of resources that we have had from the American Rescue Plan to help new planning, new -- there is a lot of interest in the health center program, the Teaching Health Center program, and so to help new folks plan and develop and get ready to potentially apply in the future.

But our budget is built to fund current awardees and then, over time, be able to bring on new folks if they meet the accreditation thresholds going forward, and they are competitive.

*The Chair. Okay. In 2019 GAO reported that between 2010 and 2017 Community Health Centers saw an increase in revenue coming from insurance, both public and private pay. How has health centers' revenue changed since 2017?

*Ms. Johnson. I can't speak to the details, but I can tell you that what has happened is that health centers have continued to be the resource in communities for people who are underserved and/or under-insured. And so across the country in communities, whether they have expanded Medicaid

or not, health centers are still the resource that is seeing people who have -- who lack health insurance, or who have Medicaid and don't have another usual source of care.

*The Chair. So does HRSA anticipate any further changes to the public and private revenue sources the health centers receive?

*Ms. Johnson. I think what we -- the one thing that we did see was some growth in people -- a small growth, but people who got marketplace coverage who had previously been uninsured may continue to see their health center provider for the continuity of care.

*The Chair. Okay, okay, thanks. As a mom with a son with Down Syndrome, I am extremely concerned by the continued reports of individuals with disabilities being denied an organ transplant solely based upon an individual's disability. As the agency tasked with administering the Organ Procurement and Transplantation Network, or OPTN, what steps has HRSA taken to address discrimination against individuals with disabilities in the organ transplant system?

*Ms. Johnson. Thank you so much for the question. We are laser-focused on reforming the system so that we have

better accountability and better transparency and oversight in the OPTN system. And part of that is about bringing more competition into the program, so that the structures, the functions that govern our IT and our policy and our governance -- right now, the -- our vendor, the Organ Procurement and Transplant Network, and the private corporation that runs outreach and the like is the same vendor. And we think that we need to separate the boards, have more accountability in the board, and that that will be a venue for us getting better fairness and equity across the system.

*The Chair. Okay. Well, I appreciate hearing more about those additional steps that you are taking --

*Ms. Johnson. Absolutely.

*The Chair. -- at HRSA, and thanks for being here today.

*Ms. Johnson. Absolutely.

*The Chair. I yield back.

*Mr. Guthrie. I thank -- the chair yields back. The chair now recognizes the ranking member of the full committee for five minutes for questions.

*Mr. Pallone. Thank you, Chairman Guthrie. I appreciate the opportunity to discuss these important programs today, and thank you and Administrator Johnson for being here today. And I also thank the administrator for coming to my Community Health Center in Red Bank recently.

I really appreciate you doing that.

However, before I discuss primary care I must note that I remain very concerned by the recent efforts of extremist Federal judges putting their beliefs between doctors and their patients, particularly with regard to the abortion pill mifepristone. If we are to have a full discussion on ways to grow our health care workforce and protect patients, we must start with ensuring that health care providers can provide the care their patients need, and prescribe the medications that have been proven safe and effective. And I hope my majority colleagues recognize how detrimental these recent court actions like the FDA versus Alliance for Hippocratic Medicine could be, not only for patients, but also for providers.

So let me ask Administrator Johnson about this.

From your perspective, what impact do you think these

decisions like this recent one in FDA versus Alliance for Hippocratic Medicine by what I consider extremist judges have on the health care workforce in this country?

*Ms. Johnson. Well, thank you for the question, Ranking Member. Obviously, we are -- there is actually -- there is, obviously, ongoing litigation, so I won't speak to the particulars of that. But I will say, you know, in health care services for a very long time we have recognized the value and the importance of the relationship between the provider and the patient, and respecting decisions that happen between the provider and the patient. And that is what our policies and our training programs are organized around, and that is what is important, is making sure that the -- that we are centered on the patient and the provider.

*Mr. Pallone. Well, let me ask -- well, I guess Chair Rodgers isn't here. Let me ask Chair Guthrie.

Every Democratic member of the committee sent you and Chair Rodgers a letter last week requesting that you immediately hold a hearing on the impact of this case. And I think we have to hear from experts on how detrimental this case could be for women and for all the Americans who rely on

FDA-approved drugs. Even the pharmaceutical industry agrees that this case has dangerous precedent-setting implications. I haven't received a response.

So if you could, tell me, Chair Guthrie, whether you will hold a hearing on this important issue.

*Mr. Guthrie. Well, we are going to continue to do oversight over the FDA, so we will have that under our committee's jurisdiction.

*Mr. Pallone. Well --

*Mr. Guthrie. We will continue to do oversight.

*Mr. Pallone. Do you know when that is likely to be?

*Mr. Guthrie. I don't have a time for it.

*Mr. Pallone. Yes. I mean, the problem is, you know, that today -- I don't know if anything happened this morning yet, but as of, I think, midnight tonight the stay of the lower court's decision could be lifted, unless the Supreme Court acts. And that would mean that this pill would not be available, for the most part, in the country. And so I really think we need to do something immediately. And I just want to reiterate that again. We should have the hearing as soon as possible.

But I wanted to -- I do want to see if -- I know I only have a little time left. I want to ask Administrator Johnson about the primary care workforce. And, you know, many people in this country struggle to access primary care because of a lack of providers. We have already discussed this. There was a report from the Kaiser Family Foundation that said over 97 million Americans live in a designated primary care health professional shortage area. And of course, the Teaching Health Center Graduate Medical Education Program is designed to address that.

So let me ask you a question. Can you explain the value of medical residence training in community-based settings rather than in hospitals, and what kind of impact the program, like the Teaching Health Center Graduate Medical program has, particularly in underserved communities?

You have got about a minute.

*Ms. Johnson. Well, I will just say that we are so excited about the way this innovative program has sort of changed the game for what primary care training can and should look like, and anchoring it in the community in the places where we want primary care providers to serve. It

makes it more likely that they will practice there, it gives them the kind of experience and access to the kind of training experiences that will then be useful to them in their primary care practice. And so it has been transformational, and it makes a huge difference in communities across the country.

*Mr. Pallone. And just the challenges, particularly because of unstable funding, you know, we have had this discussion about how, if you do this short-term and the funding is not there, it really presents challenges for the program. If you could, respond quickly.

*Ms. Johnson. It has been very difficult for programs to plan appropriately. Funding cliffs make it hard to know whether with security you can recruit your next class of residents. It makes it hard for residents who really want to train in the community to make that commitment if they are not sure the funding is there. So it creates problems, challenges for programs, existing residents, and future residents.

*Mr. Pallone. Thank you so much. I appreciate everything you have been doing on this.

And thank you, Chairman.

*Mr. Guthrie. Thank you. The ranking member yields back. The chair now recognizes Mr. Griffith for five minutes for questions.

*Mr. Griffith. So I have lots of questions about the black lung program. But unfortunately, all the questions I have are in areas that are not under your jurisdiction, so I will have to save those for somebody else.

*Ms. Johnson. Okay.

*Mr. Griffith. But there are a lot of things I think we can do to help black lung victims as we move forward. So if I can ever be of help to you on that, let me know.

*Ms. Johnson. I very much appreciate that, and we will do all we can with our -- from our vantage point, as well.

*Mr. Griffith. Thank you. So let's talk 340B. Some of the non-profit hospital systems, in my opinion, have been exploiting the 340B program to reap huge profits that fuel expansion into affluent communities, instead of continued reinvestment in communities of greatest need. In fact, my district is relatively economically stressed. We are 409th out of 435 for median household pay. So I have got for-

profit hospitals that are doing a substantial amount, and my hospitals in my area that get 340B are using it -- through my analysis, at least -- they are using it to help people. They don't have much choice, frankly. So it is a great program, and I support it.

That being said, there are bad actors out there. And one notable example happened in Virginia in what was then the district of my friend, Don McEachin. And it appears that Bon Secours Hospital System used the Richmond Community Hospital, which is clearly 340B-eligible, to expand its use of 340B at the expense of Richmond Community Hospital and their patients in that economically-stressed community. Over the years, services at the Richmond Community Hospital were cut and departments closed, while at the same time Bon Secours, it appears, was transferring millions out of the Richmond Hospital to other hospitals within the system -- some in their system maybe even as far away as Ohio, I am told.

So this is important to me. How do we make these -- how do we make reforms? What exactly do you plan to do with the information that you all are collecting? I know you have sent a number of letters out to hospitals asking them how

they are using it. What do you plan to do with that information when you get it? And if you don't get it, should we be passing legislation?

I know I am adding two or three things in there. Should we be passing legislation for more transparency?

Because I made a promise to Don that I wouldn't let this go, and neither one of us knew he was going to pass away. He called me a couple of weeks before his death and said, "Hey, as chairman of Oversight and Investigations on Energy and Commerce, I need your help.'' I promised him I would help. Help me keep my promise.

*Ms. Johnson. Well, thank you so much for raising this issue. Thank you for your work on this issue.

I had the opportunity to talk to him before he passed, as well, on this topic, and know how passionate he was about making sure resources are going to the places where they are intended.

As you noted, 340B plays a vital role for some critical safety net providers, but we need to make sure that there is accountability and transparency in the system. Our recent letters to a number of covered entities were part of that

process. Our request in the President's budget that we actually get specific designated authority for reporting -- for covered entities report -- to report on the savings from the program, and how that is benefiting the communities they serve is a specific ask we have made in the budget.

We look forward to working with you on that. We really would benefit from your assistance in making sure that we have all the tools necessary. As you probably know, we are in a lot of litigation on 340B, and so clarity about our scope and authority would be incredibly important to us.

*Mr. Griffith. All right, and I look forward to working with you on that.

Let's switch gears and go to Community Health Centers, another group that does great work in my region. I am glad to have them.

But it has come to my attention in talking with some of my Community Health Centers that Pharmacy Benefit Managers are taking predatory actions against the health centers by effectively forcing them to sign what they believe to be unfair contracts. They are forced to sign these contracts, which include provisions which give the savings, or a part of

the savings, back to the PBM, the Pharmacy Benefit Manager, instead of helping the poor folks who really need these services of the health centers.

So do you all have legal authority to address the matter, or is this an issue that we need to -- Mr. Carter and I need to put legislation in on?

*Ms. Johnson. I would ask --

*Mr. Griffith. Oh, I should have -- shouldn't have left out Mrs. Harshbarger.

*Ms. Johnson. Thank you. I would ask for your assistance here.

We -- as you may know, we also have had the issue of manufacturers not selling to covered entities via their contract pharmacy arrangements. We issued violation letters associated with that. That has been a source of considerable litigation, as well. Clarity about our authority and scope here to be able to -- because I share your view that accountability in this system is critical, and would love to work with you on that.

*Mr. Griffith. All right. I look forward to working with you. And if we need legislation, you have got three

people on this committee that are more than happy to help you in any way you need.

*Ms. Johnson. Thank you.

*Mr. Griffith. I yield back, Mr. Chairman.

*Mr. Guthrie. Thank you. The chair yields back, and the chair now recognizes Mr. Cardenas from California for five minutes for questions.

*Mr. Cardenas. Thank you very much, Chairman Guthrie, and also Ranking Member Eshoo, for holding this very important hearing.

And thank you, Administrator Johnson, for coming forward. I like your answers. Your answers are very concise. You are not copying what they do in the Senate, which is filibustering. Sometimes some of our witnesses kind of do that. But thank you for being so direct with your answers, and so helpful.

I am concerned about shortages in pediatric care. We need to look no further than this past winter, when a combination of COVID, RSV, and flu wreaked havoc on our kids and left many without access to care. Administrator Johnson, what role will increased funding for the THC GME program play

in boosting the pediatric care workforce?

And how can the program increasingly prioritize physicians who will work in medically underserved communities?

*Ms. Johnson. Thank you so much for the question, Congressman.

The Teaching Health Center Graduate Medical Education program, because it is so primary-care-focused, we have worked really hard to encourage programs to stand up pediatric programs. We have a few. We hope, with our planning and development grants, we will get more. We have trained probably close to 50 pediatricians through the program so far. We hope to continue to grow that and -- as we go forward, to ensure that this vital program is actually doing what we want in terms of training not only internal medicine and family medicine docs, but family -- but pediatricians in community-based settings.

*Mr. Cardenas. Thank you. And also I want to take a moment to discuss the critical role that Community Health Centers play.

Personally, I grew up in a household of 11 children and

2 parents. And for a good portion of my childhood, we did not have health coverage. We didn't have access to health care. Honestly, it came down to prayers and aspirin, which are -- which was the way that we handled things most of the time. And the place where we showed up, unfortunately, was the emergency room. And that still goes on to this day with too many families, whether it is one child or many children. And that -- we need to do what we can in this great country to make sure that that is not the alternative. It is either no coverage or going to the emergency room.

CHCs and FQHCs, literally, are a lifeline for families with -- like mine. For example, FQHCs, when I was about 10 years old, were created, and one of them showed up in my community, and that is when we finally got access to health care. So they are the reason why I received care when I was 10 years old and beyond.

NAVHC was the place that we went, and other CHCs are still doing this essential work in my district to this day, and they are getting creative about caring for as many people as possible. For example, some are using mobile clinics to provide care to hard-to-reach populations. Also, in many

cases, centers are even keeping extended hours to try to keep ERs, you know, out of the picture as much as possible. I am proud of the work that the CHCs do in my community, and so many questions are really focused on how to grow these lifesaving resources.

So Administrator Johnson, what else can we do from a policy standpoint to increase the reach of CHCs, especially in medically underserved and rural communities?

*Ms. Johnson. Oh, thank you so much for the question, because that is what our budget is about. Our budget is saying we not only need to sustain where we are, but this is a proven model and we know it works, so we need to ensure that we are building on it to get to more people in need. And so our budget focuses on new access points.

We know from all the health centers, as you said, when a health center shows up in your community it makes a difference for families. So getting more health centers into more communities, extended hours, making sure -- you know, if you work shift work, getting to a regular office hour appointment is hard. Health centers try really hard now, but we want to invest in making sure that they have extended

hours.

And integrating mental health and substance use disorder services into the core of what health centers do, so that primary care isn't, you know, medical services on one side and then refer you to mental health and substance use disorder, but primary care is integrated care.

*Mr. Cardenas. When -- one of the big issues is workforce recruitment. And how will this -- how will funding help ensure that CHCs are adequately staffed?

*Ms. Johnson. Yes, the funding -- the continuation and expansion of our health center resources are absolutely vital to them retaining their health workforce and growing their health workforce. And uncertainty about the future of their funding will make it challenging when it comes to retaining workforce at a time like this, when the workforce competition is so intense in the health care field.

*Mr. Cardenas. Well, thank you.

My time is about expired. Thank you, Mr. Chairman. I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair now calls on Mr. -- recognizes Mr. Bilirakis for

five minutes for questions.

*Mr. Bilirakis. Thank you, Mr. Chairman, I appreciate it. Again, thanks. This is a very important conversation today, as you know. And we are looking at multiple reauthorizations that provide such vital care and services for many of my constituents, for Floridians and all Americans.

My question is -- and I appreciate you being here, thank you. To start, I am very thankful that legislation I am working on to extend the funding for the Special Diabetes Program and the Special Diabetes Program for Indians has been noticed at this hearing.

I appreciate it, Mr. Chairman. Working with my friends, Ms. DeGette, Mr. Cole, and Dr. Ruiz, we have introduced bills that would provide level of funding for these programs for five more years. These programs are vitally important, as you know, an essential resource in our nation's investment in diabetes research, treatment, education, and prevention programs.

Diabetes is our country's most expensive chronic disease in both human and economic terms, affecting people of all

ages, races, and in every region of our country. It is the leading cause of heart disease and stroke. Additionally, it is the number-one cause of kidney disease blindness in working-age adults and lower limb amputations, unfortunately. Reauthorizing these programs will provide stability and hope for the millions of Americans impacted by diabetes. This is truly a bipartisan effort, and I look forward to working with all my colleagues to get these programs extended long-term.

Ms. Johnson, thank you again for being here. You have not mentioned diabetes in your testimony today, but I am sure you recognize its impact on the American people. I know that. What role do you believe the primary care workforce plays in addressing pre-diabetes and diabetes in the U.S. in general, please?

*Ms. Johnson. Thank you so much, Congressman, for your comments. And I do defer to my colleagues in the other agencies who run the Special Diabetes Program, but know from the long history of those programs how valuable they are to the public health and health care services.

Diabetes is a -- it is such a -- it, in and of itself, is such a challenging chronic disease for people to manage.

And the risk factors for it are just as challenging. And having an established relationship with a community health provider who often speaks your language or is from your community makes such a difference in identifying risk early, in doing the kind of modifications and work necessary to try to forestall the onset of diabetes, to try to help people manage their condition if they have diabetes. It just makes such a difference to have a usual source of care.

And when you are uninsured or under-insured, having a usual source of care is very hard unless you can turn to a Community Health Center that will see you, regardless of your ability to pay. And those Community Health Centers are often staffed by National Health Service Corps members. So all of this works together to make sure that we have that critical work.

I would also say we run a lot of maternal and child health programs as we work on maternal mortality crises and infant mortality issues. Addressing diabetes is such an important part of that equation, as well.

*Mr. Bilirakis. Thank you very much. The next question, because I still have some time, another very

important program we must reauthorize, of course, is the Community Health Center Fund. I have been an outspoken advocate for the role that Community Health Centers play in providing whole health care for so many Americans, and I am proud to have led efforts to reauthorize the Community Health Center programs in the past years. I am very grateful to join forces with Dr. Joyce, and I thank him for his leadership on this particular bill.

Locally, I am also very proud of the work that Florida Community Health Centers are doing throughout my home state. One CHC, Suncoast Community Health Center, has developed and built its own subsidiary training academy, Suncoast Academy, that provides training for dental assistants, pharmacy technicians, and later this year, medical assistants. It is really fantastic. Several CHCs around the state have begun planning or have already implemented registered apprenticeships without -- within their organizations.

So a question for you, Ms. Johnson -- and again, I know that Florida CHCs are extremely resourceful -- and I am sure they are around the country, as well, it is a great program -- and have found creative ways to increase access for

patients. You have touched on this. They have a true sense of understanding of the needs of our neighborhoods and communities. How do you intend to partner with state CHCs to support and leverage the strength -- the strengths, as well as their efforts to grow the workforce and expand services? If you could elaborate on that -- I know you touched on it -- I would appreciate it.

*Ms. Johnson. Yes, thank you. Thank you so much for the question.

I mean, one of the things that I am really excited about in the President's budget this year is a new initiative that we have proposed on the discretionary side called our Health Care Workforce Innovation Program, which would be our way to sort of -- in many ways, our health care workforce programs are defined by statute, and we lay out what the requirements are. Here we are really trying to get the best ideas from the field, like the models that Florida's health centers are implementing, and figure out what works and what we can start taking to scale so that we can actually be seeding some of these initiatives, as well. Because we hear time and time again med techs, farm techs, like a lot of the support, the

critical folks who are early in the career ladder --

*Mr. Guthrie. Yes, thanks. We are going to have to round up this series of questions and --

*Mr. Bilirakis. Yes, yes, I yield back.

*Mr. Guthrie. -- time has expired, and I thank you for that, your answer. I know we are going to get to more of that as we -- as you continue to talk, so -- but the chair now recognizes Dr. Ruiz from California for five minutes for questions.

*Mr. Ruiz. Thank you, and thank you for holding this important hearing today.

I have been a long-time advocate for the Teaching Health Center program, and have introduced bills to extend the authorization time, and as well as increasing funding because I believe in its mission, and I believe that it works.

I grew up, practiced medicine, and now represent an area that is in desperate need of health care providers. The doctor shortage is a nationwide problem, both in absolute terms and also in the distribution of physicians, but more acute in some communities like those in my district, where in research that I did back in 2010, there was 1 full-time

equivalent physician per 9,000 people. And as you know, the medically underserved criteria is 1 to 3,000.

So as you know, where a doctor is from and where they train are the two biggest indicators of where they will practice. So training physicians in health centers that are located in and directly serve communities in need is critical in addressing the provider shortage. More importantly, taking individuals from those underserved communities and training them in their underserved communities increases the probability that those communities will have physicians who will care about them and take care of them.

That is why I am proud to have joined Ranking Member Pallone to introduce the Doctors of Community Act, which will permanently fund the Teaching Health Centers program and result in the largest expansion of the program since its creation. Administrator Johnson, is there a demand for this program on the physician side, meaning do Teaching Health Centers receive a significant number of applications for residency slots, or are they struggling to get residents to apply?

*Ms. Johnson. Oh, there is demand for this program,

Congressman. There is a lot of interest both in establishing residency programs and then in recruiting residents themselves to the programs. There is a lot of interest and a lot of enthusiasm. I think people who have a dedication to a community-based service, who want to practice in high-need communities or rural areas are drawn to this program.

What is challenging both for programs and for the recruitment of residents is if there is instability in the program funding or not -- or folks not having confidence that it will be there for them through the full term of their residency.

*Mr. Ruiz. And what do you see in terms of outcomes for this program? What is the percentage of physicians that stay in the communities that they train in?

*Ms. Johnson. Well over half of them stay in the community -- in communities or in underserved communities. But we continue to see that number increasing, and we know that people are interested in making sure that -- we know that the data all supports that people who train in the community are more likely to stay in the community.

*Mr. Ruiz. So jumping topics to address another one of

my policy priorities, in this hearing we are considering H.R. 2547, the Special Diabetes Program for Indians Reauthorization Act of 2023, which I introduced with Congressman Cole. Although these programs do not fall squarely within HRSA's jurisdiction, the resources provided by the SDPI program have significantly -- impacts in the communities that HRSA serves, and the health workforce that provides diabetes care.

And as a doctor, time and time again I saw patients in the emergency department with preventable conditions related to their diabetes, the silent killer. And these problem -- this problem is continuing to get worse, particularly in communities of color with low access to health care prevention and chronic care for their chronic illness. And data shows that the incidence of type 1 diabetes is increasing among all population. Nevertheless, American Indian and Alaska Native populations have the highest prevalence of diabetes, which leads to renal failure, neuropathies, amputations, blindness, and other chronic comorbidities.

I believe that reauthorizing this program is critical to

reducing the incidence and mortality of diabetes, which overall is the seventh leading cause of death and the number-one cause of kidney failure and lower limb amputations and adult blindness.

What actions is HRSA taking to address the growing incidence of diabetes, and how is HRSA coordinating with other agencies such as the Indian Health Service to serve communities acutely affected by diabetes?

*Ms. Johnson. There is no doubt how critical the Special Diabetes Programs are to both the work that they do directly, but then also building the models that our primary care providers can learn from and implement. And that is what we do, is create learning environments and learning collaboratives across health centers so that we are sharing the best practices and knowledge so that we are able to help do the cutting-edge prevention and treatment work.

*Mr. Ruiz. Thank you. I do believe that these Teaching Health Centers should also participate in pipeline development programs --

*Ms. Johnson. Yes.

*Mr. Ruiz. -- working with local high schools in these

underserved communities, local colleges, and medical schools, so that from an early start they can start in high school, finish in medical school in residency training, like the Future Physician Leaders Program that I initiated back when I was senior associate dean at UC Riverside School of Medicine.

*Ms. Johnson. Terrific. We also fund on the discretionary side some of those programs. So building those bridges is really important to us.

*Mr. Ruiz. Wonderful, thank you.

*Ms. Johnson. Thank you.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair now recognizes Mr. Johnson for five minutes for questions.

*Mr. Johnson of Ohio. Well, thank you, Chairman Guthrie, and thank you, Administrator Johnson, for making yourself available today.

I also want to thank you for -- you and HRSA -- for your response to the February 3rd train derailment in East Palestine, a small village in my district. It is critically important that all levels of government continue to work hard and hand in hand to ensure the health and long-term viability

of that small village that I represent.

Locally, the Community Action Agency of Columbiana County stepped up immediately after the East Palestine train derailment, deploying a mobile health unit to a local church that enabled physicians and toxicology experts to perform health assessments for those individuals looking for care in the aftermath of the disaster. For residents without a physician, the health center provided quality medical and dental care to help the community recover from the event.

So my question for you, Administrator Johnson, yours is the primary Federal agency responsible for improving access to health care for people who are uninsured, isolated, or medically vulnerable. And I would argue that that encapsulates the village of East Palestine. What has HRSA's involvement been with ensuring access to those medically vulnerable citizens there?

*Ms. Johnson. Yes, thank you so much for the question and for recognizing the resources we were able to provide soon after the incident to ensure that the health center in the community was able to staff and support the mobile clinic and other resources.

We think it is vitally important that health centers are able to surge in a response, because they have community relationships and because they know where their patients are. Often for some of our centers that serve individuals who are experiencing homelessness, they have -- they are the connection to that individual and their services. So we are anxious to continue to build on that work, and we were delighted to be able to do that short-term. And we look forward to working with you and with the community on response going forward.

*Mr. Johnson of Ohio. And what are you doing to coordinate the efforts on the ground?

How have you assisted Community Health Centers like the Community Action Agency on the ground to ensure that resources are being allocated and used efficiently and effectively?

*Ms. Johnson. Yes, we have a partnership with state primary care offices, which are often the coordinating entity for Community Health Centers across the state. In the event of an emergency, we often work directly with the state primary care agency --

*Mr. Johnson of Ohio. Okay.

*Ms. Johnson. -- to make sure that we are touching all of the relevant health centers in the community. And then we work closely with our disaster response colleagues at the Federal -- at our Department and across FEMA.

*Mr. Johnson of Ohio. All right. Another broader challenge that many in my district and much of rural America deal with is workforce.

*Ms. Johnson. Yes.

*Mr. Johnson of Ohio. Every industry, from manufacturing to health care, is having trouble recruiting and maintaining a necessary and sufficient workforce. Why is this?

I mean, it could be because Washington paid countless individuals to stay at home and sit on the couch, or because we don't have things like work requirements on able-bodied Americans to receive Federal assistance. We, Washington, has incentivized people not to go to work.

To this point, can you please explain for us today how the Federal Office of Rural Health Policy is working with Community Health Centers in rural communities to train and

place health care professionals in regions like Appalachia, where I call home?

*Ms. Johnson. Yes, sir. I would say, you know, what we are seeing in health care is really -- we asked a lot of the health care workforce over the last several years, and it was incredibly traumatic and stressful for a lot of people. And we have seen some people, you know, either retire or move on to other work because of the strain of that, which is why we have made an investment in supporting the mental health and well-being of the health care workforce. We have done awards to medical centers across the country to help them focus on retaining their workforce by supporting their mental health and well being.

Our Federal Office of Rural Health Policy focuses on building rural residency programs, so that we can train in rural communities. It focuses on making sure we are supporting the viability and financial viability of rural hospitals by providing support for them directly to ensure their long-term sustainability. We provide a ton of technical assistance in rural communities. We are very focused on workforce in rural communities.

*Mr. Johnson of Ohio. Okay. Well, my fear -- and something that I would continue to sensitize you to -- is that we are seeing -- and we are seeing it daily -- is that these rural communities are often left behind for -- in favor of more urban areas with regards to this program. And I appreciate it that you are sensitive to that.

We have got a long way to go to equate health care access and the quality of health care for people in rural America.

*Ms. Johnson. No doubt.

*Mr. Johnson of Ohio. I yield back.

*Ms. Johnson. No doubt that there is a lot of work to be done in rural America, but a lot of our National Service Corps members are in rural communities. Thank you, sir.

*Mr. Johnson of Ohio. Thank you.

I yield back.

*Mr. Guthrie. The gentleman yields back, and the chair now recognizes Ms. Kuster from New Hampshire for five minutes for questions.

*Ms. Kuster. Thank you very much, Mr. Chairman, I appreciate it.

Thank you to Administrator Johnson for being with us today. As has been highlighted throughout this important hearing, we are at a key point for supporting Community Health Centers. In New Hampshire, Community Health Centers serve as a critical site of care, filling gaps in rural areas and ensuring people of all backgrounds can access the health care that they need.

Cost-effective, preventative care is under attack by conservative courts across the country trying to politicize our health care system. And it is essential we defend the health care providers who are delivering lifesaving services.

The National Association of Community Health Centers finds that, overall, Community Health Centers save the health care system $24 billion annually by increasing access to comprehensive, high-quality, preventative, and primary care. If Congress does not invest in our Community Health Centers, American health will suffer, and the cost of care will increase.

I applaud my colleagues for introducing a bill that would not lead to cuts in funding, but we must do more. We know that flat funding will prevent Community Health Centers

from meeting our constituents' needs. While I am hopeful our colleagues in the Senate will be able to raise the funding levels, the conversation must start here.

Administrator Johnson, can you speak to the importance of increasing funding for Community Health Centers, and how increases could benefit CHCs in states like New Hampshire?

*Ms. Johnson. Thank you so much for the question. That is very consistent with the way our budget is structured. We recognize that it is vitally important that we sustain where we are with health centers, but we are not meeting the needs of communities that -- to their fullest. And we have the opportunity to do that here, in particular in a couple of key areas.

We think it is important to make sure that we are expanding health centers into communities that need more sites. You know, convenience and access to health care is critical to delivery, as is making sure that we have expanded hours in health centers. Again, people who work shift work or who have child care issues, there are a host of things that can make it hard to see a doctor during normal business hours. We can expand business hours in health centers. We

can make it more convenient for people to get the care they need, and then they can go to a health center instead of going to an emergency room, which clearly costs more.

And at the same time, we think it is vitally important to recognize the moment that we are in when it comes to the needs of families around mental health and substance use disorder. And time and time again when I talk to primary care providers, they say visits that started out being about hypertension or other issues quickly become about a mental health issue. And so making sure that we can provide those services and provide that support in health centers is part of what we think is essential to meeting this moment for families' needs.

*Ms. Kuster. Great. You practically took the words out of my mouth, because I visited a site in my district just recently, and they are embedding the mental health care in the health care facility and vice versa, embedding mental health care in the -- embedding health care into the mental health facilities.

So Community Health Centers do play an essential role in combating addiction and mental health. And I am the co-chair

of the bipartisan Mental Health and Substance Use Disorder Task Force, and I have seen firsthand the innovative ways that our health centers are helping meet people where they are to deliver the care that they need, as you mentioned, conveniently and in hours that fit people's real lives.

Addiction and mental health challenges affect people of all ages, incomes, and backgrounds, which is why it is essential that Community Health Centers remain accessible. Can you explain the importance of including mental and behavioral health funding for Community Health Centers in future funding packages?

*Ms. Johnson. Thank you so much for the question. We -- you know, this is just vital to what primary care needs to be going forward. Family -- an individual doesn't experience a mental health condition separate from their physical health condition. They are one person, and we need to be able to treat them where they -- and when someone raises their hand and says they need help, we need to be able to meet that moment and help them.

Today health centers are only able to meet about 25 percent of the mental health needs of their patients and

about 6 percent of the substance use disorder needs of their patients. We clearly need to do more to make sure that we are taking care of families and meeting their critical health care needs.

*Ms. Kuster. Great. Well, thank you so much. I appreciate all your efforts.

And thank you to the committee for raising this important conversation about how we can improve access to both health care and mental health and substance use disorder, and improve workforce. Thank you, and I yield back.

*Mr. Bucshon. [Presiding] The gentlelady yields back. I now recognize Mr. Latta from Ohio for his five minutes.

*Mr. Latta. Well, thank you, Mr. Chair.

And Administrator, thanks for being with us today. You know, health professional shortages are everywhere. And I know that when I am out in my district, I don't think I can go into a facility that -- it is not one of these things that is like a few people, or a sort of many people. I mean, it is unbelievable, the numbers of individuals that we have to have filling our health care slots out there.

And, you know, it is everything from primary to dental to mental health, and -- as you were just talking about on the mental health side. But what trends have you seen in the distribution of health care professionals between HPSAs, and how is this distribution tracked at this time?

*Ms. Johnson. Thank you so much for the question, because you are right, it is not just about producing more health care providers. It is about the distribution of health care providers. Because if we just train more, those folks will go where, you know, reimbursement is highest, or where they are -- they can get their -- make enough revenue to pay down their medical debts.

That is why the National Health Service Corps is so focused on not just training new providers, but incentivizing them to practice in the communities that need them most. And we do that through our Health Professional Shortage Area designations, where we work closely with states on identifying the provider-to-population ratios in a community, the need in a community, the distance to providers in a community, and are able to define where highest needs are and be able to place National Health Service Corps members based

on need.

And thanks to the resources that we have had over the past couple of years, we have been able to fund a sizable amount of the request for that. Without the resources in the President's budget to sustain those National Service Corps numbers, we won't be able to place nearly as many.

*Mr. Latta. Wait, let me follow up on that, because, again, I was just out -- you know, this is a work period that we just came back from, so I was on the road extensively. And I know that, going through some of my rural providers out there, they are really struggling. And the problem then, of course, is they say, well, what we try to do is get somebody from a metropolitan area to come up for two to three days. And so they have this going back and forth.

But when you are tracking this, I think it is really going to be important because, again, I don't want to have a situation where somebody -- maybe somebody -- they might say that, oh, they have got somebody up here at this period of time, but they need somebody there all the time. And so -- but, you know, they are doing everything they possibly can to make sure that they can make -- treat their patients in a

timely manner.

Let me go on. You know, I understand that on the -- payment and reimbursement are an issue, and that there are a lot of ideas on how to expand the workforce and provide timely care. However, do you believe there are any regulatory barriers that hinder that workforce growth at this time?

*Ms. Johnson. Well, you know, I think that one of the things that we are looking at with our new proposed health care innovation program is for the health care community to come to us with good new ideas for how to address workforce challenges. And sometimes what we see in some of those places is folks have suggested to us there are models that have sort of accelerated training, or they have, you know, broken through some of the accreditation issues, or licensing issues, or those kinds of things.

And so what we are hoping is that this new program allows us to look at creative ideas from the community to break through any barriers.

*Mr. Latta. You know, and again, you know, following up again on this, because, again, this is one of my concerns --

and I am sure it is everybody's concern -- what this is that scenario that everybody has in the back of their mind. What happens when we don't have a sufficient number of personnel to be in a facility that is, you know, under regulation, so you have to have X number of people, and all of a sudden they say we don't have those people, but they have the great need to serve all these patients that, all of a sudden, they can't do anymore?

So, you know, here is the horrible thought. What do they start saying? Number one, we don't accept anybody else in. Number two, we have to almost do a triage in there in saying that, well, for those who we think that don't have as great a need, we are just going to have to release back to their families. And then what are we going to do?

*Ms. Johnson. Well, so I would say, sir, obviously, we have much more work to do to incentivize people to come into the health care pipeline. But we are looking at those kind of pipelines. Like, where do we have people who are on the first ladder in their career that we can get from an LPN to an RPN, and so that we can get more nurses in the workforce? Where do we have opportunities to bring high school students,

as others have have mentioned, into the workforce? So how do we do apprenticeship programs?

We have been investing in community health worker apprenticeship programs to start to get people on a path to the health care workforce. And so, while this conversation is focused on the National Health Service Corps, we have a host of investments on the discretionary side related to training more nurses, physicians, behavioral health providers as part of that effort.

*Mr. Latta. Well, it is really important because, again, seeing what I saw in the last week, you know, we are doing a tremendous job from even in our high schools. I saw things that if -- I told the students that I think people have been working on their PhDs, and we would have been in -- back when I was in high school, what these kids are doing today, absolutely unbelievable. But we just have to get these people out there.

Mr. Chairman, my time is expired and I yield back.

*Mr. Bucshon. The gentleman yields back. I now recognize Ms. Kelly from Illinois for her five minutes.

*Ms. Kelly. Thank you, Chair Guthrie and Ranking Member

Eshoo for holding today's hearing.

Ms. Johnson, thank you for being here today. And one-year postpartum suicide and substance use are the leading causes of maternal death, with suicide accounting for nine percent of the maternal mortality rate. Maternal mental health conditions such as anxiety, perinatal postpartum depression, and birth-related PTSD are the most common complications of pregnancy and childbirth, affecting one in five women.

Among those affected, 75 percent go untreated, while women of color are more likely to experience these conditions. They are also less likely to seek help. What remains so surprising is 100 percent of these conditions respond to early intervention and/or treatment.

So what current resources does HRSA have to help close the access gap to maternal mental health services?

And what additional resources are needed to improve access to mental health services for moms?

*Ms. Johnson. Yes, thank you so much for the question. It is such a critical issue. We talk about the maternal mortality crisis. I don't know that we talk enough about the

maternal mental health needs of individuals and families.

What we have been able to do at HRSA, two programs -- we do a number of things, but two programs that are -- I am particularly excited about in this space that I think are going to make a real difference.

One, our maternal depression and screening program. This is a program where what we are trying to do is help -- in the same way we are talking in this conversation about primary care providers integrating mental health, helping OB-GYNs get access to mental health experts, and so that if -- in real time, through teleconsultation -- so that if you have a pregnant woman in your office, and you have -- and you are aware of significant concerns, you can get real-time teleconsultation access to mental health providers to help you manage that, so that person isn't sent off on their own with a referral -- good luck getting an appointment -- that it can actually happen in the office.

We haven't had a ton of discretionary funding for this program, so we have only been able to fund seven states so far. But this year we got some additional money. We think we will get up to 14 states. We are very excited about the

opportunity this program presents.

And then second, I would note we have launched -- last Mother's Day we launched the National Maternal Mental Health Hotline. We have had thousands of calls to the hotline. It is 844-8339 help for moms. It is our way of helping moms have a safe space, pregnant women and family members have a safe space to have a conversation, confidential conversation with a counselor. And we have seen incredible demand for it.

We have -- we had a limited amount of resources to launch it. We have got some more in the last appropriations bill, which is going to allow us to do more outreach to get -- to make awareness better, and continue to bring people in and provide that kind of support.

*Ms. Kelly. That is fantastic to hear. And anything I can do to help you along with that --

*Ms. Johnson. Thank you.

*Ms. Kelly. -- I would love to do that.

Shifting gears, 17 individuals die each day waiting for organ transplant. Black people are four times more likely to develop kidney failure than White people, but are much less likely to receive a lifesaving kidney transplant.

Additionally, Black people also experience the highest rate of health failure, but receive heart transplants at a lower rate than their White counterparts. These are tragic inequities that are unacceptable, and that is why I was glad to see HRSA's leadership last month in announcing the Organ Procurement Transplant Network Modernization Initiative -- long title.

As our country continues to move forward at a rapid pace, with new technologies becoming available every day, we owe it to our constituents to bring our medical practice into the 21st century and save lives. Yet in a report from the U.S. Digital Service, the government's own top technologist said that the current OPTN contractor lacks sufficient technical capabilities to modernize the system. And this is one of the many reasons I am proud to cosponsor with my colleague, Congressman Bucshon, the Secure the U.S. OPTN Act.

How would you -- how would opening up the management of the OPTN network to multiple contracts improve outcomes for patients?

*Ms. Johnson. Thank you for the question, Congresswoman.

You know, I have been in this seat for about 15 months. When I first started in this role, it was crystal clear to me that we had a lot of work to do here, that the statute was old, that the systems were -- needed to be modernized. And our team has been working non-stop since then to really focus on what it is going to take to modernize the system.

And what it is going to take is more competition. And what it is going to take is us being laser-focused on ensuring we are getting best-in-class in all of the categories of work associated with the OPTN. And that is our priority, and that is what we are going to do. And we appreciate your help in that regard. The legislative action and additional tools will make it that much easier for us.

*Ms. Kelly. Well, hopefully, we can get this bipartisan bill passed.

And I yield back.

*Mr. Bucshon. The gentlelady yields back. I now recognize myself for five minutes for my line of questioning.

I want to start out by saying one of the ways we can get more physicians in underserved areas is properly reimburse primary care doctors for their services, instead of

continuing to cut reimbursement in a failed attempt to control health care costs, which -- the physicians are only about 10, 15 percent of the health care dollar. And in the long run, this would actually save us money, because it would make our population much more healthy.

I want to highlight again Congresswoman Kelly just mentioned H.R. 2544. I am proud to introduce that with Congresswoman Kelly. Again, it seeks to improve the system, the OPTN program, through competitiveness because, according to increasing numbers of reports, the OPTN struggles to obtain and distribute organs in an efficient, timely, and appropriate manner. In fact, it is believed that thousands of donated organs go to waste each year because the process of obtaining organs, matching them to a recipient, and transporting them is not happening effectively. With the technology and expertise available today, that is just unacceptable. And there definitely are also disparities in distribution amongst different populations of our fellow citizens.

This bill allows HRSA to improve the OPTN program. It clarifies that HRSA does not have to implement a single

contract for all aspects of the program, and encourages a competitive process to choose the best contractors for each OPTN function. I don't have a question. Those have already been answered by you. But that is why I feel like legislative action is necessary.

I also want to say I was a surgeon before I was in Congress. And during my residency in the early nineties I spent time on the transplant service at the Medical College of Wisconsin in Milwaukee, Wisconsin, a strong, solid organ transplant program at that time, and still is today. And so, talking to the faculty members when I was a resident, I began to understand how the system worked or didn't work, even 30 years ago after what had been put in place 40 years ago. So I have direct experience with this, and it needs fixed.

Again -- I would like to again draw your attention to the 340B program. Multiple members have talked about it. I think Dr. -- Morgan Griffith really outlined one of the problems that happened in Virginia. This is widespread, in my view. I have been working on this for five or six years.

As you know, Congress failed to establish clear parameters for the program, in my view, forcing HRSA to try

to determine how it should be run. I am in the process of working with many others, including the committee, to draft legislation to increase the transparency in 340B so that Congress and the public can better understand when the program does or does not benefit patients. And that is the goal of the program. It was instituted to make pharmaceuticals available in underserved populations, including rural America and many areas of urban America. And that is the goal.

I appreciate that Secretary Becerra, who was here testifying recently, concurred during a hearing last month that more transparency is needed. Understanding that we must move forward in the most efficient, least burdensome manner possible, I would like to know -- and you may have answered some of this -- what data HRSA already collects on 340B. What data points does HRSA already collect from program participants in the 340B program?

*Ms. Johnson. Thank you for the question. Thank you for your leadership on this issue.

As I mentioned previously, we are very anxious to work with you on transparency issues, on accountability issues,

because at the end of the day this is a safety net program that is vital to many safety net providers, and we want to make sure that, across the system, that there is accountability and that resources are going in the appropriate direction.

We obviously -- we collect a series of data related to allocations and acquisition. We do some of that through mechanisms that are specific to individual providers, individual manufacturers. And so -- but to the extent we have publicly-shareable data, we will get that to you.

*Mr. Bucshon. Great, yes. Can you -- if you can, commit to providing that list.

Does HRSA track the total dollar value of 340B drugs that each covered entity is buying?

*Ms. Johnson. We track the total in aggregate.

*Mr. Bucshon. Okay, in aggregate but not individually.

Am I correct that, up until last year, HRSA did not regularly post any sales data on the program?

*Ms. Johnson. I am not sure that I can speak to what happened before last year, but we can get you that answer.

*Mr. Bucshon. Okay. And it is my understanding that in

the past researchers have had to use FOIA requests to obtain limited sales data showing covered entity purchases at the 340B price, although information on discounts and chargebacks have never been provided when requested. Why is that?

*Ms. Johnson. So again, I am really interested, we are really interested in transparency in this program.

We have found ourselves to be somewhat limited by some recent Supreme Court decisions related to FOIA issues, but we will be happy to work with you on what we can.

*Mr. Bucshon. Yes, I want to just say I strongly support the 340B program, but we certainly need more transparency.

I yield back. I now yield to the gentlelady, Ms. Blunt Rochester, for her five minutes.

*Ms. Blunt Rochester. Thank you, Mr. Chairman, and thank you, Administrator Johnson, for your testimony.

Today we are examining several pieces of legislation to strengthen health care access for vulnerable communities and bolster the health care workforce. Having served as Delaware's deputy secretary of health and social services, our secretary of labor, and head of personnel, I am

particularly pleased that we are considering H.R. 2411, the National Nursing Workforce Center Act, legislation I am leading with my Republican colleague, Congresswoman Young Kim.

This bill will strengthen the nursing workforce and arm states with the tools that they need to implement solutions based on local conditions. Many disciplines in the health care sector are facing workforce challenges. But as the largest health care profession, nurses are the canary in the coal mine.

Just last week the National Council of State Boards of Nursing released new research showing the impact of the COVID-19 pandemic on the nursing workforce. The report shows that 100,000 registered nurses have left the workforce over the past 2 years due to pandemic-related burnout, and that, in total, almost 1 in 5 of the more than 4.5 million licensed nurses in the U.S. intend to leave before 2027.

As the nursing landscape rapidly evolves, stakeholders need up-to-date actionable information on emerging nursing trends, and this must occur more frequently than once every four years. In HRSA's 2021 Health Workforce Strategic Plan,

HRSA acknowledges that workforce supply and demand data is not static. The demographics of the nation's population shift over time, as do factors such as labor force participation, and that for data that do exist, data analysis is difficult, as the quality and granularity vary widely, and data sources, formats, and occupational definitions are inconsistent.

Based on this assessment and what I am seeing in my own community, I believe we need a strategy to not only centralize the study and development of nursing workforce practice and policy, but we also need to better support state-level entities in addressing state-specific nursing workforce challenges.

State-based working -- state-based Nursing Workforce Centers who have a consistent mandate and reporting structure to HRSA can help fill this gap. And a core function of Nursing Workforce Centers is to collect and analyze data at the state and local levels. But they can do so much more to support a more resilient, dynamic, and engaged nursing workforce, including training, mentoring, and leadership development.

Administrator Johnson, does HRSA's Health Workforce Research Centers program have the authority to fund a nursing-focused research or technical assistance center? Yes or no?

*Ms. Johnson. Thank you so much for the question, Congresswoman. Thank you for your focus on this.

And it would be hard to talk about nurses without saying that we owe them an incredible debt of gratitude for what they have done historically, and what they have -- especially what they have done in the last several years. And it shouldn't just be about our gratitude, but it should be in action. And so we really do look forward to working with you on this issue.

I think we are working with our lawyers to assess our statutory authority with respect to what we can and can't do under current regulations, and I look forward to working --

*Ms. Blunt Rochester. So the answer is you are not sure.

*Ms. Johnson. Yes.

*Ms. Blunt Rochester. Okay, thank you. How might HRSA collaborate with state-based entities? And more

specifically, could this collaboration contribute to the stabilization of the nursing workforce in this country?

*Ms. Johnson. We think it is really important across all of our workforce analysis to work with states. There are academic centers in many states that are focused on nursing. There are academic centers focused on other parts of the workforce. It doesn't make sense for us to do this work alone, or to replicate what is happening on state levels. It should be in collaboration, and that is our goal, and that is what we hope our National Workforce Center is doing.

*Ms. Blunt Rochester. Great. Thank you, Mr. Chairman. I ask unanimous consent to enter into the record a statement from my dedicated co-lead, Congresswoman Kim, and letters of support from AARP, the Center for American Progress, the National Forum of Nursing Workforce Centers, Health Impact, the American Hospital Association, and the American Health Care Association.

And I want to just quickly shift to the Strengthening Community Care Act, which I am co-leading with Representatives Joyce Fletcher and Stefanik. We are very proud of this bill, and we know it is very important and

timely as we reauthorize the National Health Service Corps and the Community Health Center Fund for five years. I am going to go right to my question, because I have, like, 10 seconds.

Since most health centers are already providing care related to mental health and substance use disorder, as you mentioned, how can us having a requirement improve access to these services and help address the opioid crisis?

*Ms. Johnson. Thank you for the question. It is -- what -- we are doing what we can with what we have. We are nowhere meeting demand. And so there is an incredible opportunity here in communities across the country that have been ravaged by the opioid epidemic to leverage the footprint of health care services that are already in their community to deliver the kind of substance use disorder services that will get people on a pathway to recovery.

*Ms. Blunt Rochester. Thank you so much.

And thank you, Mr. Chairman. I yield back.

*Mr. Guthrie. [Presiding] Thank you, I appreciate it.

Without objection, the documents you have requested are submitted for the record.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. We appreciate your work on this. I think you have several pieces of legislation before us today, so -- I was looking at the list. So this might be the Blunt Rochester hearing today. So thanks for your hard work on these issues.

The chair now recognizes Mr. Hudson from North Carolina for five minutes.

*Mr. Hudson. Thank you, Mr. Chairman.

Ms. Johnson, thank you for being here today, and I appreciate your long history of public service. And I also want to acknowledge what a feat it must be to juggle over 90-plus programs. And I really appreciate that, and appreciate you being here today.

Based on recent reporting, it is my understanding that the Biden Administration is launching a $5 billion-plus program to accelerate the development of new coronavirus vaccines and treatments dubbed Project NextGen. I would just like to note the committee has not been briefed or received any information on this initiative. So unfortunately, I have to go on what has been reported in the national media. But I am both concerned and interested to know where the $5 billion

came from for this program. Reporting that I have read indicates that "the pot of money'' was financed through money "saved from contracts costing less than originally estimated.''

What are these contracts? I specifically asked Secretary Becerra when he was in front of this committee just a few weeks ago about approximately 5 to $6 billion of unexpired, unobligated funding. And Secretary Becerra claimed this funding was, in fact committed and again, "in the pipeline to be signed on the dotted line.'' Was he referring to Project NextGen?

I have also heard from my Appropriations colleagues this funding came from the Provider Relief Fund and the American Rescue Plan funding, and was intended for testing. Administrator Johnson, can you please provide any clarity on this? Was any amount of funding intended for HRSA Provider Relief Fund reallocated to the recently-announced Project NextGen?

*Ms. Johnson. Thank you for the question, sir. I can't speak to the particulars of the NextGen project. I don't know the details there, and would refer you to our department

of budget experts on that question.

I will say that, as we get to the end of the Provider Relief Fund allocations, there are some instances where there are resources that we might have held for applications or for reviews of reconsiderations, where reconsideration applications came in less than we anticipated. So there are resources that are available through the Provider Relief Fund.

*Mr. Hudson. But to your knowledge, have those been transferred to this new project, NextGen?

*Ms. Johnson. I believe that -- again, the budget office will be able to answer that for you more directly. I don't know that resources have to be transferred for that purpose, so --

*Mr. Hudson. Okay. And then you talked a little bit about some of these unobligated funds or unspent funds. Can you please speak to any contracts that you are aware of that "cost less than originally estimated,'' or were used to subsidize this new project? Are there any specific --

*Ms. Johnson. I am sorry, I don't know the details. I don't know what that is referring to.

*Mr. Hudson. Well, could you get back to us if you talk to your budget folks --

*Ms. Johnson. I am happy --

*Mr. Hudson. -- about funds --

*Ms. Johnson. -- happy to --

*Mr. Hudson. -- that are transferred to Project NextGen?

*Ms. Johnson. I am happy to talk to the budget team and ask them to -- and raise the questions that you have asked.

*Mr. Hudson. I mean, honestly, they will probably respond to you quicker than they would respond to me.

*Ms. Johnson. Well, I --

*Mr. Hudson. So if you could get back to us on that, I would really appreciate it.

*Ms. Johnson. Thank you, sir.

*Mr. Hudson. And then in your written testimony -- just shifting gears here -- I appreciate you mentioned the importance of assistance to rural communities. I represent a rural community, and I work very closely with our Community Health Centers, and they do a tremendous job.

And during a recent visit to one of these -- Moncure

Community Health Center, I saw the need for more flexibility, like the legislation that came out of this committee that authored the Mobile Health Care Act, which allows them to use those funds in rural and underserved communities for things like mobile health units, and we have had a lot of success with those. We have been able to provide mental health access to schools that normally wouldn't have access to mental health. As you know, that is a real crisis right now. So, you know, anything we can do to continue to offer flexibility to these rural Community Health Centers, I would encourage you. But that has been a real success story.

And then Representative Pallone mentioned another critical need in health care today -- I hear everywhere I go -- is workforce. And, you know, throwing money at a solution is not always the best -- or a problem is not always the best solution. We have had some success in North Carolina. Numerous Community Health Centers have formed partnerships with the University of North Carolina, as well as Meharry, an HBCU, to provide workforce.

One huge success story also has been increased training resources and furthering wellness activities in Randolph

County, North Carolina, resulting in decreased costs for employee health insurance over the past three years. You know, these kind of partnerships, this kind of innovation is really showing results. So I would just encourage you any way that HRSA can help encourage this kind of innovation and this kind of creativity, it is working. So we would love to see more of it.

*Ms. Johnson. I very much appreciate that. Thank you. We actually fund Meharry through a host of our discretionary programs on workforce training. So I am really pleased to hear that you have seen these programs in action.

*Mr. Hudson. Great, thank you.

Mr. Chairman, I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair recognizes Ms. Barragan from California for five minutes for questions.

*Ms. Barragan. Well, thank you. Thank you, Mr. Chairman, for having this important hearing.

Administrator Johnson, our nation faces a healthcare worker shortage. Just last week in my congressional district I met with one of my hospitals who was telling me about the

worker shortage and the impact it is having.

So the worker shortage -- and the dental sector is not exempt from these workforce challenges currently being discussed. The shortage of dental providers impacts patients' access to oral health care across the country. In fact, research by the ADA's Health Policy Institute indicates that one in three dentists do not have full appointment schedules because of staffing issues.

What is HRSA doing to address the dental industry workforce shortages, particularly with respect to dental hygienists?

And does HRSA have plans to reopen any of the oral health training programs, such as the State Oral Health Workforce Program?

*Ms. Johnson. Thank you for the question, and for highlighting what is a critical need. Far too often oral health gets overlooked when we talk about critical health care issues, and it is essential to overall health, and is a place where we need to make sure that there are providers in underserved and rural communities.

We -- dentists and dental hygienists are part of the

National Health Service Corps. They are all -- dentistry is also an eligible discipline in the Teaching Health Center GME program. So we are training dentists directly, and we are supporting loan repayment for dentists to get into the communities in need.

And as you mentioned, we have our discretionary programs, as well. And we are, in that regard, limited by appropriations. And so we will do what appropriations resources allow us to do in that regard.

*Ms. Barragan. Great, thank you. In January the Geiger-Gibson Project on Community Health at George Washington University noted the potential effect of the Medicaid unwinding on Community Health Centers, stating that the Medicaid unwinding is expected to have significant ramifications for Community Health Centers. The unwinding is estimated to decrease total health center revenue, with an associated loss in patient capability of 1.2 to 2 million patients, and a staffing capacity loss of 10 to 18,500 staff members.

Medicaid is a critical funding source for community health centers. Medicaid is really important in my

congressional district, very working class. And I am concerned that the loss of Medicaid coverage for millions of patients will decrease the ability of health centers to serve all the patients who need care, not to mention the number of Latinos. As a chair of the Congressional Hispanic Caucus, I am concerned about the amount of Latinos that may lose coverage.

How does HRSA plan to help Community Health Centers as the Medicaid population is expected to decrease? And is there more Congress can do to help?

*Ms. Johnson. Well, thank you for raising it. We share your concern. It is vitally important that people who remain Medicaid-eligible don't lose Medicaid coverage for some paperwork or bureaucratic reason, because they don't get the right paperwork or don't know to respond. That is why we are really focused on making sure all of our enrollment assistors, all of the ways that we can partner with health centers and with other community organizations, our other grantees to get the word out to people that they are -- that these reviews are coming, and they need to be able to respond to them, and to support people in that is critical.

But there are going to be people who are transitioning off of coverage. So we want to also make sure that they get into marketplace coverage as quickly as possible. That matters not just for those individuals and their families, but for the fiscal viability of the health centers that we are talking about here today. And so that is why it is so important that we work together on the continuation of mandatory funding for these providers.

*Mr. Brown. Great, thank you. My last question is just a really general question.

When I had my meeting last week with Long Beach Memorial about the worker shortage issue, I have a sister who is a nurse, too. You hear firsthand the stories of how challenging it is for those in the field. You know, what can we be doing?

I know that there is, you know, the children's, you know, medical education, like, training program and the adult version of that, and I know there is a huge disparity in funding there. We know that there is a, you know, nursing shortage, bills. But what would you -- be your suggestion on how to best address this?

*Ms. Johnson. The workforce issues writ large? Yes?

*Ms. Barragan. Yes, the shortages that we are having.

*Ms. Johnson. Yes. The path we have laid out in the President's budget is sustaining the commitment we have made to National Service Corps at the level we have made it over the next three years: training more nurses by solving some of the bottleneck issues that make it harder for people to get into nursing because we don't have enough faculty; training more mental health and substance use providers through our existing programs.

Our budget proposal would allow us to train 18,000 new providers, and ensuring that we create our Health Care Workforce Innovation Program to develop new models for more rapidly training people to get into the workforce.

*Ms. Barragan. Thank you. We also need to make sure that people can afford to go to nursing school, student loan debt relief, and other programs of that nature.

Thank you, and I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back. The chair now recognizes Dr. Joyce from Pennsylvania for five minutes for questions.

*Mr. Joyce. Thank you for yielding, Chairman Guthrie, and thank you for holding this important hearing.

One of the most consistent issues that I have heard in my district in Pennsylvania is the shortage of physicians and health care workers and barriers to access to primary care. For this reason, last week I introduced H.R. 2559, the Strengthening Community Care Act, with Chairwoman Stefanik, Representative Blunt Rochester, and Representative Fletcher.

And I would further like to thank Representatives Carter, Bilirakis, DeGette, and Spanberger for their support of this measure.

This critical piece of legislation would provide for Community Health Centers across the country, including centers in my own district like Keystone Rural Health Center, Broad Top Area Medical Center, and Heineman Area Health Center, which helps serve the needs of over 250,000 individuals, patients in Pennsylvania's 13th district.

This bill will also reauthorize the National Health Service Corps, which supports more than 20,000 primary care medical, dental, and behavioral health providers through scholarships and loan repayment programs.

I, like many on this panel, have heard from communities throughout my district about the need for expanded access to behavioral health care and substance use disorder treatment, and Community Health Centers play an incredibly valuable role in providing mental and behavioral health care to vulnerable populations.

Administrator Johnson, what percentage of CHCs provide these specifically behavioral health services in communities today in America?

*Ms. Johnson. Yes, thank you for the question. I think most health centers try to provide some level of mental health services, but it is a significantly smaller percentage. We can get to the particulars on substance use disorder.

What we know is that, even when they do, they can only meet about a quarter of the demand for mental health services and about six percent of the demand for substance use disorder services.

*Mr. Joyce. Thank you. And how important is the stable and sustainable Federal funding in the Strengthening Community Care Act to our health centers' ability to continue

to provide this access to behavioral health care?

*Ms. Johnson. Yes, thank you. I don't know that I have seen the particulars of the bill. I will say, writ large, sustainable, predictable funding makes an incredible difference to retaining the health workforce, to delivering services in the community, to planning for what you can do going forward to surging to meet critical health needs.

*Mr. Joyce. Again, I thank you. How do Community Health Centers typically comply with the requirement to provide emergency services and ensure continuity in primary care services that a patient should receive?

*Ms. Johnson. So Community Health Centers are required and closely monitored by us to ensure that they have in place all of either directly or contracted relationships that allow them to comply with all of the section 330 requirements.

*Mr. Joyce. And on an additional matter, we are hearing from Community Health Centers and other providers who rely on 340B that large PBMs are pickpocketing their 340B savings through predatory contracts, and without sharing any of the savings with their patients.

There has been plenty of talk about the need for more

transparency on how 340B is being used. You mentioned earlier in the discussion here today that you collect specific data at HRSA. But on this matter specifically, can you speak to whether HRSA can address these issues through the existing authority, or does it need Congress to intervene?

*Ms. Johnson. I believe, Congressman, that we would benefit from your assistance in this regard, because we are continually reaching roadblocks when it comes to our authority. So we would benefit from working with you on this topic.

*Mr. Joyce. And I agree with you. It is time for Congress to intervene and stop those roadblocks from occurring.

Once again, I thank you for being here today.

And Mr. Chairman, I yield the remainder of my time.

*Ms. Johnson. Thank you.

*Mr. Carter. [Presiding] The gentleman yields. The chair now recognizes himself for five minutes for questions.

Ms. Johnson, thank you for being here. I appreciate this very important -- obviously, what you do, and this

agency is extremely important.

I too want to chime in, as I know some of my colleagues have already, about the 340B program because, as the oldest pharmacist in Congress, I am very concerned about it, and I am very concerned because of my FQHCs, and because of the hospitals, the rural hospitals.

I represent the entire coast of Georgia and a lot of south Georgia. As we like to say in Georgia, there are two Georgias. There is Atlanta and everywhere else. And I represent everywhere else. And a lot of that is rural areas. And certainly, the rural hospitals depend on this program, and they have been very concerned about what has happened with some of these manufacturers who are refusing to participate. And quite honestly, I can't blame them.

I think the program needs guardrails. It does not need to be eliminated. It needs to go back to what it was intended to be, what it was intended to serve, and the population that it was intended to serve. Unfortunately, as has been pointed out, there are a lot of hospitals, a lot of health care systems that, unfortunately, are not using it and utilizing it the way that it should be.

So having said that, I know that there was a report in -- by the New York Times, the Wall Street Journal, and other outlets by investigative journalists that some of the non-profit hospitals are doing exactly that, and that is that they are -- some of the DSH hospitals are using the program to pad their profits without regard to the needs of the vulnerable patients.

And the second is how -- the second thing that I want to point out is, of course, the PBMs. And I am no fan of the PBMs, as I am sure you know, but they are getting into the 340B program. And it doesn't surprise me one bit that they are. But they are getting in. They are stealing discounts that were intended for the patients.

Both of these issues need to be addressed. Both of them need to be addressed. And just as my colleague, Dr. Joyce, just mentioned, we want to help, and legislatively, if we need to. And as you indicated, it appears that we need to.

So let us help you. There has been suggestions of starting a 340C program -- I am sure you have heard of that -- just to quantify and to specifically identify who this program is to be for.

Now, I am not suggesting that all DSH hospitals are abusing the program or pushing the envelope on the program, if you will. But there are those that are doing that, and particularly in the oncology practices, particularly with cancer patients. And that is a big concern, as well. Some of these health care systems are buying out oncology practices for no other reason except to utilize the 340B program. And that is not what it was intended for. You know that as well as anyone.

So again, we stand ready to help you with any kind of legislation that you need.

Specifically, what is the agency doing to curb these abuses?

I know we have got a couple of lawsuits that are out there right now, and we are expecting to hear the results of some of them, hopefully, soon.

*Ms. Johnson. Yes, thank you for raising the issue. We have been taking action such as, you know, when -- where we have seen manufacturers not selling to covered entities via their contract pharmacy arrangements, we have sent violation letters to manufacturers in that instance. We have -- that

is the source of a considerable amount of litigation, and our authority is being challenged in that regard.

We also recently sent a series of letters just to covered entities as part of our ongoing compliance work with questions containing -- concerning their use of -- you know, their compliance with covered entity requirements.

We are working to use all the tools that we have. We recognize that there -- that we would benefit from additional tools here for the -- because we share the goal of accountability in this program.

Like you, we recognize there is a critical role for 340B for safety net providers and community -- across community. It makes a real difference. But we also want to make sure that there is accountability.

*Mr. Carter. Good, good. Very quickly, with what little time I have left, Community Health Centers have been successful in expanding access to affordable and quality health care all throughout my district, and I am very proud of that.

Last year I was proud to support the Mobile Health Care Act that gave Community Health Centers the flexibility to use

Federal funding and establish new mobile unit delivery sites. And many of them have done that to the benefit of a lot of people in our rural area. So how will the additional flexibility around new access points funding support mobile health units and Community Health Centers' ability to reach more underserved communities and patients, which is what we want them to do?

*Ms. Johnson. Yes, I mean, the provisions in our budget that are really about trying to do more access points is because what we hear from Community Health Centers again and again is we could better reach the population who needs us most if we had a little more start-up resource to get into a few more communities. And that is what we -- that is why we included that in the budget.

*Mr. Carter. Good. Thank you very much, again, for being here today.

My time is expired, and at this time I am going to recognize the gentlelady from Washington, Dr. Schrier, for her five minutes.

*Ms. Schrier. Thank you, Mr. Chairman.

And thank you, Administrator Johnson, for coming today

to speak on these critical programs that strengthen our health care provider pipeline and bolster our health care workforce.

First let me just say about the Special Diabetes Program I have type 1 diabetes, and I just want to thank Representatives DeGette, Bilirakis, Ruiz, and Cole for their work to reauthorize the Special Diabetes Program and the Special Diabetes Program for Indians. They are vital programs that can help ensure progress on predicting and delaying, treating, possibly curing one day with an artificial pancreas -- something that I have been hoping for for 38 years now. These programs are also critical to helping patients manage diabetes and complications, and I am extremely supportive and look forward to their passage.

Second, I want to highlight, as some of my colleagues already have, the shortage of providers in the U.S., and we are feeling this most acutely in rural areas and underserved areas. But we saw early retirements and, really, mass resignations, much of that related to the pandemic. So we need a bigger pipeline and a faster pipeline for new providers, and we also need ways to incentivize those

providers to practice in rural communities like parts of my district and in underserved communities.

What I have heard in some of the Community Health Centers in my district -- like HealthPoint, for example -- they have highlighted the importance of stable and consistent funding for Teaching Health Center Graduate Medical Education. In fact, some of the residents who I met were pretty anxious that the funding for their program might dry up before they finished their three-year residency program.

So Administrator Johnson, Ranking Member Pallone noted the importance of sustained and stable funding for these programs, along with several of my colleagues. Can you talk about why stability of funding is so important for Community Health Centers and graduate medical education to continue to generate providers in rural areas?

*Ms. Johnson. Thank you so much for the question. We ask a lot of Community Health Centers, and then we ask a lot of residents who come to train in Community Health Centers. We want them to manage people who have complex health conditions, who lead complex lives, and ensure that they have a usual source of care and are available to them as readily

as possible so that they are as healthy as possible, and we are keeping people out of emergency rooms, and we are getting them primary care. All of that is challenging work on a good day.

When the source of your funding is uncertain, and variable, and not guaranteed for the full life of your time in residency or for the full life of your budget planning as the head of a health center, that is very distressing and hard for us to recruit residents. It is hard for us to retain leadership in health centers. It is hard for our health centers to recruit staff. All of that is difficult without sustainability, and without really understanding the growth path that we know health centers need to be able to continue to meet demand by having extended hours, by having more sites.

*Ms. Schrier. Thank you. I don't recall when I graduated from medical school having these rural opportunities, distant opportunities, or even having to think about whether a residency program that I chose to start would have funding all the way through. And so I can understand that anxiety.

You know, I also wanted to highlight some of the work being done on the ground in Washington State by our Community Health Centers and Teaching Health Centers. Both Columbia Valley Community Health, CVCH, and Community Health of Central Washington offer these rural residency training programs. In fact, Washington State University's medical school has been a big driver of this.

I was wondering if you could talk specifically about rural residency programs, and why they are so important for maintaining a workforce in rural communities.

*Ms. Johnson. Yes, it is just -- it is hard to start up a residency program. It is -- it takes a lot of work. It takes getting accredited. It takes having the staff and the faculty, and it takes recruiting a strong faculty and a good curriculum and all of that work. That is hard to do in a rural area if you don't have some support.

And so our Office of Rural Health Policy is able to support the development of rural residency programs to get them on the path so that then they can come into other GME programs, and it makes a huge difference in communities across the country.

*Ms. Schrier. Thank you. We talked about see one, do one, and teach one, and this is reminding me of that. Go to a rural area, train there, stay there, teach the next generation of rural providers. So thank you very much.

I am out of time. I yield back.

*Ms. Johnson. Thank you.

*Mr. Carter. The gentlelady has yielded. The chair now recognizes the youngest pharmacist in Congress, the gentlelady from Tennessee, Mrs. Harshbarger, for five minutes.

*Mrs. Harshbarger. Thank you, Mr. Chair, and thank you, Administrator Johnson.

You know, I represent a rural district in east Tennessee, and I believe your agency reports that more than 80 percent of rural counties in the U.S. are considered medically underserved. Does that sound about right, 80 percent?

*Ms. Johnson. I would have to validate that for you, but I agree with you.

*Mrs. Harshbarger. But I have seen statistics that only one-third of NHSC placements are in rural communities. And

after they complete a typical two-year commitment, too many of those members leave for higher-paying jobs. In part, they -- to continue paying down their school debt, for example.

And I guess my question to you is what can we do to ensure that the NHSC adequately serves the country's rural, medically underserved areas?

*Ms. Johnson. Thanks for the question, because this is a great part of the National Service Corps that is not totally as well understood, which is we will further incentivize you after you complete your first obligation with us. We will give you a continuation and continue to help pay down more of your debt if you stay in the community you are in.

So we have -- I actually just visited a site in a rural community where we had people who had been there for more than the two-year service commitment because we were continuing -- as long as they had eligible debt, we were continuing to help them pay down. And they were starting a family, they were going to live there --

*Mrs. Harshbarger. Well --

*Ms. Johnson. -- because that is where they --

*Mrs. Harshbarger. Yes, we want them to. You know, we need to look at innovative solutions to keep these physicians in the area.

And I helped introduce a bipartisan Rural American Health Corps Act with David Kustoff here in the House and Senator Blackburn in the Senate. And I would just recommend my colleagues sign on to that legislation. And it is sort of a sister program to NHSC, and it helps with loan repayment in a lot of ways. So -- and I would love to work with you for technical feedback on that bill. So --

*Ms. Johnson. We would be --

*Mrs. Harshbarger. -- that would be --

*Ms. Johnson. We would be delighted to do that. Thank you.

*Mrs. Harshbarger. Absolutely.

But I do want to talk about yesterday the Administration announced a $1.1 billion program to continue to provide COVID-19 vaccines and therapeutics to underserved Americans, the HHS Bridge Access Program. And it is my understanding that 1.1 billion to fund this program was pulled from the Provider Relief Fund. And what I want you to do, can you

confirm that that 1.1 billion came from the HRSA Provider Relief Fund for this new, unrelated program?

*Ms. Johnson. We had previously been funding supports and services for individuals who are uninsured. And as the -- as vaccines and therapeutics transitioned to commercialization, it has been recognized that it would be very important that we are reaching underserved communities and uninsured communities. And so, as an allowable use of Provider Relief Funds, funds are being used to support --

*Mrs. Harshbarger. So is that --

*Ms. Johnson. -- program.

*Mrs. Harshbarger. Will that program ended in December of 2024?

*Ms. Johnson. I believe that is accurate.

*Mrs. Harshbarger. Okay. I guess my question is, how did you come to that specific $1.1 billion number that you need between now and next December?

*Ms. Johnson. Yes, I believe that -- and again, I would need to consult with our colleagues across the department who helped design the program.

*Mrs. Harshbarger. Yes.

*Ms. Johnson. But I believe it was looking at where uninsured needs are, and where we thought, because of the cost associated with administration of these vaccines and therapeutics --

*Mrs. Harshbarger. Well --

*Ms. Johnson. -- what that would look like.

*Mrs. Harshbarger. Okay, that brings me to another question. Was there an assumption that annual boosters would be recommended and incorporated into that 1.1 billion?

*Ms. Johnson. I don't know the answer to that question, but I am happy to get back to you on that.

*Mrs. Harshbarger. Okay. If you could find that, because -- I guess I am asking that because assumptions were made around anticipated demand, and there has clearly been a decrease in COVID-19 vaccine uptake. So, you know, that is just my question. How did you get to that 1.1 billion?

But if you could do that, that would be fantastic --

*Ms. Johnson. I am happy to follow up with you on that point. Thank you.

*Mrs. Harshbarger. And I know I have got a minute left. I wanted to talk about Countermeasures Injury Compensation

Program, and I thank you for your recent response to the congressional letter that was sent by our colleague, Rich McCormick of Georgia. And a lot of the colleagues here signed on to that.

In our letter we expressed concerns over the delays that are being experienced by individuals making claims under the CICP, and sought information regarding how your agency intends to address the barriers to compensation reported by our constituents. My question is how many reviewers are being used for the nearly 12,000 COVID vaccine injury claims on file?

*Ms. Johnson. I believe we have done a series of hiring because we have recognized the need to grow this program, which, you know, historically, for the 10 years it had been around, had only gotten 500 claims over the life of the program.

*Mrs. Harshbarger. Yes.

*Ms. Johnson. So we have scaled up hiring.

*Mrs. Harshbarger. Many more now, yes.

*Ms. Johnson. And I believe we are at 38 now.

*Mrs. Harshbarger. Thirty-eight? How is the CICP

prioritizing these claims? And in particular, is there any focus on death claims?

*Ms. Johnson. We are -- I will need to get back to you on the particulars --

*Mrs. Harshbarger. Okay.

*Ms. Johnson. -- of that. Yes.

*Mrs. Harshbarger. Yes, well, I have got other questions, but I will submit them to you.

[The information follows:]

**********COMMITTEE INSERT**********

*Mrs. Harshbarger. And with that, thank you for being here --

*Ms. Johnson. Thank you.

*Mrs. Harshbarger. -- and I yield back.

*Mr. Carter. The gentlelady yields back. The chair now recognizes the gentlelady from Iowa, Dr. Miller-Meeks.

*Mrs. Miller-Meeks. Thank you very much, Chair Carter, and thank the committee for having this hearing.

So let me first say that I am a physician, as well as a former director of the Iowa Department of Public Health, so very familiar with Health Professional Shortage Areas, HPSA, our Maternal and Child Health Grants.

But I just want to say that workforce is a complicated issue, and it is complicated because it -- when you are looking at physician workforce, especially, people just don't locate where reimbursement is the highest. And let me just say that in our small community of 26,000 people we had a very vibrant medical community. And I am fully supportive of our FQHC, but our FQHC also decimated our provider community. Our FQHC does not pay property tax, which put an increased burden on the private practices that got displaced, which

were paying property taxes.

You know, who pays for electronic health records when you have to institute that, or electronic billing, or all of the other mandates that individual practices have had?

And so you have had from the start and the inception of the Affordable Care Act, 50 percent of physician practices were independent or a small group, meaning not consolidated. And now only 20 percent of those practices. So the majority of physicians are now either hospital employees or large group employees.

With that, noticing in your testimony you had mentioned that you had reached a milestone of 20,000 family medicine providers, pediatricians, obstetricians -- I won't go through the entire list. That was a historic high. So is that 20,000 people that are in practice now, or is that 20,000 people over the 50 years?

*Ms. Johnson. That is 20,000 people who are in the field today.

*Mrs. Miller-Meeks. Okay. You also mentioned that you have a retention rate of two years beyond the service obligation. What is the current service obligation in the

National Health Service Corps?

*Ms. Johnson. The service obligation is two years for the first award, and then the options for continuations depending on allowable --

*Mrs. Miller-Meeks. And what is an award?

*Ms. Johnson. $50,000.

*Mrs. Miller-Meeks. So 2 years for each $50,000 in loan --

*Ms. Johnson. Two years for the first $50,000, that is right.

*Mrs. Miller-Meeks. Of loan repayment.

*Ms. Johnson. Loan repayment.

*Mrs. Miller-Meeks. Okay. And so what is the total cost of the program?

*Ms. Johnson. The total appropriation for the National Service Corps today -- this year we are at $417 million.

*Mrs. Miller-Meeks. And what is your overhead cost -- i.e. how much of that money goes out to loan repayment, and how much of that stays within the institution?

*Ms. Johnson. I don't know the answer to that off the top of my head.

*Mrs. Miller-Meeks. Could you get me the answer to that?

*Ms. Johnson. Absolutely.

*Mrs. Miller-Meeks. And so -- and what is the retention rate beyond two years? Because I can tell you what the retention rate is on our J-1 visa programs beyond the 3 years of obligation.

*Ms. Johnson. Beyond the 2 years -- the first 2 years beyond the 2 years of obligation, our retention rate is 86 percent.

*Mrs. Miller-Meeks. How many stay beyond? So after two years -- so, like, for five years, what is the retention rate?

*Ms. Johnson. I have -- what I can tell you is the -- like, after the completion rate of two years, the two years that followed -- at the end of the two years that follow that, the retention rate is 86 percent.

*Mrs. Miller-Meeks. Okay. Thank you for clarifying that.

Are you also aware of -- in the National Residency Matching Program, have you looked at the stats on matching

rates for family practice and emergency medicine?

*Ms. Johnson. We keep abreast -- our team keeps abreast of matching rates.

*Mrs. Miller-Meeks. Okay. And so is the matching rate 100 percent for family practice?

*Ms. Johnson. I don't know the answer to that off --

*Mrs. Miller-Meeks. The answer to that is no, and you just told me that you keep track of those.

*Ms. Johnson. Our team keeps track of that. That is correct.

*Mrs. Miller-Meeks. Okay. So the matching rate for family practice -- we do not fill the number of slots that are available. And if you look at a university academic medical center, their slots will be 100 percent filled; those at a training health center are not 100 percent filled.

So -- and when we are talking about increasing providers, what is it that we can do to increase or narrow that delta between the number of slots that are available and the number of unfilled positions? And 25 percent of those positions are currently filled by foreign medical graduates, which I think is great.

*Ms. Johnson. You know, it is critically important that we have as much lead time on recruitment. And so that is why we think stability in the program is really important, because it is hard to recruit. You know this better than I do. It is hard to recruit --

*Mrs. Miller-Meeks. Well, the delta has been increasing. So I can send that data to you. I should have put up a graph.

*Ms. Johnson. No, it -- but it --

*Mrs. Miller-Meeks. But the delta is increasing. So from -- even from, you know, 2013, prior to the pandemic, there has always been a gap between the number of programs offered and the fill rate. That delta has been increasing, certainly a little bit exacerbated by the pandemic, but it was also fairly significant before the pandemic.

*Ms. Johnson. Yes, there have always been challenges with the fact that the funds have to be renewed. And early on in the program there were challenges with the stability of the fact that the dollars were allocated on the fiscal year, not the academic year.

*Mrs. Miller-Meeks. Okay, thank you for that. I would

say to investigate that more.

My last question is, you know, as a physician I practice, I see patients on weekends. I see patients at night when I am practicing. So why do we have to have 250 million investment to extend office hours?

I would just say you have to have evening and weekend office hours. As a Federal Government, if we are subsidizing an FQHC, a Training Health Center, a Community Health Center, I would make that part of that program, is that they have extended office hours in order to be able to adapt to and respond to their patient consumer demand.

Thank you. I yield back.

*Mr. Carter. The gentlelady has yielded back. The chair now recognizes the gentleman from Texas, Mr. Crenshaw, for five minutes.

*Mr. Crenshaw. Does that mean I can schedule an eye appointment with you? I didn't know that. All right.

*Mrs. Miller-Meeks. I would see you.

*Mr. Crenshaw. I need a checkup.

*Mrs. Miller-Meeks. I would drive you to your --

*Mr. Crenshaw. I got issues. All right.

Thank you for being here. Look, when we evaluate these programs -- I agree with my colleague here about the need to use our money wisely. We have to assess how effective the money is that we are spending. So I want to drill down on a couple of policies, make sure we are actually strengthening our access to care and continuity of care.

You know, many of the programs we are talking about today are meant to advance primary care. That is a big passion of mine. I think that is where any patient enters the health care system, so that is where, legislatively, we should enter health care reform. And look, I think there is a few opportunities that we could look at here to make this better.

Inflation, soaring workforce costs, that has caused a lot of problems. It means it is really hard to recruit health professionals and retain them. This is particularly true for Community Health Centers. So I would like to submit a record -- for the record a statement from Lone Star Family Health Center, which serves thousands of people in my district to show that these workforce challenges are real for them, as well.

Community Health Centers are supposed to improve access to primary care services that can reduce costs to public insurance programs, while also preventing emergency room visits that are extremely costly. So that is the value-add that we are looking for. But when you can't hire anyone -- and we are not just talking about physicians here, we are talking about dental hygienists, we are talking about medical assistants -- it becomes pretty difficult to provide that care.

So I have supported legislation to remove unnecessary red tape for licensing medical professionals. Can you comment on this in general terms?

What do you need to help us hire more people, make it easier to hire more people? What are the barriers that we need to overcome?

*Ms. Johnson. Thanks for the question. One of the things that we have been working on lately is ensuring that we are linking some of our grant dollars to apprenticeship programs so that we are not just training, but we are training and doing on-the-job training, as well, so that we can prepare people for that first step in the health

professions career ladder, and then really working to bring people up the career ladder as we move people into the health care workforce.

We also in our budget this year have a new initiative, proposed initiative that we call our Health Care Workforce Innovation Proposal, which is really about addressing some of the key barriers, getting ideas and new innovative ways to do health care training, and to try to scale what works best.

*Mr. Crenshaw. Is it you are trying to reform training? Can you be more specific? I am curious about that.

*Ms. Johnson. So I think that, you know, what we hear from some places is maybe the training period is longer than it needs to be --

*Mr. Crenshaw. Okay.

*Ms. Johnson. -- or maybe we could do some things creatively to match people differently, those kinds of things.

*Mr. Crenshaw. Okay, that is good. Licensing reform, any thoughts on that?

*Ms. Johnson. You know, we -- through some of our telehealth work we have actually been working on the compacts

that states use to -- in health professions to ensure that providers can work across state lines. We are really interested in ways to encourage those kind of best practices.

*Mr. Crenshaw. Okay. I think you would like the bill that we are supporting. I hope we can -- I hope we could pass that.

As you know, National Health Service Corps is supposed to be a deal where physicians receive scholarships and loan repayment in exchange for practicing in at-need communities. But a recent study prepared for the Department of Health and Human Services suggests clinicians who don't participate in that, without those benefits, actually practice in Health Professional Shortage Areas more often and for longer than those who do. So that tells me we might be wasting money on some of these folks.

There was an average 13 percent gap between non-program providers and participating providers. That is just strange. So how long -- I have a couple of questions. How long does the average National Health Service Corps participant practice in a shortage area after their obligation is complete?

I think I am repeating these questions, but --

*Ms. Johnson. Yes, and so there is the base obligation to stay in the service. They have a service obligation to stay for two years. If they get a continuation, sometimes they stay for multiple years.

And our data is -- where we look two years after they complete their service obligation, 86 percent of people are still in underserved communities.

*Mr. Crenshaw. Okay. There is obviously some kind of problem here, isn't there? So are we not using this money correctly? Is there better ways to incentivize, or at least exploring better ways to incentivize practitioners in those underserved areas?

*Ms. Johnson. We are always looking for ways to continue to grow the workforce in the communities that need them the most, which is why we also have the Teaching Health Center program, which is about not just -- you know, loan repayment is about getting people there who are already through residency. Teaching Health Centers is actually about doing the residency in the community where you want people to practice. And then we also have National Health Center

scholarship programs, where people make the commitment as part of their medical school education.

*Mr. Crenshaw. Okay. Well, I am out of time.

Thank you, I yield back.

*Mr. Carter. The gentleman yields back. I believe that is all the witnesses.

I ask unanimous consent to insert in the record the documents included on the staff hearing documents list.

Without objection, that will be the order.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Carter. I remind members that they have 10 business days to submit questions for the record, and I ask the witnesses to respond to the questions promptly. Members should submit their questions by the close of business on May 3rd.

Ms. Johnson, thank you for being here.

*Ms. Johnson. Thank you.

*Mr. Carter. I appreciate it, and appreciate the work that your committee -- your agency does.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:35 p.m., the subcommittee was adjourned.]