

EXAMINING THE EXTENSION OF SAFETY NET HEALTH PROGRAMS

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTEENTH CONGRESS FIRST SESSION

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FRIDAY, JUNE 23, 2017

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:23 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Burgess, M.D. (chairman of the subcommittee) presiding.

Present: Representatives Burgess, Guthrie, Barton, Upton, Shimkus, Murphy, Lance, Griffith, Bilirakis, Mullin, Hudson, Collins, Carter, Walden (ex officio), Green, Engel, Schakowsky, Butterfield, Matsui, Castor, Sarbanes, Luján, Schrader, Kennedy, Cárdenas, Eshoo, DeGette, and Pallone (ex officio).

Also Present: Representatives Costello, Dingell, and Ruiz

Staff Present: Zachary Dareshori, Staff Assistant; Jordan Davis, Director of Policy and External Affairs; Paul Edattel, Chief Counsel, Health; Adam Fromm, Director of Outreach and Coalitions; Caleb Graff, Professional Staff Member, Health; Jay Gulshen, Legislative Clerk, Health; Peter Kielty, Deputy General Counsel; Alex Miller, Video Production Aide and Press Assistant; Mark Ratner, Policy Coordinator; Kristen Shatynski, Professional Staff Member, Health; Jennifer Sherman, Press Secretary; Josh Trent, Deputy Chief Counsel, Health; Jacquelyn Bolen, Minority Professional Staff Member; Jeff Carroll, Minority Staff Director; Waverly Gordon, Minority Health Counsel; Jerry Leverich, Minority Counsel; Rachel Pryor, Minority Health Policy Advisor; Tim Robinson, Minority Chief Counsel; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and C.J. Young, Minority Press Secretary.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. The Subcommittee on Health will now come to order. The chair wishes to observe that today's hearing was originally scheduled to occur last Wednesday morning. But on that Wednesday morning, the Capitol Hill family and the entire country was shocked and horrified to learn about an awful attack that took place against our own. This past week has been sobering and difficult for all of us in many different ways, a number of friends, indeed. A member of this very committee is still in the hospital. They continue to need our prayers and best wishes as they fight to heal, to recover, and, in coming days, join us again. Last week's awful

tragedy reminds us that what unites is more important than what divides us. We are not first Democrats or Republicans, we are Americans. We love our country, and we respect our colleagues. We are saddened, but we are strong. We are troubled, but we will unite around our common duty and our common service to our fellow countrymen that spirit of unity.

Pause for just a brief moment of quiet reflection for those, especially the member of the committee who is not able to be here today. But, of course, we still have other people who are recovering from their injuries.

The chair will recognize himself 5 minutes for an opening statement.

In 2015, this committee passed the Medicare Access and CHIP Reauthorization Act—you are welcome—which extended funding for many of the Nation's safety net programs, including the community health center funding and the State Children's Health Insurance Program. With funding for both the community health center fund and the SCHIP program set to expire yet again at the end of this fiscal year, our committee has the responsibility of taking a critical look at how these programs operate, and setting out a long-term path to funding, and, perhaps, reauthorization.

The Community Health Center Fund plays an important role in supplementing the services that federally qualified health centers are able to deliver to underserved communities by providing care to all Americans regardless of income, regardless of ability to pay. Additionally, the Community Health Center Fund provides resources for the National Health Service Corps which actually provides scholarships and loan repayment opportunities to new doctors willing to serve in medically underserved areas. This program has proven effective at placing providers, providers who are young and energetic and willing to work hard in some of the most medically unserved and challenging areas.

The State Children's Health Insurance Program provides healthcare coverage to over 8 million children across the Nation through flexibility capped allotments to states. The program has been able to successfully support children while providing states with opportunities to tailor their respective programs as to best meet the needs of their populations. However, the programs are not without challenges. In regards to the Community Health Center Fund, we are interested in seeing how federally qualified health centers can best maximize this investment. Succeeding in underserved areas can be difficult, and I look forward to learning more as to how the federally qualified health center can continue to deliver results and where improvements might be made.

As for the State Children's Health Insurance Program, there are multiple points for consideration. As is the case with other Federal insurance programs, there are considerable concerns regarding the long-term sustainability of the program. Following the passage of the Affordable Care Act, the program's Federal match rate rose an unprecedented 23 percent, providing some states with as much as a 100 percent Federal match. This increase in funding has challenged the program by both shifting the nature of shared responsibility of the State Children's Health Insurance Program to the Fed-

eral Government and making states more dependent on Federal dollars.

The issue is further complicated by concerns raised by the Congressional Budget Office on the efficacy of the enhanced match rate. According for the Congressional Budget Office, an elimination of the enhanced match rate would basically not impact coverage rates for children in the country, while a continuation of the enhanced funding would add another \$7 1A½ billion to the deficit over the next 5 years if no other policies were undertaken to offset its cost.

So today's hearing should focus on how to best proceed with the Affordable Care Act's increased funding for the State Children's Health Insurance Program, the increased funding rate, and what a continuation of this funding would mean for taxpayers, and what it would mean for covered children.

With these challenges before us, I would like to welcome our witnesses and thank them again for joining us today, thank them for their forbearance as the hearing got rescheduled twice.

On the CHIP front, we have Ms. Jami Snyder who serves as the Associate Commissioner for Medicaid and CHIP in my home State of Texas, and Ms. Cindy Mann who served the administration as the administrator and director of the Center for Medicaid and CHIP services at the Center for Medicare and Medicare Services from 2009 to 2014. I am interested in hearing today how each of your experiences on both sides of this partnership has worked, and where you believe we can improve the ability of states to meet the needs of children in the program.

And finally, Mr. Michael Holmes serves as the CEO of Cook Area Health Services, which I believe is in Minnesota. And as the treasurer for the National Association of Community Health Centers, Mr. Holmes, I look forward to your testimony today on the role that the Community Health Center Fund has played in supporting your work. There is much to discuss today. I look forward to our conversation. Both the Community Health Center Fund and the State Children's Health Insurance Program provide State and local opportunities to improve access to care in the United States.

I yield back the balance of my time, and recognize the ranking member of the subcommittee, Mr. Green of Texas, 5 minutes for an opening statement, please.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

The Subcommittee will come to order.

The Chairman will recognize himself for an opening statement.

In 2015, this Committee passed the Medicare Access and CHIP Reauthorization Act, which extended funding for many of the nation's safety net programs, including the Community Health Center Fund and the State Children's Health Insurance Program (SCHIP). With funding for both the Community Health Center Fund and the SCHIP program set to expire yet again at the end of the fiscal year, our Committee has the responsibility of taking a critical look at how these programs operate and setting out a long-term path to reauthorization.

The Community Health Center Fund plays an important role in supplementing the services that Federally Qualified Health Centers (FQHCs) are able to deliver to underserved communities by providing care to all Americans, regardless of income or ability to pay. Additionally, the Community Health Center Fund provides resources for the National Health Service Corps, which provides scholarships and loan

repayment opportunities to new doctors willing to serve in medically underserved areas. This program has proven incredibly effective at placing providers, often those who are young, energetic and willing to work hard, in the most medically underserved areas.

The SCHIP program provides health care coverage to over 8 million children across the nation. Through flexible capped allotments to the States, the program has been able to successfully support children while providing States with opportunities to tailor their respective programs as to best meet the needs of their respective populations.

However, these programs are not without challenges. In regards to the Community Health Center Fund, we are interested in seeing how FQHCs can best maximize this investment. Succeeding in underserved areas can be difficult, and so I look forward to learning more as to how FQHCs can continue to deliver results and where improvements to the program can be made.

As for the State Children's Health Insurance Program, there are multiple points for consideration. As is the case with other federal insurance programs, there are considerable concerns regarding the long-term sustainability of the program. Following the passage of the Affordable Care Act, the program's federal match rate rose an unprecedented 23%, providing some states with as much as a 100% federal match. This increase in funding has challenged the program by both shifting the nature of the shared responsibility of SCHIP to the federal government, and by making states more dependent on federal dollars.

This issue is only further complicated by concerns raised by the Congressional Budget Office (CBO) on the efficacy of the enhanced match rate. According to the CBO, an elimination of the enhanced match rate would basically not impact coverage rates for children in the country, while a continuation of the enhanced funding would add an additional \$7.2 billion to the deficit over the next five years if no other policies were adopted to offset its cost. Therefore, today's hearing should focus on how best to proceed with ACA's increased SCHIP funding rate and what a continuation of this funding would mean for taxpayers and for covered children.

With these challenges before us, I would like to welcome our witnesses and thank them for joining us today as we unpack these important issues:

On the CHIP front, we have Ms. Jami Snyder who serves as the Associate Commissioner for Medicaid and CHIP in my home state of Texas and Ms. Cindy Mann, who served as the Administrator and Director of the Center for Medicaid and CHIP Services at the Centers for Medicare and Medicaid Services (CMS) from 2009 to 2014. I am interested in hearing today how each of your experiences on either side of this has partnership worked, and where you believe that we can improve the ability of States to meet the needs of children covered under the program.

And finally, Mr. Michael Holmes serves as the CEO of Cook Area Health Services and as the Treasurer for the National Association of Community Health Centers. Mr. Holmes, I look forward to your testimony today on the role that the Community Health Center Fund has played in supporting your work.

There is much to discuss today, and I look forward to our conversation on these programs. Both the Community Health Center Fund and the State Children's Health Insurance Program provide state and local opportunities to improve access to care in the United States.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman. And, again, we appreciate the loss we had, the injuries you had, and particularly to our committee member, last week. But I am glad he is progressing very well. The Children's Health Insurance Program, CHIP, and Federally Qualified Health Centers, FQHCs, are critical components of our healthcare safety net. Funding for both expires at the end of this fiscal year, and timely reauthorization is utterly critical. That said, we cannot talk about either without talking about Medicaid, and, literally, the elephant in the room. The American Health Center Act, or TrumpCare, guts Medicaid, makes structural changes that would inevitably lead to the rationing of care after seeing the House Republican's bill to kick off 14 million enrollees on Medicaid, cut 834 billion from programs, the Senate plan to kick even more

kids off of Medicaid over time, and make even steeper cuts somehow managing to be more mean than even the House bill.

In 3 years, the Senate bill will start the process of kicking millions off their Medicaid coverage. And then as if that wasn't enough, starting in 2025, the plan leads to even more Medicaid cuts that every year becomes deeper cuts than the year before. CHIP is designed to sit on top of a strong Medicaid program, and reauthorizing it while simultaneously destroying Medicaid is simply unacceptable.

TrumpCare jeopardizes coverage for millions of kids with Medicaid and CHIP, and the Trump budget doubles down on cuts that directly hurt kids. To make matters worse, the Trump administration's budget proposals, an additional \$610 billion cuts to Medicaid, eliminates enhanced CHIP matching for states, rolls back the requirement on states to maintain current kids' eligibility in CHIP, and cuts support for CHIP kids over 250 percent of the Federal poverty level.

More than $\frac{1}{3}$ of all children in the U.S. and almost half the kids under age 6 are covered by Medicaid or CHIP. The vast majority of these children, more than 90 percent, are covered by Medicaid.

I strongly support CHIP and will continue to urge my colleagues to fully extend the program for 5 years. And I have long championed community health centers and want to see the health center fund extended for the same amount of time. Without an extension of funding, the health center program will be decimated. Given all the uncertainty my colleagues are introducing in the health insurance programs, a clean extension of these two pillars of the healthcare safety net is of utmost importance. But again, extending these programs without destroying Medicaid is unacceptable. CHIP stands on the shoulders of a strong Medicaid program. And in fiscal year 2016, Medicaid provided more than 40 percent of the community health center's funding. They are tied together as three legs on a stool that helps children get healthcare they need. No child should be left off worse because of Congress's actions.

With that, Ms. Chairman, I would like to yield 1 minute to my colleague from Massachusetts, Joe Kennedy. And after Congressman Kennedy, I yield the remainder of my time to Congresswoman DeGette.

Mr. KENNEDY. Thank you to the ranking member.

Ladies and gentlemen, anybody who has welcomed a child into this world knows that moment when you lock your eyes with your son or daughter the first time, the promise that you make to protect them under any circumstance. You learn quickly, sometimes far too quickly, that no matter how hard you try, nature will test the strength of that promise because children are not immune to an unexpected accident or a life-altering diagnosis. Facing that tragic reality, we as a country and as a community invest in their care through CHIP, through Medicaid, through a ban on lifetime caps into a strong community health center program. It is that recognition that our children are society's most precious resource that brings us together here this morning. But TrumpCare threatens the fundamental guarantee of compassion for our kids. It segregates and stigmatizes children not just for their illness, but for

the fate and fortune of their family. And that is a vision that, for our healthcare system on our Nation, that we should never accept.

Thank you, and I yield back.

Ms. DEGETTE. Thank you.

We used to all agree in this country that every child, regardless of his or her parents' income, should have a chance at a healthy start. That is why we have been working in a bipartisan way to make this country get closer to that goal. I worked on the very first CHIP bill in 1999. And because of the bipartisan collaboration, 95 percent of Americans children have coverage. That is an all-time high. So why would Congress pass this TrumpCare bill which will take coverage away from over 3 million children? There would be an unprecedented \$834 billion cut in Medicare which covers more than 35 million kids. Half of the 9 million children in CHIP are actually in Medicaid. And so, Mr. Chairman, it is really hard for me to see how we can have a bipartisan reauthorization of CHIP by the end of September without a strong bedrock foundation of Medicaid.

I yield back.

Mr. BURGESS. The gentleman from Texas yields back his time. The chair thanks the gentleman. The chair recognizes the gentleman from Oregon, Mr. Walden, 5 minutes for an opening statement, please.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. I thank the chairman.

Today marks a really important step forward in this committee's work to strength our healthcare safety net by examining the extension of two very important safety net programs. Both the Children's Health Insurance Program, CHIP, the Community Health Center Program, have enjoyed strong bipartisan support for many years. Under current law, Congress needs to renew funding for these important programs, since the current funding streams will soon expire. We recognize that CHIP and community health centers play a significant role in the Nation's safety net for millions of Americans, for millions of American children, and pregnant women who are generally low- to moderate-income, and millions of individuals who may be medically underserved or face other barriers to care.

Individuals and families served by these programs are not just program enrollees: They are our neighbors. They are our friends. In my district alone, there are 12 federally-qualified health center organizations with 63 delivery sites leveraging more than \$41 million in Federal money in order to serve over 240,000 patients. In many parts of rural eastern Oregon, a health center can serve as the main primary care provider in the communities that face a shortage of private practice doctors. And in three of my counties, there are no physicians, and there are no hospitals. The Student Loan Repayment Incentive offered through the National Health Service Corps also helps staff those centers and ensure patients in those communities can see a provider in a timely manner. So I am glad to be here and join my colleagues, hopefully on both sides of the aisle, in moving this process forward. We are united in the ef-

fort to protect patients and to support innovative patient-centered solutions at state and local levels.

As a result, there are strong bipartisan recognition that CHIP and the health center program play key roles in our Nation's healthcare delivery system by providing health coverage and medical care for millions of low income Americans.

Both programs have demonstrated successes in helping reduce cost for patients and families, improve health outcomes, and deliver cost-effective care. We view our state and local partners in these programs as key allies in the common cause of putting patients first. This is a shared responsibility.

In my State of Oregon, our health centers partner with local providers, health systems, and the patient community through coordinated care organizations that work to provide comprehensive services focusing on prevention, chronic disease management, and locally controlled patient-centered care.

Today, we start our funding extension discussion by hearing from experts who have firsthand experience running CHIP programs and health centers. We want to better understand if these programs face barriers to innovation. We want to hear creative strategies to deliver quality care, and we seek your guidance on what is working and what is not.

As we move forward, this committee also faces important considerations regarding extending funding for these programs. There are decisions to be made regarding how much funding should be provided, for how long, and how Congress should pay for it so as not to burden the next generation with additional debt.

Particularly, the committee will closely examine the question of whether the 23 percent bump for a state's match for CHIP is appropriate to continue as we look at funding questions. I have concerns the 23 percent increase upends the traditional financial Federal-state partnership.

As we embark on this effort, I know we all share the goals reducing cost and ensuring patients served by these programs have the peace of mind that they can continue to access timely, high quality care. And it goes without saying that this needs to be bipartisan. We look forward to working with our colleagues on the other side of the aisle. And it is important to note as well that CHIP is one of those programs that is actually a block grant to the states that seems to perform quite well when we rely on our state partners in this effort.

So with that, Mr. Chair, unless others on our side seek the balance of my time, I am more than happy to yield back to get on with the hearing.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Today marks an important step forward in this committee's work to strengthen our health care safety net by examining the extension of two popular safety net programs. Both the Children's Health Insurance Program (CHIP) and the Community Health Center Program have enjoyed strong bipartisan support for many years. However, under current law, Congress needs to provide additional funding for these programs since current funding streams will soon expire.

We recognize that CHIP and community health centers play a significant role in our nation's safety net for millions of Americans—children and pregnant women

who are largely low-to-moderate income, and millions of individuals who may be medically underserved or face other barriers to care.

Individuals and families served by these programs are not just program enrollees—they are our neighbors, and friends. In my district alone, there are 12 federally-qualified health center organizations, with 63 delivery sites leveraging over \$41 million in federal dollars in order to serve over 240,000 patients. In many parts of rural Eastern Oregon, a health center can serve as the main primary care provider in the communities that face a shortage of private practice doctors. The student loan repayment incentives offered through the National Health Service Corps also help staff those Centers and ensure patients in those communities can see a doctor in a timely manner.

So I am glad to be here and join my colleagues on both sides of the aisle in moving this process forward. We are united in the effort to protect patients and to support innovative, patient-centered solutions at the state and local levels.

As a result, there is strong bipartisan recognition that CHIP and the Health Center Program play key roles in our nation's health care delivery system by providing health coverage and medical care for millions of low-income Americans. Both programs have demonstrated successes in helping reduce costs for patients and families, improve health outcomes, and deliver cost-effective care.

We view our state and local partners in these programs as key allies in the common cause of putting patients first. In Oregon, our health centers partner with the local providers, health systems, and the patient community through Coordinated Care Organizations that strive to provide comprehensive services focusing on prevention, chronic disease management, and locally controlled, patient-centered care. So we want to start our funding extension discussion by hearing from these experts who have first-hand experience running a CHIP program and a health center. We want to better understand if these programs face barriers to innovation, we want to hear creative strategies to deliver quality care, and we seek guidance on what's working and what's not.

As we move forward, this committee also faces important considerations regarding extending funding for these programs. There are decisions to be made regarding how much funding should be provided, for how long, and how Congress should pay for it so as not to add to the burden of federal debt that Americans already face.

Particularly, the committee should closely examine the question of whether the 23 percent bump for a state's match for CHIP is appropriate to continue as we look at a funding question. I have concerns that the 23 percent bump upends the traditional financial federal-state partnership.

As we embark on this effort, I know we all share the goals of reducing costs and ensuring patients served by these important programs have the peace of mind that they can continue to access timely, high quality care.

Mr. BURGESS. The chair thanks the gentlemen. The gentleman yields back.

The chair would observe that there is a vote on the floor. There is still almost 9 minutes left. So with the committee's permission, I am going to recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for an opening statement, after which we will recess for votes until votes have concluded on the floor. Mr. Pallone, you are recognized for 5 minutes, please.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

A little over a month ago, House Republicans voted to repeal the Affordable Care Act and gut the Medicaid program in order to give tax cuts to the rich and privileged few. The result, 23 million people could lose health insurance, 3 million of them children. And then yesterday, Senate Republicans finally made public their bill where they proposed even steeper cuts to Medicaid. And now, today, Republicans will talk about the importance of our safety net programs, the Children's Health Insurance Program, CHIP, and

the Community Health Center Fund. I agree wholeheartedly about the importance of extending these programs. But what our Republican colleagues seem to ignore is that our safety net is interconnected. To tear down Medicaid, which is supported by CHIP and community health centers, is misguided and hypocritical. Mr. Chairman, I believe we should judge a Nation by how it treats its children. CHIP covers 8.9 million kids. It stands on the shoulders of a strong Medicaid program that covers 37.1 million more children. Every single one of those kids deserve access to a doctor and access to good healthcare, yet every Republican on this committee voted for a bill in committee that capped health coverage for kids in every one of our communities. And as a result of that vote, 3 million children would lose their health insurance, and that is simply not right.

Today we will have a conversation about community health centers also, that providers that serve so many of our most vulnerable children, the Community Health Center Fund provides 70 percent of the funding for the health center program, which accounts for 20 percent of revenue for community health centers. According to estimates, failure to reauthorize this funding will result in the closure of approximately 2,800 health centers, and 50,000 clinicians and other staff losing their jobs, and most importantly, 9 million patients losing access to care.

So I strongly believe in a swift reauthorization of this funding for community health centers. At the same time, I will remind my Republican colleagues again that Medicaid is the largest single funding source for community health centers, providing more than 40 percent of their revenue during fiscal year 2016. We can't ignore the devastating consequences that Republican efforts to cut Medicaid by \$834 billion over the next 10 years will have on community health centers and millions of Americans. And this includes four in 10 children living in poverty nationwide who currently receive care at community health centers.

So, Mr. Chairman, GOP efforts to repeal the ACA and jeopardize the Medicaid program will harm children significantly. So I urge my colleagues to first immediately reverse course and stop the dismantling of the Medicaid program.

I yield the remainder of my time split between Ms. Castor and Mr. Luján. I guess we will start with Ms. Castor.

Ms. CASTOR. Thank you, Mr. Pallone.

We are at a remarkable place here in America after decades of bipartisan work. The overwhelming number of American children have health coverage, 95 percent. That is something to celebrate. And I wanted to thank you all of the policymakers, the doctors, the nurses, folks back in our local communities that have worked to achieve a 95 percent coverage rate. This is smart policy. This makes America stronger. Kids are healthier, they do better in school, they miss fewer days of school, they are more likely to attend college, and they earn higher wages. But all of this progress is at risk because the GOP has produced bills—one here in the House, one that is even worse in the Senate that came out yesterday, that will rip coverage away from America's kids.

All of the progress we have made is at risk. Why? Just to give massive tax cuts to wealthy special interests? Those are not our

values. Our values are reflected in the fact that we work together in a bipartisan way to make sure kids can see a doctor and get the care that they need. But what the GOP bills do is the most radical detrimental restructuring of children's healthcare ever proposed under the 50 years of Medicaid. And it must be rejected. And, in fact, it is wholly inconsistent for us to be talking about CHIP reauthorization, because Medicaid and CHIP are so closely interconnected. You cannot have a CHIP reauthorization without a strong Medicaid initiative. So let's jettison those plans and work together to cover the remaining 5 percent of kids that don't have healthcare coverage.

And I am happy to yield the balance to my colleague, Mr. Luján.

Mr. LUJÁN. Medicaid is the single largest health insurer for children. Because of Medicaid, the CHIP program, and ACA, 95 percent of all children now have health coverage at an all-time high. Sadly, Medicaid is in the crosshairs of our Republican colleagues. And you have heard the numbers: 37 million kids who depend on Medicaid nationwide, half a million in New Mexico alone; the 3 million of the 23 million people who will lose coverage are children. It is simple. A strong CHIP program depends on a strong Medicaid program. You can't reach out with one hand in the guise of reauthorizing CHIP while cutting \$1 trillion from Medicaid with the other. You just can't have it both ways.

I yield back.

Mr. BURGESS. The chair thanks the gentleman. Does the gentleman from New Jersey yield back?

The gentleman from New Jersey yields back.

The chair thanks the gentleman. Chair makes a technical observation that SCHIP is authored until the end of fiscal year 2019 as was accomplished in the Affordable Care Act. It was only funded through fiscal year 2015. This is the second funding bridge that has had to occur because of the fiscal cliff that was built into the ACA.

We now stand in recess until immediately after the last vote.

[Recess.]

Mr. BURGESS. The chair would remind members pursuant to committee rules all Member's opening statements will be made part of the record. And we do want to thank our witnesses for being here today taking time to testify before the subcommittee on this important issue. Each witness will have the opportunity to give an opening statement, followed then by questions from members. Again, as previously mentioned our witnesses, but today we will hear from Mr. Michael Holmes, Chief Executive Officer, Cook Area Health Services; Ms. Jamie Snyder, Associate Commissioner for Medicaid SCHIP Services, Health and Human Services Commission State of Texas; and Ms. Cindy Mann, partner in Manatt Health. We appreciate you being here today.

Mr. Holmes, you are now recognized for 5 minutes for an opening statement, please.

STATEMENTS OF MICHAEL HOLMES, CHIEF EXECUTIVE OFFICER, COOK AREA HEALTH SERVICES; JAMI SNYDER, ASSOCIATE COMMISSIONER FOR MEDICAID/SCHIP SERVICES, STATE OF TEXAS, HEALTH AND HUMAN SERVICES COMMISSION; AND CINDY MANN, PARTNER, MANATT HEALTH

STATEMENT OF MICHAEL HOLMES

Mr. HOLMES. Thank you, Chairman Burgess, Ranking Member Green, members of the subcommittee. My name is Mike Holmes. I am the CEO of Cook Area Health Services, a Federally qualified community health center providing medical, dental, behavioral healthcare in nine locations to more than 12,000 patients in rural northern Minnesota. On behalf of the more than 1,400 community health center organizations nationwide, I wanted to thank the subcommittee for the longstanding bipartisan support you have consistently shown for community health centers.

Since 1979, Cook Area Health Services has provided critical healthcare access to patients and communities who would otherwise go without. Our service area covers more than 8,300 square miles, and many of our patients travel 50 miles or more to access care. Each one of our sites is located in a town where the population is fewer than 600 people.

As with many rural community health centers, we are the only game in town. Our health center story is just one part of a much larger national story. For more than 50 years America's community health centers, also known as FQHCs, have served as the medical home for our Nation's underserved communities and populations.

Today, health centers represent the Nation's largest primary care network, providing high quality care to more than 25 million patients. Our record of success would not be possible without the ongoing support of Congress. And I am here today to urge you to continue that support by extending your investments in the health center program, and specifically, the community health centers fund, which provides enormous value to patients, communities, the health system, and the taxpayer.

Our success is reflected in the core requirements every health center must meet, each health center must be open to all. We must serve our medically underserved area of our population; we must offer comprehensive ranges of primary care services; and each health center is governed by a consumer majority board which works closely with health center leadership and clinicians to develop innovative responses to community needs.

In 2010, Congress created a dedicated source of funding to sustain and grow the national investment in health centers, with an initial 5-year authorization, the CHC fund directed resources to both operational expansion and capital investment in health centers. As a result of this investment, new health center sites were added in more than 1,100 communities, health centers are serving approximately 6 million additional people, and they have expanded services like behavioral and dental care.

At our health center this funding allowed us to add new access points in Tower, Minnesota, and helped us expand dental services in three other communities and to significantly expand our care coordination services. In 2015, Congress extended the Community

Health Center Fund for 2 additional years alongside CHIP and a number of other programs. With that extension nearing its expiration date, we strongly urge you to renew these investments and to do so for at least 5 years so that health centers like mine can continue to provide reliable access to our patients.

Without action by the end of the fiscal year, health centers and our patients face major disruptions in care. HHS has estimated that should Congress not act by September 30th, it would lead to the closure of 2,800 health center sites, loss of over 50,000 jobs, and, more importantly, a loss of access to care for some 9 million patients.

In conjunction with my testimony today, the Minnesota delegation has given me a letter, noting their support for health centers and the impact on Minnesota CHCs. In my written testimony, I have highlighted several other programs which fall under the subcommittee's jurisdiction. Two key workforce programs are set to expire on the same timeline as the health centers' fund.

The National Health Service Corps, which provides scholarships and loan repayments to clinicians willing to work in underserved areas, is a key tool health centers use as we recruit and retain clinical staff. Fifty-four percent of National Health Service Corps clinicians practice in health centers today. Additionally, the Teaching Health Centers Graduate Medical Education program brings physician residency training right into community-based settings like FQHCs where providers are needed the most.

And finally, I would like to note that the Medicaid program is extremely important to health centers and those we serve. And every State the program works hand in hand to turn the promise of coverage into the reality of care. Nearly half of all health center patients are covered by Medicaid.

This is a time of rapid change in our health system. Health centers probably help with that change, even though as we remain committed to our basic founding principle, ensuring that every American in need has a place to go for high quality care. That purpose is made into reality every day for 25 million patients because of the support of Congress. And that support begins here in this subcommittee. I urge you to continue that support by extending these critical programs on a timely basis, and appreciate the opportunity to testify before you today and thank you for making health centers an ongoing priority.

[The prepared statement of Mr. Holmes follows:]

Testimony of Michael Holmes

Chief Executive Officer, Cook Area Health Services
House Committee on Energy and Commerce, Subcommittee on Health
Hearing on "Examining the Extension of Safety Net Health Programs"
June 14, 2017

Introduction

Chairman Burgess, Ranking Member Green, and Members of the Subcommittee,

My name is Mike Holmes. I am the CEO of Cook Area Health Services (CAHS), a Federally Qualified Community Health Center providing medical, dental and behavioral health care in nine locations to more than 12,000 patients in rural northern Minnesota. On behalf of our patients, board and staff, as well as the more than 1,400 community health center organizations nationwide, I want to thank the Subcommittee for the long-standing and bipartisan support you've consistently shown for community health centers.

Since 1979, CAHS has provided critical health care access to patients and communities which would otherwise most certainly go without. Our service area covers more than 8,300 square miles, and many of our patients travel 50 miles or more, often over secondary roads, to access care in our health center. Every one of our sites is located in a town with a population of less than 600. The large majority of our patients are either uninsured or publicly insured through Medicare and Medicaid. As with many rural community health centers, we are the only provider in most of the communities we serve. Our physicians are also the sole provider staff for two small critical access hospitals. We also participate in a federally-designated Health Center Controlled Network (HCCN) called Northern Minnesota Network, which drives operational efficiency and technology adoption across five member health center organizations.

Our health center's story at CAHS is just one part of a much larger national story. For more than fifty years, America's community health centers, also known as FQHCs, have served as the primary care medical home for our nation's medically underserved communities and patients. Health centers are a cost-effective and local solution to the national challenge of providing access to primary and preventive care that is accessible, affordable, and of the highest quality. Thanks to support from bipartisan administrations and Congresses, the reach of health centers has grown significantly. Today FQHCs represent the nation's largest primary care network, serving more than 25 million patients in every state and territory, and are continually working to provide integrated, comprehensive care to our patients.

Nationally, 92% of health center patients have incomes below 200% of the Federal Poverty Level. Health centers serve nearly 8 million children. Half of health center locations are in rural communities like ours. Across the country, health centers employed nearly 190,000 individuals in 2015, bringing high-quality jobs to some of the most economically hard-hit communities in America.

Our collective record of success would not be possible without the ongoing support of Congress. I am here today to urge you to continue that support by extending your investments in the Health Centers program and specifically the Community Health Centers Fund, which has proven to provide enormous value to patients, communities, the health care system and the taxpayer.

The Health Center Model of Care

The successful community health center model is reflected in the core requirements every health center must meet, as defined by statute. Every health center must be open to all patients, regardless of insurance status or ability to pay. Health centers must operate in a medically underserved area or serve a medically underserved population. Health centers are governed by consumer-majority boards, who work closely with health center leadership and clinicians to develop innovative responses to community needs. And every health center must offer a comprehensive range of primary care services. In recent years, with support from this Subcommittee, health centers have not only added new locations, but have increasingly integrated behavioral health, oral health, vision care, pharmacy, substance use disorder treatment and other services into our comprehensive care delivery system.

Health centers are on the front lines of nearly every major health crisis our country faces. In 2015, Health centers served more than 300,000 of our nation's veterans – often working with the VA to collaboratively address provider shortages, especially in rural communities. Health centers were a critical part of the response to public health threats like the Zika virus and the Flint water crisis. And as the opioid epidemic has grown in scope and severity, hundreds of health centers nationwide ramped up their capacity to provide comprehensive substance use disorder treatment in response.

The Community Health Center Fund and Recent Investments

In 2010, in recognition of the need for a robust primary care infrastructure to accompany changes in the coverage landscape, Congress created a dedicated source of funding to sustain and grow the national investment in Health Centers. With an initial five-year authorization, the Community Health Center Fund, or CHCF, directed resources toward both operational expansion and capital investment for Health Centers, while also boosting support for the National Health Service Corps, a critical tool for strengthening the clinical workforce in health centers.

CHCF investments have been made in several areas: adding service delivery sites in new communities, expanding services and capacity, construction and renovation of health center facilities, technology adoption, and quality improvement activities. Each year, Congress has given direction to the Health Resources and Services Administration (HRSA), the agency which oversees the Health Centers program, as to how to prioritize new investments.

As a result of these investments, new health center sites were added in more than 1,100 communities. Health centers are serving approximately 6 million additional people. But beyond this growth in reach, health centers are also providing more comprehensive care. Compared to 2010, in 2015 the number of behavioral health visits at health centers grew by 57% and the number of dental visits grew by 43%. At our health center, CHCF investments have allowed us to add a new access point in Tower, MN. They have also helped us expand dental services in three other communities and to significantly expand our care coordination services.

In 2015, on an overwhelmingly bipartisan vote, Congress extended the Community Health Center Fund authorization for two additional years as one of the Health Extender provisions included in the Medicare Access and CHIP Reauthorization Act, or MACRA. With that extension nearing its expiration date, we strongly urge you to renew these investments, and to do so on a long-term basis, for at least five years,

so that health centers like mine can truly provide a stable and reliable source of access to our patients - and recruit and retain a comprehensive health care workforce - in an ever-changing health care system.

We are proud of the bipartisan support health centers have earned, and see it as a direct result of the high-quality care we provide to our patients and the value we provide to the health system and the taxpayer. Earlier this year, a letter signed by 290 Members of the House of Representatives, and led by two members of this Committee, Representatives Bilirakis and Green, stressed the importance of Health Centers and the need to keep funding for the program whole. In his FY18 budget, President Trump called for an extension of CHCF Funding, and Health and Human Services (HHS) Secretary Price has repeatedly described investing in community health centers as a top priority of the department.

Swift action by Congress to extend these investment will not only help secure and stabilize health centers, it will prevent the major loss of access and disruption to the health system that would quickly result from a failure to act. Indeed, HHS *itself* has estimated that should Congress not extend the CHCF by September 30th, it would lead to the closure of 2,800 health center sites, loss of over 50,000 jobs, and most importantly, a loss of access to care for some nine million patients nationwide.

At Cook Area Health Services, the potential impact of losing CHCF funding would be immediate and severe. The loss of over \$2,000,000 in annual funding would leave us no choice but to close a minimum of two to three access points. As a result there will be no care in these communities. For many of our patients, medical or dental care will be 40 to 50 miles away and as with most rural communities, there is no public transportation. We would also have to eliminate services and reduce staff. There are no good options in dealing with this type of funding reduction. System-wide, this level of disruption would inevitably drive up costs across the health care system, as more and more patients would turn to costlier settings like hospital emergency rooms for routine primary and preventive care, or simply forgo that care.

Importance of Coverage and Workforce Development

While I deeply appreciate the Subcommittee's focus today on the Community Health Center Fund and on the Children's Health Insurance Program, I do want to very briefly highlight several other programs which fall under the subcommittee's jurisdiction, each of which plays a critical part in ensuring health centers remain able to serve underserved communities.

In every state, Medicaid and health centers work hand-in-hand to turn the promise of coverage into the reality of care for low-income and vulnerable patients. Nearly half of health center patients nationally are covered by Medicaid, and Medicaid reimbursement represents the largest source of operating revenue for health centers nationwide. As I've mentioned, by statute and mission, health centers serve all, regardless of whether a patient who comes to us has health insurance coverage. But any health center can tell you the difference coverage makes – especially in terms of accessing needed specialty care beyond our walls. We are also proud that health centers deliver value back to the larger Medicaid program. A recent landmark study across 13 states found that when compared to patients served in other settings, health center Medicaid patients had 24% lower *total* costs of care. In 2015, health centers served 16% of all Medicaid patients, while accounting for just 1.7% of total Medicaid spending.

For nearly all health centers, especially those like CAHS in very rural areas, recruiting and retaining a committed and dynamic workforce is the most pressing challenge. Two key programs are an enormous

asset to us in addressing this challenge. The National Health Service Corps (NHSC), which provides scholarships and loan repayment to clinicians willing to serve in underserved areas, is a key tool health centers leverage as we recruit and retain clinical staff. 54% of NHSC clinicians practice in health centers today. Another important workforce program for Health Centers is the Teaching Health Centers Graduate Medical Education (THCGME) program, which brings physician residency training right into the community-based settings, like FQHCs, and into the underserved areas where providers are needed most. Data show that physicians trained in THCGME sites are much more likely to remain in those communities than physicians trained elsewhere.

Conclusion

This is a time of rapid change in our health care system. Even as health centers proudly help drive that change through delivery system innovation and a push toward value-based care, we remain committed to our basic founding purpose: ensuring that every American in need has a place to go for high-quality care. That purpose, that mission, is made into a reality every day for 25 million patients because of the support of Congress, and that support begins here in this Subcommittee. I appreciate the opportunity to testify before you today, and we thank you for making health centers an ongoing priority.

Mr. BURGESS. Thank you, Mr. Holmes. The committee thanks you for your testimony.

Ms. Snyder, you are recognized for 5 minutes for an opening statement, please.

STATEMENT OF JAMI SNYDER

Ms. SNYDER. Good morning, Chairman Burgess, Ranking Member Green, and distinguished members of the Subcommittee on Health. Thank you for the opportunity to provide testimony on the Children's Health Insurance Program. My name is Jami Snyder, I serve as the Director of the Medicaid and CHIP programs for the State of Texas.

This morning, I would like to provide insight into how CHIP has worked for the State of Texas in response to the subcommittee's inquiries concerning the reauthorization legislation. The Texas Health and Human Services Commission implemented the state's CHIP program in 1998. The program currently serves approximately 380,000 children. Since implementation, the state has seen a notable reduction in the overall rate of uninsured children below 200 percent of the Federal poverty level, from 18 percent in 1998 to 6 percent in 2015.

CHIP statute allows states the flexibility to operate CHIP as a Medicaid expansion program, as a separate state program, or as a combination of the two. Texas has historically operated CHIP as a separate program, which has afforded Texas the freedom to design a system that aligns with the state's philosophy of ensuring accountability in the management of public funds, and increasing personal responsibility for program participants.

Unlike the Medicaid program, which offers an extensive and prescriptive medical benefit for children, CHIP regulations offer states flexibility to tailor the CHIP benefit package to meet the unique needs of the populations served. This allows CHIP to function as a nimble program that is more easily able to respond to changes in the states' fiscal outlook, emerging Federal legislation, as well as the evolving needs of beneficiaries.

Since the onset of the program, Texas has delivered CHIP services through a managed care model. The state currently contracts with 17 managed care organizations, delivering services to CHIP members Statewide. The managed care delivery system offers additional advantages as MCOs are incentivized through a risk-based, capitated payment system to contain costs while implementing innovative service delivery and provider payment mechanisms to improve health outcomes for their members.

Medicaid regulations make it difficult for states to implement cost-effective, or effective cost-sharing mechanisms for the full range of Medicaid beneficiaries. In contrast, CHIP offers states greater flexibility to design programs in which families retain a measure of responsibility for the cost of their child's care.

Most families in CHIP pay an annual enrollment fee, and all families in CHIP make copayments for office visits, prescription medications, inpatient hospital care, and nonemergent care provided in an emergency room setting.

CHIP is a critical part of the health care safety net in Texas, offering a healthcare benefit to children who do not qualify for the

Medicaid program. Texas' overall experience is that CHIP simply works. It provides reliable medical and dental benefits to the covered population at a rate of \$156 per member, per month, which is \$67 less on a per-member basis than the cost for coverage for the state's Medicaid population.

The state's quality data also offers evidence of the efficacy of the program, indicating a 21 percent increase in children age 3 to 6, accessing well child visits, and a 90 percent increase in children receives recommended vaccines in the first 2 years of life for measurement years 2011 through 2015.

A decision to not reauthorize the CHIP program would result in a loss of over \$1 billion in funding annually to the State of Texas, and a corresponding loss of healthcare coverage for more than 380,000 children. If funding for the program is not extended beyond September 2017, it is estimated the state will exhaust remaining resources by February 2018. As such, Texas would be faced with the prospect of dismantling the CHIP program. And as mandated by the ACA, the state would also be expected to continue adherence to maintenance of effort requirements at a lower Medicaid Federal matching rate for over 250,000 children now served under the state's Medicaid program.

Through its routine budgetary planning process, Texas has assumed continued funding for the CHIP program for fiscal years 2018 and 2019 at the enhanced Federal matching rate. Should Congress elect not to move forward in reauthorizing CHIP, the State of Texas will no longer be able to administer this critical program, which has a proven track record of success, stemming from its adherence to the fundamental principles of state administrative flexibility, personal responsibility, and innovation aimed at enhancing outcomes for beneficiaries.

[The prepared statement of Ms. Snyder follows:]



Testimony Before the
Committee on Energy and Commerce, Health Subcommittee, House of Representatives
Hearing on "Examining the Extension of Safety Net Health Programs"

Written Testimony by Jami Snyder, Associate Commissioner for Medicaid and CHIP Services,
Texas Health and Human Services Commission

June 14, 2017

Good morning Chairman Burgess and members of the subcommittee on health. Thank you for the opportunity to provide testimony on the Children's Health Insurance Program (CHIP). My name is Jami Snyder. I serve as the director of the Medicaid and CHIP programs for the state of Texas. This morning, I would like to provide the subcommittee insight into how CHIP has worked for the state of Texas, including its successes and challenges under current law, in response to the subcommittee's inquiries concerning the reauthorization legislation.

Under the direction of the state legislature and executive leadership, the Texas Health and Human Services Commission implemented the state's CHIP program in 1998. The program currently serves approximately 380,000 children.¹ Since CHIP implementation, the state has seen a notable reduction in the overall rate of uninsured children below 200 percent of the federal poverty level, from approximately 18 percent in 1998 to approximately six percent in 2015.² This reduction is attributable, at least in part, to the availability of CHIP as a coverage option for children under the age of 19.

¹ Texas Health and Human Services Commission, System Forecasting. June 2017.

² CHIP Annual Report to the Centers for Medicare and Medicaid Services, Federal Fiscal Year 2016.

The CHIP statute allows states the flexibility to operate CHIP as a Medicaid expansion program, as a separate state program, or as a combination of the two. Texas has historically operated CHIP as a separate program. Implementing and operating CHIP as a standalone program has afforded Texas freedom to design a system that aligns with the state's philosophy of ensuring accountability and stewardship in the management of public funds and increasing personal responsibility for program participants.

Unlike the Medicaid program, which offers an extensive, yet prescriptive medical benefit for children, federal CHIP regulations afford states flexibility to tailor their CHIP benefit package to meet the unique needs of the population served. This flexibility in benefit package design also allows CHIP to function as a nimble program that is more easily able to respond to changes in the state's fiscal outlook, new federal legislation, as well as the evolving needs of beneficiaries.

The CHIP benefit package in Texas aligns more closely with comparable benefit packages available through the commercial insurance market. Tailoring CHIP in this way has facilitated the establishment of a predictable program budget and the provision of CHIP services to more children, consistent with federal funding levels. This approach has also allowed Texas to remain within its federal funding allotment, in turn, preventing the need to establish a waitlist for CHIP applicants. The state's benefit package is cost-effective, including a basic set of health care benefits that focus on primary health care needs.

In addition to basic medical benefits, other benefits offered in Texas' CHIP program include inpatient and outpatient behavioral health services, vision exams and corrective lenses, hearing exams and hearing aids, physical, occupational, and speech therapy, and durable medical equipment. All CHIP members may also receive up to \$564 in dental benefits per enrollment period.

CHIP allows states to place reasonable limitations on the scope of services members may receive. For example, Texas imposes a \$20,000 annual limit on durable medical equipment. By way of comparison, hard service caps are not allowable for children in the Medicaid program under federal Early and Periodic Screening, Diagnostic and Treatment requirements. Such limitations allow the state to more effectively operate the program within its federal allotment.

Since implementation, Texas has delivered CHIP services through a managed care model, rather than a fee-for-service delivery system which is common to many states' Medicaid programs. Texas currently contracts with 17 managed care organizations (MCOs), delivering services to CHIP members statewide. Operating CHIP through this model facilitates administrative efficiency by alleviating the need to concurrently maintain and administer an operationally complex, resource intensive fee-for-service system. The managed care delivery system offers additional advantages, as MCOs are incentivized through a risk-based, capitated payment system to contain costs while implementing innovative service delivery and provider payment mechanisms to improve health outcomes for their members. MCOs are also able to offer health-related value-added services not covered under CHIP, such as sports physicals and car seats, at no cost to state and federal taxpayers. These services are similar to those available in commercial insurance plans.

Federal Medicaid regulations make it difficult for states to implement effective cost-sharing mechanisms for the full range of Medicaid beneficiaries. In contrast, CHIP offers states greater flexibility to design programs in which families retain a measure of responsibility for the cost of their child's care. Most families in CHIP pay an annual enrollment fee to cover all children in the family. All CHIP families make co-payments for office visits, prescription medications, inpatient hospital care, and non-emergent care provided in an emergency room setting. CHIP annual enrollment fees and co-payments vary based on family income. The total amount a family is required to contribute out of pocket toward the cost of health care services is capped at five percent of family income.

CHIP is a critical part of the health care safety net in Texas, offering a benefit package to children who do not qualify for the Medicaid program. Texas' overall experience is that CHIP simply works. It provides reliable medical and dental benefits to the covered population at a rate of \$156 per member per month, which is \$67 less on a per member basis than the cost of coverage for the state's Medicaid population. While the CHIP and Medicaid regulatory structures differ, in Texas, the MCOs responsible for delivering Medicaid managed care services for low-income Medicaid beneficiaries also administer the CHIP product. As such, the Texas CHIP program benefits from economies of scale, allowing the state to leverage innovations across both programs. This includes enhancing health outcomes through the state's Pay for Quality initiative and maintaining a robust network of providers, consistent with network adequacy standards established for MCOs serving both the CHIP and Medicaid populations. The state's quality data offers evidence of the efficacy of the program as currently structured, indicating a 21 percent increase in children, age three to six, accessing well child visits, and a 90 percent increase in children receiving recommended vaccines in the first two years of life for measurement years 2011 - 2015.

A decision to not reauthorize the CHIP program would result in a loss of over \$1 billion in funding annually to the state of Texas and a corresponding loss of health care coverage for more than 380,000 Texas children. If funding for the program is not extended beyond September 2017, it is estimated the state will exhaust remaining resources by February 2018. As such, the state would be faced with the prospect of dismantling the CHIP program, an endeavor that would require a minimum of seven months, given considerations such as the need to ensure proper member notice, the implementation of an enrollment freeze in advance of program termination, regulatory changes, state plan amendment approval, the execution of contract amendments as well as necessary system changes. As mandated by the Patient Protection and Affordable Care Act, the state would also be expected to continue adherence to maintenance of effort requirements at the lower Medicaid federal matching rate for over 253,000

children now served under the state's Medicaid program. Through its routine budgetary planning process, Texas has assumed continued funding for the CHIP program for fiscal years 2018 and 2019 at the enhanced federal matching rate. Should Congress elect not to move forward in reauthorizing CHIP, the state of Texas will no longer be able to administer this critical program, which has a proven track record of success, stemming from its adherence to the fundamental principles of state administrative flexibility, personal responsibility and innovation aimed at enhancing outcomes for beneficiaries.

Mr. BURGESS. The chair thanks the gentlelady for her testimony. Ms. Mann, you are recognized for 5 minutes please for an opening statement.

STATEMENT OF CINDY MANN

Ms. MANN. Good morning, Chairman Burgess and Ranking Member Green, and distinguished members of the subcommittee. I am pleased to be here this morning. I am Cindy Mann, a partner at Manatt Health, and I work on matters primarily focused on public coverage, and particularly the Medicaid and the Children's Health Insurance Program. And as noted, prior to joining Manatt, I served as the Director of the Center for Medicaid and CHIP services at CMS responsible for Federal policy, Federal oversight of Medicaid and CHIP and supporting statement implementation of these programs. I am going to focus today on my testimony on the role of CHIP in providing affordable coverage to children, the issues facing Congress on the expiration of the funding. But I also do want to note the strong support of the comments by Mr. Holmes in terms of the incredibly important value and critical function of federally qualified health centers.

With 20 years of experience with the CHIP program—it is hard to believe it is 20 years behind us—we know what has made this program successful, and we know what has put it in jeopardy. CHIP works when it has robust and stable funding, and when it has a strong Medicaid program with which to partner in covering children.

Let's look first at the CHIP's history on financing. When the program was first started, the funding was ample for states that were just ramping up their program, but very quickly by 2002, some states began to see shortfalls in their funding, and we saw a mismatch between the allotments and states' needs in terms of coverage of children. And that was not unexpected. In some respects, Congress didn't know how many states would pick up the CHIP program, what the participation rates would be, but it gives us an example of what happens when you have a mismatch in funding.

Georgia, for example, reluctantly froze enrollment from March to July of 2007, and only lifted a freeze after Congress passed a supplemental budget. Florida froze enrollment, it froze it for just 5 months, and during those 5 months, 44,000 children, CHIP children, were placed on a waiting list. When CHIP was reauthorized in 2009, there was strong support from the Congress to avoid those kinds of shortfalls and enrollment freezes. CHIP has provided ample funding and revamped the system for distributing dollars. It built in new adjusters; it built in contingency funding; and a new system for redistributing funds across states.

That funding formula has been maintained through the subsequent extensions. Going forward, adequate financing for CHIP must be assured. Beyond extending the basic program funding, Congress also needs to consider the issues that have been raised so far, the 23 percentage point increase in the match rate, and the maintenance of effort provision, both of which were in the Affordable Care Act.

As my colleague from Texas noted, the enhanced funding for the CHIP program is very much integrated into state budgets and

helping a number of states to adopt a plan for program improvements. But we must also recognize that that enhanced funding goes hand in hand with the maintenance of effort provision. Without the maintenance of effort provision, millions of children will be at risk of losing coverage, or paying much higher costs for that coverage.

CHIP made affordable coverage available to millions of children, but given the marketplace changes, the uncertainties of the futures of subsidies and cost-sharing reductions, indeed, even the uncertainties in the Medicaid program. It is essential to protect not just the funding for the program, but children's eligibility for coverage. And I would suggest that it is unlikely we would continue the MOE requirement without also supporting state's ability to fund that requirement and that need for stable coverage for children.

Next, let me just circle back to my point about CHIP working, in large part, because of the foundation of Medicaid. Medicaid, of course, is the much larger program covering about 37 million children, the two programs depend on each other, kids go back and forth between the two programs all the time as family circumstances change. But even more fundamentally is that Medicaid supports CHIP by covering so many of the children with the greatest healthcare needs: lowest income children, children in poor health, kids in foster care, kids with disabilities.

CHIP wasn't designed to do that heavy lifting. It doesn't have the financing structure, it doesn't have the benefit structure to do that. CHIP is an incredibly critical part of that coverage continuum for children, but it can't do the job alone.

Finally, I would say that Congress has much to be proud of, given its long-standing support of children's coverage. Together, Medicaid and CHIP have brought the uninsurance rate for children below 5 percent. It was over 15 percent in 1997 when CHIP was first enacted. It is a historic low, and it is a great achievement, but with sweeping changes to Medicaid now under consideration, and CHIP reauthorization outstanding, much is at stake for our Nation's children.

Thank you for your time and support.

[The prepared statement of Ms. Mann follows:]



Testimony Submitted to the
Subcommittee on Health
Committee on Energy and Commerce

By Cindy Mann, JD¹
Partner
Manatt, Phelps & Phillips

June 14, 2017

¹ Application for admission to the District of Columbia Bar pending. Practicing under the supervision of Jill DeGraff, a member of the District of Columbia Bar. Admitted to practice in New York and Massachusetts.
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Good morning Chairman Walden, Congressman Barton, Congressman Pallone, Subcommittee Chairman Burgess, Congressman Guthrie, Congressman Green, and distinguished members of the Subcommittee. Thank you for the invitation to participate in this hearing on examining the extension of safety net health programs.

I am Cindy Mann, a partner at Manatt, Phelps & Phillips. At Manatt, I work with clients, including states, health care providers and provider organizations, foundations, and consumer organizations, on matters relating to health care coverage, delivery system reform, and financing, focusing primarily on publicly financed coverage and particularly, Medicaid and the Children's Health Insurance Program (CHIP). I also currently serve as an advisor to the Bipartisan Policy Center on the future of health care. Prior to joining Manatt, from June 2009 through January 2015, I served as Deputy Administrator for the Centers for Medicare & Medicaid Services (CMS) and as Director of the Center for Medicaid and CHIP Services. In that capacity, I was responsible for federal policy and oversight of Medicaid and CHIP and for supporting state implementation of those programs. Previously, I was a research professor at Georgetown University's Health Policy Institute and founded the Center for Children and Families, a research and policy organization focused on children's coverage. I also served as the Director of the Family and Children's Health Programs Group at the Health Care Financing Administration (now CMS), where I directed federal implementation of CHIP and Medicaid with respect to children, families and pregnant women from 1999 to 2001, the early years of CHIP implementation. I have over 30 years of experience in these matters both at the federal level and in states.

My testimony today will focus on the role of CHIP in providing affordable, comprehensive health coverage to low-income children and the key issues facing Congress given the expiration of federal funding for CHIP on September 30, 2017. I will highlight CHIP's success and bipartisan support, as well as its role in the children's coverage continuum, recognizing that CHIP's future and its ability to continue to perform well for children across the nation is closely tied to the future of Medicaid, which today covers more than 37 million low-income children nationwide.² The foundation of Medicaid makes it possible for CHIP to do its part.

Examining CHIP's 20-Year Success as a Safety Net Program

CHIP covers 8.9 million children nationwide, including children covered through the Medicaid program for whom states claim CHIP enhanced funding, as well as children enrolled in separate CHIP programs. As you know, states have a choice to use their CHIP funding to either expand Medicaid to children, serve children through a separate program or employ a combination of these two strategies. Of those enrolled under any of these options, 97% have household income at or below 250% of the federal poverty level (FPL).³ Together—Medicaid and CHIP—have been primarily responsible for a historic decline in the children's uninsurance rate.

² <https://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf>

³ <https://www.macpac.gov/wp-content/uploads/2017/03/The-Future-of-CHIP-and-Childrens-Coverage.pdf>



Between 1997 and 2012, the uninsurance rate for children was cut in half⁴ and has continued to decline, reaching 4.8% in Fiscal Year (FY) 2015, an all-time low.⁵

CHIP's success is the result of a number of factors:

- First, from the program's inception in 1997, there has been a strong, bipartisan commitment to children's coverage at the federal, state and community levels. While it was not initially clear how states would react to the new federal funding opportunity provided by CHIP, by 2000, this commitment to children's coverage—boosted by CHIP's enhanced federal funding—had translated to all 50 states and the District of Columbia implementing CHIP. The focus on children's coverage also prompted states and communities to promote enrollment of eligible children by simplifying the application process for both Medicaid and CHIP and undertaking targeted outreach efforts; as a result, participation rates—that is, the proportion of eligible children actually enrolled and covered by Medicaid and CHIP—have increased steadily over the years.
- Second, Congress' longstanding commitment to ensure an adequate federal financing stream for CHIP has been critical to the program's success. Established as a block grant administered through capped state allotments, federal CHIP funding proved too little to meet many states' needs during the program's first decade, resulting in states freezing enrollment and encountering other significant operational and budgetary challenges. However, beginning with the Children's Health Insurance Program Reauthorization Act (CHIPRA) in 2009 and continuing through CHIP's most recent reauthorization in 2015, Congress' commitment to the future of CHIP has been demonstrated by the authorization of sufficient financing and incorporation of financing features that have supported coverage in the years since. CHIP's past experience—first with shortfalls and enrollment freezes and then with adequate and timely funding—demonstrates why it is so important for Congress to act now to fully finance the program.
- Finally, CHIP's success also is based on its close connection to Medicaid; the majority of the 8.9 million children whose coverage is financed through CHIP are enrolled in Medicaid and others move between Medicaid and CHIP as family income or children's health needs change. In many ways, CHIP works well because of the foundation of coverage provided by and financed through the Medicaid program, which covers the nation's lowest-income children and plays a unique role for children with complex medical needs.

⁴ https://kaiserfamilyfoundation.files.wordpress.com/2014/07/8615-the-impact-of-the-children_s-health-insurance-program-chip-what-does-the-research-tell-us.pdf

⁵ Georgetown Center for Children and Families analysis of the American

Community Survey, <https://ccf.georgetown.edu/wp-content/uploads/2016/11/Kids-ACS-update-11-02-1.pdf>



Key Issues for CHIP

Ensuring Adequacy of Federal Funding for CHIP

Ample funding has propelled CHIP's success and ensured stability in coverage for children in recent years and is a critical factor to safeguard the program's continued ability to serve the nation's low- and moderate-income children. History shows a direct correlation between adequate financing and states' abilities to operate without shortfalls and to cover eligible children. From FY 1998-2001, as states ramped up their CHIP initiatives, the federal CHIP allotment was sufficient to meet federal CHIP expenditures, but between FY 2002-2008, those allotments proved inadequate. As a result, many states stopped enrolling eligible children by adopting enrollment caps or freezes.⁶ For example, facing a \$124 million shortfall, Georgia froze its CHIP program from March 11-July 1, 2007.⁷ The impact on children was swift: when Florida instituted a freeze on July 1, 2003, more than 44,000 CHIP-eligible children were placed on a waiting list by mid-November 2003.⁸ Research by the Kaiser Family Foundation shows that while most states' freezes lasted less than year, their impacts endured even after the freeze was lifted.⁹ Moreover, shortfalls contributed to significant uncertainty for states, families, and health care providers, and on multiple occasions, prompted Congress to adopt short term, stop-gap measures to shore up funding to states facing shortfalls.¹⁰

These early experiences contributed to a strong resolve across party lines to ensure the adequacy of future CHIP allotments during subsequent CHIP reauthorizations. Under CHIPRA, Congress not only significantly increased federal CHIP allotments for an additional five years (FY 2009-13) but also revamped CHIP's financing structure to provide new cushioning under CHIP's capped funding model. Beginning in FY 2009, the federal CHIP allotment more than doubled from the average federal CHIP allotment during the program's first decade (\$10.6 billion in FY 2009 compared to an average of \$4.0 billion per year from FY 1998-2008).¹¹ By FY 2013, the annual federal CHIP allotment was \$17.4 billion. Beyond authorizing federal CHIP allotments that the Congressional Budget Office (CBO) correctly projected would exceed federal CHIP outlays,¹² Congress included a number of additional measures to make the capped funding model more responsive and sustainable. CHIPRA revamped the state allotment formula (including allowing adjustments for population, health care inflation and changes in eligibility

⁶ http://ccf.georgetown.edu/wp-content/uploads/2012/03/Federal%20medicaid%20policy__CHIP-not-a-model-for-block-grant.pdf

⁷ http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/37/11/86098649PR-PeachCare_Enrollment_Freeze_Lift.pdf

⁸ http://ccf.georgetown.edu/wp-content/uploads/2012/03/Federal%20medicaid%20policy__CHIP-not-a-model-for-block-grant.pdf

⁹ <https://kaiserfamilyfoundation.files.wordpress.com/2002/12/4081-north-carolina-health-choice.pdf>

¹⁰ http://ccf.georgetown.edu/wp-content/uploads/2012/03/Federal%20medicaid%20policy__CHIP-not-a-model-for-block-grant.pdf

¹¹ This does not account for the shortfall funding or CHIP bonus fund; <https://www.gpo.gov/fdsys/pkg/GPO-MACPAC-MACBasics-CHIP-2011-09/pdf/GPO-MACPAC-MACBasics-CHIP-2011-09.pdf>

¹² <https://www.cbo.gov/sites/default/files/recurringdata/51296-2009-03-chip.pdf>



and benefits), developed a contingency fund, and established a new redistribution plan for allocating unspent allotments to states facing shortfalls. Congress reaffirmed its commitment to robust federal funding for CHIP in the Affordable Care Act (ACA) and when it passed the Medicare Access & CHIP Reauthorization Act (MACRA) of 2015. In reflecting upon CHIP's success, it is clear that adequate funding—evidenced by appropriations that have exceeded expenditures for nearly the past decade—has enabled CHIP to provide coverage for a growing number of children and to maintain program stability.

The Future of the Enhanced FMAP and the Maintenance of Effort Provision

Beyond the overall level of funding, Congress also must consider whether and how it will address the 23 percentage point increase in the federal CHIP match rate and the maintenance of effort (MOE) provision adopted in the ACA. From CHIP's inception, states have received an enhanced federal medical assistance percentage (eFMAP) for CHIP (historically a 30% reduction in the state share under the regular FMAP rate), and since October 1, 2015, they have received an additional 23 percentage point increase to the match rate, boosting the federal share of CHIP funding to between 88 and 100%.

This enhanced federal funding has helped make it possible for states to maintain coverage for children (as required by the MOE provision), and in some instances, adopt discrete program improvements. A recent survey conducted by the National Academy for State Health Policy (NASHP) indicated that nine states used or planned to use the federal funding increase to enhance their CHIP benefits, invest in outreach and marketing to improve coverage rates, pursue health services initiatives or expand coverage to new populations.¹³

These enhanced federal funds are now fully integrated into states' budgets and a key source of funding for sustaining CHIP. Both the Medicaid and CHIP Payment and Access Commission (MACPAC)¹⁴ and the National Governors Association (NGA)¹⁵ recommend extending the enhanced CHIP match for five years through FY 2022.

In addition, the boost in the matching rate goes hand in hand with the requirement that states maintain children's coverage levels, a provision that extends, under current law, through FY 2019. Stability of the current CHIP and Medicaid eligibility levels is particularly critical given the uncertain future of the individual and small group markets and Marketplace subsidies—which many of the CHIP children would seek to use if CHIP coverage was curtailed. Even if these children were able to secure coverage in the individual market, relative to CHIP, they would face reduced benefits and their families would experience higher costs. Thus, it is important for Congress to retain and extend both the MOE and the enhanced financing provisions. Putting CHIP coverage at-risk in these uncertain times is both unnecessary and ill-advised. MACPAC

¹³ <http://www.nashp.org/wp-content/uploads/2017/02/2017-CHIP-Survey-Results.pdf>

¹⁴ <https://www.macpac.gov/wp-content/uploads/2017/01/Recommendations-for-the-Future-of-CHIP-and-Childrens-Coverage.pdf>

¹⁵ <https://www.nga.org/cms/nga-letters/CHIP-reauthorization>



proposes extending both the current match rate and the MOE for five years. At the very least, withdrawing the enhanced match ahead of the slated FY 2019 expiration date (and the expiration of the MOE provision) would be particularly problematic for states and disruptive to children's coverage.

Maintaining Medicaid as a Strong Foundation of Coverage for Low-Income Children

CHIP was established in 1997 to provide coverage for children in families with too much income to qualify for Medicaid but too little income to afford private insurance. At that time, 10 million children nationwide—nearly 15% of all children¹⁶—did not have health insurance.¹⁷ The program emerged as way of enabling states to expand children's coverage beyond the Medicaid eligibility levels in effect at the time, while permitting considerable operational flexibility. As noted, states have flexibility in designing their program as either a Medicaid-expansion, separate CHIP or combination approach, and they also have flexibility in benefit design, though they must meet certain minimum standards. In partnership with Medicaid, CHIP has been able to have an outsized impact given its relative program size. Without the steady presence of Medicaid to cover the country's poorest, most vulnerable children, CHIP's impact would have been significantly more limited.

The record-low levels of uninsurance among children achieved in recent years is due to both CHIP and Medicaid. This is true not only because Medicaid is a far larger program, but also because the combined presence of Medicaid and CHIP offer families continuity of coverage as family incomes and circumstances fluctuate. The Congressionally-mandated CHIPRA evaluation found that one in four children enrolled in a separate CHIP program and half of all children enrolled in a CHIP-funded Medicaid expansion were covered at some point in the year in "regular" Medicaid. Over a three-year period, children moved between the two programs at even higher rates.¹⁸ Without a stable Medicaid program to turn to, millions of CHIP children could lose coverage over a relatively short period of time.

CHIP's success is also due in part to the availability of more robust coverage through Medicaid. CHIP's benefit design, while pediatric-focused, is not as broad as Medicaid's, although some states have applied the Medicaid benefit standard in their separate CHIP programs. According to MACPAC, Medicaid finances 40 times as much care as CHIP overall, due both to the relative sizes of the programs and to Medicaid's role in the lives of children with significant health care needs.¹⁹ Partly as a result of the lower incomes of the children served and partly as a result of eligibility design,²⁰ Medicaid is responsible for a greater share of children in poor health and

¹⁶ <http://www.urban.org/research/publication/uninsurance-among-children-1997-2015-long-term-trends-and-recent-patterns>

¹⁷ <https://www.macpac.gov/subtopic/history-and-impact-of-chip/>

¹⁸ https://aspe.hhs.gov/system/files/pdf/77046/rpt_CHIPevaluation.pdf

¹⁹ Manatt analysis of MACPAC spending data (FY 2015); Medicaid: \$556 B; CHIP: \$13.7 B

²⁰ Medicaid covers 100% of children in foster care nationwide, as well as children with higher income levels through states' disability pathway and medically-needy options.



those with the most complex medical needs such as cancer, cerebral palsy, and autism, among other special health care needs.^{21,22} The Kaiser Family Foundation estimates that for more than 4 million children with special health care needs nationwide, public insurance, including Medicaid and CHIP, represent their sole source of health coverage.²³ Notably, more than one fifth (22%) of these children live in families with income below the FPL, while another 22% are in families with household income between 100-199% FPL.²⁴ Without Medicaid as the bedrock of public coverage for poor children and those with complex health care needs, either CHIP would face greater costs as states tried to fill the gap left behind by Medicaid or many children would face impediments accessing needed care. For CHIP's success to be assured in the future, Medicaid's future also must be secure.

Likewise, CHIP also has bolstered Medicaid's success. Most notably, CHIP offers coverage to children whose family income brings them over their state's Medicaid eligibility level and for whom affordable employer-based coverage is unavailable. But, the impact goes beyond coverage. The advent of CHIP prompted many states to examine their enrollment processes, not only for CHIP but also for Medicaid, leading to significant simplifications that helped boost participation in both programs. In addition, as states adopted CHIP outreach efforts, many families learned that their children were Medicaid-eligible, helping to drive down the overall uninsurance rate among low-income children (i.e., the "welcome mat" effect). CHIPRA also provided states with a new option to streamline the eligibility and renewal processes for both Medicaid- and CHIP-eligible children using Express Lane Eligibility (ELE).²⁵ A recent study conducted by the Office of the Inspector General found that all 14 states that initially adopted ELE reported benefits, including reduced costs and administrative burden.²⁶ Finally, through CHIP, federal and state policymakers have launched quality of care initiatives to improve children's coverage across public programs (influencing private insurance as well). These gains further highlight not only CHIP's contributions to children's coverage but also its critical partnership with Medicaid.

The Need for Timely Congressional Action

With federal funding for CHIP set to expire on September 30, 2017, Congressional action is needed as soon as possible to ensure program continuity, budget certainty for states, and, most importantly, stable coverage for children. According to MACPAC, unless federal CHIP funding is extended, four states and D.C. are projected to exhaust their federal funding allotments by

²¹ https://www.macpac.gov/wp-content/uploads/2015/03/State-Children%E2%80%99s-Health-Insurance-Program_CHIP-Fact-Sheet.pdf

²² <http://khn.org/news/chip-offers-families-with-seriously-ill-kids-more-financial-protection-than-aca-plans/>

²³ <http://www.kff.org/medicaid/issue-brief/medicaid-and-children-with-special-health-care-needs/>

²⁴ <http://www.kff.org/medicaid/issue-brief/medicaid-and-children-with-special-health-care-needs/>

²⁵ <https://www.medicaid.gov/medicaid/outreach-and-enrollment/express-lane/index.html>

²⁶ <https://oig.hhs.gov/oei/reports/oei-06-15-00410.pdf>



December 31, 2017, and all but one state are expected to exhaust their federal funding by June 30, 2018.²⁷

Without an assurance from Congress on the extension of CHIP funding, many states will be left scrambling as early as this summer. Though the ACA's MOE provision requires states to maintain 2010 Medicaid and CHIP eligibility levels for children through FY 2019, separate CHIP states are not required to maintain coverage in the absence of federal funding. Thus, unless a state with a separate CHIP can replace federal funds with state dollars, these states will be forced to cap enrollment or terminate their CHIP programs. Doing so would require some states to begin making operational decisions this summer and then (or soon thereafter), noticing CHIP enrollees and terminating provider contracts.

This would have consequences for millions of children and families. Approximately 3.7 million children are enrolled in a separate CHIP program. While MACPAC estimates that approximately 2.6 million of these children would enroll either in subsidized Marketplace coverage or a parent's employer-sponsored insurance (ESI), the remaining 1.1 million of these children are projected to become uninsured if states terminate their CHIP programs.²⁸ Even for families that manage to secure an alternative source of coverage, they can expect to see their out-of-pocket costs rise substantially compared to out-of-pocket spending under CHIP. While the impact would vary by family, MACPAC projects that by adding a child to a parent's ESI, families could face an average of nearly \$3,800 more in out-of-pocket costs annually; for some families, the additional out-of-pocket costs could reach almost \$9,000 more than with CHIP, greater than 20% of a family's income.²⁹ Though not nearly as steep, MACPAC estimates that children moving from CHIP to subsidized Marketplace coverage also would face higher cost-sharing, mainly in the form of higher deductibles and copayments but also premium costs for some children.³⁰

Children with special health care needs may be the most impacted during this transition. An analysis conducted by The Wakely Group in 2016 found that in some states, these children could go from having no cost-sharing in CHIP to over \$10,000 in out-of-pocket costs annually in the Marketplace.³¹ Compounding these substantial cost increases and concerns around benefit design is the uncertainty surrounding states' Marketplaces and the availability of sufficient subsidies in the American Health Care Act of 2017. These findings reinforce the need for Congress to act quickly to secure the future of CHIP.

²⁷ <https://www.macpac.gov/wp-content/uploads/2017/03/Federal-CHIP-Funding-When-Will-States-Exhaust-Allotments.pdf>

²⁸ <https://www.macpac.gov/wp-content/uploads/2017/01/Recommendations-for-the-Future-of-CHIP-and-Childrens-Coverage.pdf>

²⁹ <https://www.macpac.gov/wp-content/uploads/2015/03/Sources-of-Coverage-for-Children-If-CHIP-Funding-Is-Exhausted.pdf>

³⁰ <https://www.macpac.gov/wp-content/uploads/2015/03/Sources-of-Coverage-for-Children-If-CHIP-Funding-Is-Exhausted.pdf>

³¹ <http://www.wakely.com/wp-content/uploads/2017/03/CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-Oct-2016.pdf>

Recommendations

Several nonpartisan and bipartisan entities, including MACPAC,³² NGA,³³ the National Association of Medicaid Directors (NAMD),³⁴ the Bipartisan Policy Center,³⁵ and the American Academy of Pediatrics (AAP),³⁶ among others, have issued recommendations on the future of CHIP. Their recommendations are based on ensuring that children continue to have access to affordable health coverage and that states have budget and program certainty in the years ahead.

Notably, these entities all support extending CHIP funding. MACPAC, NGA and the AAP recommend extending federal CHIP funding (including the enhanced matching rate) for five years (through FY 2022), and MACPAC and the AAP also recommends extending the MOE for the same time period. Similarly, the Bipartisan Policy Center recommends extending both federal CHIP funding and the MOE through FY 2021. In addition, during their respective confirmation hearings earlier this year, Health and Human Services Secretary Tom Price voiced his support for extending CHIP and suggested that an eight-year extension of CHIP would be better than a five-year extension;³⁷ similarly, CMS Administrator Seema Verma voiced her support for reauthorizing CHIP for “as long as possible.”³⁸ Taken together, these actions would help ensure continuity of coverage for children, particularly given the current uncertainty surrounding other sources of health coverage in the U.S.

While the President’s budget proposes to extend federal funding CHIP, the proposed two-year extension should be strengthened, in line with the five years proposed by MACPAC and NGA, along with an extension of the other key provisions discussed. A two-year extension, while valuable, provides little stability given state budgeting cycles and leaves states less able to plan, modify and improve their programs, a point confirmed by state CHIP directors in their communications with NASHP.³⁹ In its recommendation to Congress on the future of CHIP, NAMD echoed the importance of a timely extension of CHIP funding to assure states of budgetary and operational certainty.⁴⁰ There is little disagreement that CHIP has been a resounding success and little reason to put its future into question. Stability is even more important now given the questions associated with the future of states’ Marketplaces and the critical importance of enabling states to continue providing affordable, pediatric-specific

³² <https://www.macpac.gov/wp-content/uploads/2017/01/Recommendations-for-the-Future-of-CHIP-and-Childrens-Coverage.pdf>

³³ <https://www.nga.org/cms/nga-letters/chip-reauthorization>

³⁴ <http://medicaiddirectors.org/wp-content/uploads/2017/03/NAMD-Letter-CHIP-and-D-SNP-reauth-FINAL.pdf>

³⁵ <https://cdn.bipartisanpolicy.org/wp-content/uploads/2017/02/BPC-Health-CHIP.pdf>

³⁶ American Academy of Pediatrics letter to Orrin Hatch (May 23, 2017).

³⁷ <https://www.c-span.org/video/?422427-1/hhs-nominee-representative-tom-price-testifies-confirmation-hearing>

³⁸ <https://www.c-span.org/video/?423823-1/cms-administrator-nominee-seema-verma-testifies-confirmation-hearing>

³⁹ <http://www.nashp.org/wp-content/uploads/2017/02/2017-CHIP-Survey-Results.pdf>

⁴⁰ <http://medicaiddirectors.org/wp-content/uploads/2017/03/NAMD-Letter-CHIP-and-D-SNP-reauth-FINAL.pdf>



coverage that serves as a much needed complement to Medicaid for millions of low-income children nationwide.

CHIP, in partnership with Medicaid, has been a remarkably successful program. Its bipartisan support over the past 20 years and its contribution to driving down the uninsured rate among children nationwide are just two of the many indications of its success. While Congress is in the midst of considering changes to the nation's health care system, it is imperative to heed the lessons from this program, whose inception and continuing success have their roots on both sides of the aisle. In the face of ongoing uncertainty in the health care system, there has never been a more important time to act with quick resolve to secure the future of children's health coverage.

Mr. BURGESS. The chair thanks all of our witnesses for their testimony today, and appreciate your being here and your being flexible with us as this hearing was rescheduled a couple of times.

I now want to go to vice chairman of the committee, Mr. Guthrie, 5 minutes for his questions, please.

Mr. GUTHRIE. Thank you very much. Before I get into my questions, I know we have had some comments from some of my colleagues, and the others on Medicaid and the way the AHCA dealt with Medicaid. As we know, Medicaid is a program that is growing rapidly and could implode. So what we decided to do, and we very carefully sat down and walked through the AHCA, was how are we going to move forward? And the principled way of moving forward, I know there is a block grant option in the bill, but the principle way we decided to move forward was on an approach to Medicaid, that in the 1990s, was bipartisan. As a matter of fact, every sitting Member of the Senate who was in the Senate in the 1990s on the Democratic side signed a letter to President Clinton supporting an option of going to per capita allotments, some being key ranking members and then leadership on the other side.

Medicaid, over the next 10 years, under our proposal, will grow, not cut, will grow by 20 percent, so I just want to make sure the record reflects more than some of the rhetoric we have heard.

First, Ms. Snyder, in addition to basic medical benefits, Texas' CHIP program include behavioral health services; vision exams and corrective lenses; hearing exams and hearing aids; physical, occupational and speech therapy; and durable medical equipment. There is also limited dental benefit. In your testimony, you seem to contrast this with Medicaid extensive, yet prescriptive medical benefit for children. I believe every member of this committee wants to ensure low-income children have adequate access to healthcare, whether in Medicaid or CHIP. But it sounded like you might have some ideas on the way Medicaid could better serve children. Do you have any ideas you would like to share with us?

Ms. SNYDER. Thank you, vice chairman. Absolutely, we are a fundamental believer in Texas in both the Medicaid and CHIP programs. I think, as is evidenced by my testimony, we enjoy the flexibility that the CHIP program offers to states in designing a benefit that actually is responsive to the population that served under the CHIP program, which is a population of children that don't qualify for Medicaid. Certainly, we always in Texas are, and like many other states, looking at opportunities to infuse elements of personal responsibility into programs such as Medicaid, and clearly, we already have done so with CHIP. But we do realize that the populations that are served under those programs are distinctly different, and so want to be cognizant of those differences in terms of the populations as we consider cost-sharing opportunities, benefit limitations, and so forth.

Mr. GUTHRIE. Thank you. Mr. Holmes, also, the reliance community health centers is very important in our health safety net. And in 2015, we extended the community health center fund for 2 additional years. In your testimony, you call on us to do a longer-term basis for at least 5 years. Maybe some of the reason for that is self-evident, but would you like to describe what is better for you in a

longer extension over a 2-year extension, the things you can do differently, or maybe more efficiently?

Mr. HOLMES. Thank you, Mr. Vice Chairman. Two years is a short period of time for safety net providers to go into the workforce and recruit new providers. One of the more difficult conversations any safety net provider has when they are trying to bring in new physicians, new dentists, is to have that discussion about, if the lead time to recruit these providers is 1 to 2 years, to say, we hope to have a job for you in 2 years. It really limits our ability to have realistic conversations with new providers that we need to help serve our patients. Two years is a short planning cycle for any small business to try and address changes in the environment, and certainly, in a healthcare environment that is changing rapidly. And a longer planning cycle just would make us more effective in how we deliver care to our patients.

Mr. GUTHRIE. Thank you. Also, every health center must meet statutory-defined criteria to receive in HRSA, section 330 grant. One of the conditions that must be made in order for health centers to receive one of these grants, and how does an applicant demonstrate to HRSA the need for health services? And I have a 30-second time left.

Mr. HOLMES. There are 19 basic requirements to fund to be eligible to receive health care center funding. Each one of those areas must be defined and documented in a competitive grant application which occurs every 3 years at the current time.

Mr. GUTHRIE. And what you do is critical, so we really appreciate your efforts. We appreciate it.

I yield back.

Mr. HOLMES. It is critical for us to show Congress that we do what we say we are doing, and that we are who we say we are. And without that, we want to have a process that is transparent for all organizations to say, this is what we do, this is who we serve, and this is how we can care for our patients.

Mr. GUTHRIE. Thank you. I yield back.

Mr. BURGESS. I thank the gentleman. The gentleman yields back. The chair recognizes the gentleman Mr. Green for 5 minutes of questions please.

Mr. GREEN. Thank you, Mr. Chairman. I would like to ask unanimous consent to place in the record letters from both a number of associations encouraging a 5-year extension on funding for the Children's Health Care Program.

Mr. BURGESS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. GREEN. One thing I think is really important and I highlight that Medicaid and CHIP are linked together, and many of our CHIP kids receive Medicaid benefits. In fact, two-thirds of the CHIP kids actually receive the more comprehensive Medicaid benefit package, because states have recognized how important coverage is for children. That is why I am disturbed by what the House has done passing TrumpCare, and what the Senate looks like they are poised to do next week.

The conversation about children's coverage is something that this committee should have before passing legislation, capping, and blocking, granting coverage for 37 million children. This morning,

I read that 3 million children will lose coverage under the House bill, and Senate cuts to Medicaid are even deeper over time. Even one child losing coverage in our country is unacceptable. We can do better for our children.

Ms. Mann, can you start off with some of the important contexts we should have as we consider the reauthorization in CHIP, which I want to be clear, I strongly support and believe Congress must immediately do. What do people mean when they say CHIP stands on the shoulders of Medicaid? And can you discuss the history of CHIP and how it worked with Medicaid programs to bring us to the highest rate of coverage for children in our history?

Ms. MANN. Thank you. I would be glad to address that question. CHIP was established to extend coverage to children who otherwise weren't going to be eligible for Medicaid, and states could cover those children, either in Medicaid or in separate CHIP programs. So the idea that CHIP sits on top of Medicaid is, in fact, exactly how it is designed by Congress, and how it is operated in the program. And why CHIP needs that support is that Medicaid really does, as I noted, much of the heavy lifting. Both in terms of numbers, Medicaid covers about 37 million children, CHIP covers over 8 million children. Medicaid covers the children who are often in the poorest health, foster care kids, kids with disabilities. Any child, when they get a disability, when they get a chronic illness, they often have to turn to Medicaid, even if they are eligible for the CHIP program. It is not necessarily designed to be that robust a benefit package. They work hand in hand.

And at the same time, what CHIP has done is really helped modernize the Medicaid program over the years. When CHIP was started, it really got a lot of energy around children's coverage, and people started to look at not just how to design the new CHIP program, but what should we do to improve the Medicaid program? So simplified applications made it easier for families to enroll. That had a lot to do with the success and the uninsured rate that we have seen. So the two really are side by side and complement each other, and are needed for the continuum of coverage for children.

Mr. GREEN. Following up on my colleague from Kentucky, do you have anything to say about the flexibility of Medicaid between different states with different Medicaid programs?

Ms. MANN. There is a great deal of flexibility in Medicaid. In fact, often you hear from Members of Congress and others, oh my God, it is such a complex program, in part, because there are 56 jurisdictions that administer it, and there is quite a bit of distinction and differences among them because of the flexibility accorded to states in the program.

States have a lot of flexibility to design their delivery system as a managed care, is it fee for service? Accountable care organizations? They design their payment system; they design their care management system. The area where Medicaid is clear, however, is on the benefit protection for children. It is actually 50 years, almost to the day, where Congress adopted the early periodic screening and diagnostic treatment program to make sure that all kids in Medicaid get screened for vision, hearing, developmental delays, other problems. And if they have a medical problem, the benefit requirement in Medicaid is that they get treated.

Mr. GREEN. I am almost out of time. Texas receives a 1115 waiver that, I think, bipartisan, we supported. There is flexibility in states. Although, before I was elected to Congress, served 20 years in the state legislature, and I watched how we were funding Medicaid back then. And my concern is that the flexibility—we also vote this Federal money, in Texas, our match is two-thirds Fed, one-third state, of course, Louisiana gets a little better than that. Someday maybe we will get to that level. But we also need to have guidelines for what we know that funding will go through.

Ms. MANN. Absolutely.

Mr. GREEN. So I want flexibility, but I also make sure it is spent on the healthcare for poor people, including children.

Ms. MANN. Absolutely.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. BURGESS. The gentleman yields back.

The chair thanks the gentleman. The chair recognizes the chairman of the full committee, Mr. Walden. The gentleman from Oregon, for 5 minutes, please.

Mr. WALDEN. I thank the chairman. And I want to thank our witnesses for your testimony. We appreciate what you do in our states, and communities, and what those you represent here today do.

Mr. Holmes, in your testimony, you say that many of your patients travel over 50 miles off and over secondary roads to access care in your health center, and that oftentimes, you are the only provider in the communities you serve. In addition to isolation and distance, what other challenges exist that we should know about in care and delivery that are unique to rural areas? And I would just preface that by saying my district would extend from the Atlantic Ocean to Ohio. And so it is bigger than nearly every state east of the Mississippi River. So I am used to pretty remote, rural, extreme remote, whatever the furthest-out remote nomenclature is, we got it in my district. But can you speak to some of those issues and the reimbursement issues?

Mr. HOLMES. Delivery of care in a service area that is almost the size of New Jersey is challenging. It is challenging because we are in small communities. Two of our health center sites are attached to critical access hospitals. And the critical access hospitals are small. They are 14 beds, and 16 beds, they have attached long-term care units. We have to be able to recruit providers to see these patients. We are in a frontier area, and it is long distances between sites. If we are not there, no one else is there. The next level of care for our system, or our health delivery system, is 40 to 50 miles away to an entry point.

When we look at rural areas, it is where we have our agriculture; it is where we have our forest products; it is where we have our mining; and we can't relocate those jobs to urban areas. We have to deliver care to the people that are working in those industries, and it presents challenges of distance, and time, and access. Payment reimbursement methodologies that come to FQHCs help on a per-visit basis to subsidize or offset some of the infrastructure costs. I could be much more economically efficient if I had all of my patients and all my providers in a single site, but I can't, because I can't have patients traveling 60, 70, 80 miles in.

Mr. WALDEN. Let me ask, I am thinking about the clinic I have in Fossil, Oregon, it is 92.2 miles to The Dalles, Oregon, where Mid-Columbia Medical Center is. That would be most likely the nearest hospital, so more than 90 miles away. This is one of three counties where we have physician assistants, but beyond that, no other access and no hospital in this three-county region.

Talk to me about telemedicine and what role it can play and what you encounter. I understand the recruitment issue, and some of that goes back to the states because they want to do their board certification. So I have had various health centers and providers say, we can wait 6 months to a year to get through the process from the State of Oregon to get approval to get somebody here, and meanwhile, they go somewhere else, perhaps. We are not as bad as some, not as good as others. Can you talk about telemedicine?

And then, I had an amendment before it became law and then it expired on sort of bonus payment for home healthcare, because it is more expensive to go out and back 90 miles each way to take care of somebody in a remote area. Perhaps you could address those things?

Mr. HOLMES. We have a common electronic medical record platform across all of our sites. We have some clinics that are mid-level provider sites only. They are staffed by nurse practitioners or physician's assistants. If they have issues or questions about care of a patient, they can route that chart to one of our physicians in one of our other sites for assistance in care delivery.

We have some telemedicine capabilities. We have telemental health services with the University of Minnesota, Duluth, where we can have patient's access, some psychiatric and psychology care. And we do have some telederm setups. But part of the problem we have with telemedicine is that in the rural areas, there is not a significant infrastructure for high speed internet.

Mr. WALDEN. Right.

Mr. HOLMES. So we can't do home monitoring, because in many places, there is not even a cell service, cell phone signal. And so we end up having patients coming into our sites, which is the closest access point they can. And we will work with the patient there, whether it is with direct hands-on care, or through some telemedicine.

Mr. WALDEN. That is helpful. We also have jurisdiction over spectrum and broadband buildout. It is a big bipartisan effort on our committee to get access. We just had a hearing this week, as a matter of fact, on getting access to unserved areas first with the Federal support, and then underserved after that, and how we mapped that and really figure out where those areas are. So thank you all for the work you do and for your testimony today.

I yield back.

Mr. BURGESS. The gentleman yields back the chair. The chair recognizes the gentleman from New Jersey, the ranking member of the full committee, Mr. Pallone, 5 minutes for questions, please.

Mr. PALLONE. Thank you, Mr. Chairman.

I believe deeply in the CHIP program. I want to see a full 5-year extension of current CHIP policy. However, I also believe deeply in the Medicaid program. And I know that a lot of our success with the CHIP program is due, in part, because it bills so seamlessly on

top of the Medicaid program in its current form. And as virtually every stakeholder agrees, the TrumpCare bill passed by the House would decimate coverage for 23 million people, 3 million of them children. What is worse is that the Senate's own TrumpCare bill doubles down against kids. And it is a fact that these proposals are bad for kids.

So with that in mind, Ms. Mann, I wanted to ask you some questions. First, why is the current full 5-year extension of the CHIP program with the maintenance of effort in the so-called 23 percent bump in payments for states so critical now more than ever?

Ms. MANN. Thank you. MACPAC, the pediatricians, and NGA have all recommended a 5-year extension. MACPAC with 23 percentage points and the maintenance of effort, and I think for good reason. And I think it goes back to the points that Mr. Holmes made about health center funding. These 2-year cycles are just not sufficient for states to be able to really do the kind of planning and improvements that make sense for kids. And I also think the other side of that is to look at what is going on broadly in the healthcare marketplace right now. If CHIP were to end more abruptly, then children will be at risk of not having coverage, or if they find coverage, they will have significantly higher out-of-pocket costs.

This is really a time of great uncertainty in our healthcare marketplace, small "m", and it is really a time, given the bipartisan support for children's coverage, to give CHIP 5 years to be stable and to do the job it needs to do for children.

Mr. PALLONE. Well, I obviously agree with you and the importance of an immediate and full extension, but I also share the same belief about reauthorizing the community health center fund. I think we need to do it immediately. But again, when you talk about the health center program, a lot of success due, in part to the Medicaid program, which provides more than 40 percent of community health center revenue each year. And unfortunately, all that success, I think, is jeopardized with TrumpCare. And yet my colleagues argue that a cap on the Medicaid program is not a cut at all. In fact, the administration was up here testifying on the budget of the Ways and Means chair arguing that TrumpCare was not a cut to Medicaid at all. So I would like to hear from someone who knows a lot about Medicaid and CHIP, many have likened the capping of the Medicaid program to be just like managed care, which, in Medicaid, is quite widespread. Is the cap in Medicaid like managed care?

Ms. MANN. Well, I will jump in and answer that. And I am sure Ms. Snyder also has a view on that. It is very unlike managed care. States use managed care largely for CHIP programs and for their Medicaid programs. They set rates, they set rates at a regular period of time. They adjust rates based on the acuity and the needs of the population that are served. They take into account policy changes, healthcare cost changes, and they are constantly reexamining their rates.

In the cap in the bill, it is set based on spending from years back, moved forward, adjusted by a national trend rate that is not related to the actual needs and cost of serving people in that state. And it doesn't adjust based on acuity of the needs; it doesn't adjust based on the healthcare costs in that community.

Mr. PALLONE. So what is going to happen to benefits and provider revenue with a capped or block granted Medicaid program?

Ms. MANN. Well, states have three major levers to do significant reductions of spending in the Medicaid program: enrollment, provider payment rates, and benefits. I think likely, with the kinds of changes that are proposed, all three will be relied on by states. But if you think about going to provider rates, which is maybe the first place states will turn, we worry a lot about access for kids. Access is in good shape for kids right now in our Medicaid program, but if we thin out the payment rates for providers, if we lower our payment rates for managed care organizations, we are going to have access issue and problems of serving children, as well as seeing some children who are on optional kinds of programs, kids with brain injuries and other types of HCBS services, Home and Community Based Services may be losing their coverage and services all together.

Mr. PALLONE. Are there any winners for this policy, regardless of what states are carved out? And is it going to matter?

Ms. MANN. Well, no states are carved out, and I think it is just a fact of math that when there is a Federal and state partnership to share all costs and the Federal Government is saying, I am pulling out of that partnership, and I am setting my limits at a certain amount, and the state is responsible for everything above that, every state becomes a loser in that formula.

Mr. PALLONE. All right. Thank you. Thank you, Mr. Chairman.

Mr. GUTHRIE [presiding]. Thank you. The gentleman from New Jersey yields back. The gentleman from New Jersey is recognized.

Mr. LANCE. Thank you, and good morning to the distinguished panel.

Is it the view of the panel that the current formula for Medicaid, which is open ended, as I understand it, should continue as it exists permanently without any analysis of a potential modification? I ask the question legitimately and I was one of 20 Republicans not to vote for the healthcare plan on the floor of the House of Representatives. Ms. Mann, I will start with you.

Ms. MANN. I think the shared commitment, the shared partnership around underlining financing of the program is critical and needs to be retained. I think there are always areas of improvement. There has been years of complaints about how the FMAP itself, how that share is actually the formula for that. That could be looked at, though it is a quagmire of political complications when one does.

Mr. LANCE. I think that is the understatement of the day. As I understand it, the costs have increased relatively significantly in the last decade. Is that accurate?

Ms. MANN. The costs per enrollee, actually, in the Medicaid program, have grown much more slowly than either commercial insurance or Medicare. Medicaid costs have grown, but that is because it is covering many more people.

Mr. LANCE. Others on the panel who would like to address the issue?

Ms. SNYDER. I would be happy to respond to the question.

Very similar to Ms. Mann, I think we can all agree that there is always opportunity for improvement when we look at the fund-

ing formula for Medicaid as it currently stands. As a state, I can tell you Texas is looking very closely at the implications of the ACA, as well as the proposal that has been advanced by the Senate, specifically for the implications for the State of Texas and how the proposed funding formulas would play out for the program, versus the funding formula that we are now working with.

Mr. LANCE. Yes.

Mr. HOLMES. From a rural standpoint and a small safety net provider standpoint, I think it is important to recognize that not all Medicaid patients are evenly distributed across all payer types and across all providers. In the rural areas, there is a higher level of Medicaid population and where nursing home care paid by Medicaid may be 64 percent nationally. In the nursing homes that I am familiar with, their Medicaid population is 90 percent. And so there is a disproportionate percentage in some of our communities that rely on Medicaid. And so any time we have a change in that system, I worry about unintended consequences and how the rural providers, and rural safety net providers, and all safety net providers adapt to those changes.

Mr. LANCE. Regarding rural America, is this particularly important as it relates to those in nursing homes, as opposed to children and other populations served by Medicaid?

Mr. HOLMES. In the rural areas, we still have a significant nursing home population, a long-term care population, but we have a disabled population, and we have a population of moms and kids.

Mr. LANCE. Well, that is true across the country, obviously. Is there a disproportionate percentage in rural America in one of the cohorts you have just mentioned?

Mr. HOLMES. I believe that there is a disproportionate share in the rural areas for long-term care, because we have an aging in rural parts of the country. A lot of the younger people have moved out of the rural areas to urban areas where the jobs are. And so we have a graying of the population in these rural communities. Along with that graying of the population, I think there is a greater reliance on some of the programs to help provide care.

Mr. LANCE. Thank you. I think that this is an issue that deserves a great deal of attention, and I am not one who wants to make this a partisan issue. I think that it is a very difficult issue, and we have to examine it, in my judgment, based upon the facts that we want to cover as many Americans as possible. We also have a responsibility to the tax-paying public with a rising Federal debt. And I hope that we can examine these very difficult issues in a bipartisan capacity moving forward, because I do not think that this is an issue that should be politicized.

I yield back 17 seconds.

Mr. GUTHRIE. The gentleman yields back his 17 seconds. The lady, Ms. Matsui from California, is recognized.

Ms. MATSUI. Thank you very much, Mr. Chairman.

CHIP and the Community Health Centers' Fund are critically important programs for serving children and families in our communities. And I do look forward to working with my colleagues to continue their funding in the future, and hopefully far into the future. However, we all know we can't have a conversation about safety net that CHIP and community health centers provide with-

out including Medicaid as their foundation, because Medicaid is the foundation of our Nation's safety nets.

Forty-one percent of children in California are on Medicaid and CHIP. That is about two in every five kids. I say 41 percent on Medicaid and CHIP because you can't separate the two. CHIP eligible children in California, in fact, receive services through the Medi-Cal program. The CHIP and community health centers programs and the children and families they serve, will be devastated by the Medicaid cuts proposed by the TrumpCare bill.

Ms. Mann, I am going to ask you this, because the way it looks now, if the TrumpCare bill goes through, billions of dollars will be cut from Medicaid. Would states be able to continue to cover the same number of people? Would they be able to cover the same type of services? Where might they cut? And are there examples of difficult choices states have had to make when budgets were squeezed?

Ms. MANN. Sure. The Medicaid program, I think, certainly as CBO has projected, the reductions in Medicaid funding \$834 billion over 10 years would result in about 14 million people in the Medicaid program losing coverage. That will grow over time due to the impact of the caps, and how the caps get tighter and tighter over time just because of the way the math works. So, we will see necessarily, I think, lots of impacts to the program, both on that coverage number, but also in terms of whether we see limitations on the kinds of benefits to people are able to access. States will have to look, for the first time, I think, really closely at so-called outlier cost people: elderly people, children who are in special waiver programs, for example, whose expenditures are so much higher than the cap would be. Every time they enroll somebody in that situation, the state will lose a lot of money under the way the caps are designed.

We also see big concerns about access, whether lower payments to providers, lower payments to health plans will narrow networks, children won't be able to get access to specialty care, and the kind of services that they need in a timely way.

Ms. MATSUI. So it seems to me you will be rationing care here. It seems to me they would have to make very difficult decisions as to what population will get the care that they need.

Ms. MANN. What you will have even more than you have now, there are always issues at the state level about funding the Medicaid program. It is a big expenditure. States do not just spend their money without a lot of examination. But under a capped environment, you will have both cuts and a limit. And that will increase the competition between populations and between providers inside the state.

Ms. MATSUI. OK. Thank you.

I would ask you also about in California, children receive full EPSDT, which is Early and Periodic Screening, Diagnostic and Treatment services through Medi-Cal. Can you talk about the impact of access to these services on children and families? And can you talk about the differences in the benefits and resulting health outcomes?

Ms. MANN. EPSDT was really designed initially because of concern about low-birth weight babies, about children growing up,

even children going into the Armed Forces, and as young adults and not being in healthy shape. It is really a very sensible benefit package that says there should be screening, diagnostic testing. And then it simply says that when a child needs treatment, as recommended by their doctor, they get the treatment that they need. That is an incredibly important service that is available to children, and, I think, the kind of standard we all want for our children. With reductions in spending, that might be a hollow promise; you might have the promise even for EPSDT if it is still there, but can a child find a provider, can a child get to a dentist, can that child get to the specialist that they might need for a particular kind of circumstance.

Ms. MATSUI. I see I am out of time and I would like to submit my questions for the record.

Thank you. I yield back.

Mr. GUTHRIE. The gentlelady yields back. The gentleman from Virginia, Mr. Griffin, is recognized for 5 minutes.

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

Mr. Holmes, you have been talking about some of the rural issues, and I appreciate that, because my district is larger than the State of New Jersey. And you indicated that the territory that you cover is about the size of New Jersey, or a little bit less than that. And one of the things that has been rattling around in my head is that—the telemedicine issue that you touched on earlier is that we ought to be able to figure out a way to save money longterm, maybe not initially but longterm, by using telemedicine and not only save some money but increase the effectiveness of the care in the rural areas or at least make it more accessible. For example, I have a bill in that deals with making sure that folks, by telemedicine, talking to the appropriate neurologist, et cetera, can get a quicker response on getting the tPA, in the case of a stroke. Because, obviously, if you are in a rural area, sometimes you can't get to the hospital where the right doctor has to look at you currently to give that medication. But we can speed it up.

You mentioned that you all are providing some services for mental health. I think that is extremely important, because if we can catch that, just like with the stroke, instead of having somebody in long-term care, which we have talked about and how expensive that is, tPA can stop a lot of that. Likewise, with mental health, if we catch it early in a regular clinic and we are doing that a little bit in my district now. What we found is that people are much more likely to go to the clinic, the community center, if they can just step into the other room and get the mental health, even if it is by telemedicine, because we don't have the ability to have population to have psychologists or psychiatrists in every one of those communities. But there is still a certain stigma. Maybe that is not the way it is supposed to be, but there is, particularly in rural areas, to getting mental health services. If they can just step into another room in the clinic, nobody knows whether they are getting their foot looked at for toe fungus or whether they are getting a mental health evaluation.

So just some comments on that, and do you believe that there might actually be some savings there longterm, particularly in

rural settings, because we prevent folks from having more serious maladies.

Mr. HOLMES. I believe there are opportunities for cost savings by integrating behavior health into primary care, along with medical services. We have a couple of rooms set up in some of our clinics that have the telemedicine capabilities, the hookups for behavioral healthcare. Those patients are scheduled routinely. There is no indication that it is a specialty behavioral health visit for that patient when they are in the waiting room.

And some of the other things we do is that we do have some behavioral health specialists that come in from some of the local mental health agencies to our clinics. And they have office space and exam room space embedded right into other space. So we try and care for the patients in the best way that we can within the local situation, within the local facilities.

There still are reimbursement challenges with telemedicine. The originating facility is not usually a part of the reimbursement methodology. So you have to build the infrastructure without having payment for that infrastructure. You have to maintain it. You have to have enough bandwidth to have interactive television in those interactive conversations.

Mr. GRIFFITH. All right. Let me springboard off of that. And I believe I have got my names right. Sometimes I get them wrong. But the Stark Act, currently, if I understand correctly, prevents us from using some of our facilities in conjunction with a hospital that might be willing to pay for some of that infrastructure, because at one time, they were worried about collusion and raising the bills. Today, I have got underserved areas. I could use some space in a nursing home, long-term care facility, and put in some telehealth stuff, even if it was in conjunction with the hospital, because, in all fairness, I only got one hospital that's really in competition if you are talking about somebody having a heart attack. But my folks have to travel about 45 minutes to get there.

So do you think we need to also look at maybe relaxing some of that, particularly when we can get into underserved areas?

Mr. HOLMES. Antitrust issues are certainly an issue for medical delivery, especially now when we are seeing the development of large systems of care and yet we have small providers that are trying to deliver services in a cost-effective way. Small areas don't have the depth of resources to have competitive services. We have to find the best way to deliver that care to our populations. But we have to be, at this point, careful of antitrust issues. And it is always something that is in the back of our minds.

Mr. GRIFFITH. So what you are saying is we have to try to figure out the balance. We would prefer to have competition, but where there is no competition, maybe we need to take a look at giving some flexibility on the antitrust issues to make sure that we are getting services there.

Mr. HOLMES. Yes, sir, I agree.

Mr. GRIFFITH. All right. I yield back, Mr. Chairman. Thank you.

Mr. BURGESS. Thank you. The gentleman's time has expired.

And now recognize Mr. Luján from New Mexico.

Mr. LUJÁN. Thank you.

Mr. BURGESS. Five minutes.

Mr. LUJÁN. Thank you, Mr. Chairman.

Ms. Mann, I keep hearing on the news that TrumpCare doesn't cut Medicaid, yet the CBO said that is just not true. And I am looking at these quotes from different stakeholders. The American Academy of Pediatrics says, "The U.S. and its healthcare legislation fails to meet children's needs." There is too much at stake for those of us who care for children to be silent. Pediatricians will continue to speak out for what children need until we see legislation that reflects it. The Children's Hospital Association are unified in calling on the Senate to reject the bill. They say, at its core, the bill is a major step backwards for children and their health. And the American Academy of Family Physicians say that this legislation would have a profoundly negative impact on Americans.

So, Ms. Mann, can you set the record straight? Is TrumpCare a cut for children, families, and for everyone in the Medicaid program?

Ms. MANN. Yes.

Mr. LUJÁN. That is a pretty straightforward answer. Just so that I am clear, you respond to that question with a resounding yes.

Ms. MANN. With a resounding yes. There is \$834 billion taken out of the program. There is 14 million people, by CBO standards, losing coverage. There is countless other changes that states will have to make if those cuts are imposed. And children will suffer both from the caps, from their parents losing coverage, from the loss of the expansion. There is enormous ramifications to the Medicaid program. Negative ramifications.

Mr. LUJÁN. I appreciate that clarification, Ms. Mann. When I asked that question during our 27-hour markup in this committee, I was responded to several times that Medicaid was not cut. I appreciate the clarification of the reduction, the cut of \$834 billion from the Medicaid program.

Ms. Mann, as we have heard today, the Children's Health Insurance Program is an important provider of health insurance coverage for nearly 9 million American children. However, the Medicaid program is a primary source of coverage for low-income children covering four times as many kids as CHIP. In New Mexico, for example, there is over 414,000 kids that rely on Medicaid and 15,000 kids that rely on CHIP.

Can you please describe the role that Medicaid plays in children's coverage?

Ms. MANN. Sure. And that ratio that you have in New Mexico is pretty much what the national average looks like. It is, first of all, a much larger program, as you noted from your New Mexico figures. Medicaid just covers so many more children. And it covers infants. It covers newborns. It covers kids at school age. It covers adolescents. It covers 100 percent of a state's foster care kids, for example. Any child who has been determined disabled under the Social Security definitions, they go into the Medicaid program. They don't go into the CHIP program. Covers early intervention services for very young children. Covers school-based healthcare services. It is a program with lots of different functions and lots of different ways in which it serves the child population.

Mr. LUJÁN. And I think you addressed the next question I had, which was what would the concern be associated if the Senate

passed their bill or the House-passed Republican repeal bill, otherwise called as TrumpCare, would pass and how it would affect CHIP. I think you eloquently described that.

Our Nation's leading children's health providers advocates, including the American Academy of Pediatrics, Children's Defense Fund, Family Voices, First Focus, March of Dimes have all spoken out against the Republican repeal bill. And in a March 22 statement, they wrote: In addition to the bill's initial proposal to fund Medicaid through per capita caps, the Republican bill would allow states to choose a block grant model, which would eviscerate existing protections afforded to children and pregnant women in the Medicaid program. Comprehensive EPSDT benefits would no longer be required for children, allowing states to ration limited dollars by drastically cutting back pediatric services.

And, Mr. Chairman, I would like to ask for unanimous consent to submit their statement for the record.

Mr. BURGESS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. LUJÁN. And just as I close, Mr. Chairman, I appreciate the conversation about the concerns, Mr. Holmes, with the impact in rural communities. I represent a district that takes about 8 1A½ hours to drive across. This is critically important. When we talk about the concerns to these rural healthcare facilities, the conversations that were taking place about the importance of mental and behavioral health programs in these small clinics, if these bills become law that would eliminate the Affordable Care Act, we would see those programs get eliminated, if not disappear.

And when it comes to getting broadband access across America, I certainly agree. I have said it once, I will say it again: If there is a debate taking place with TSA about being able to have a phone conversation on an airplane once you board in Los Angeles, California, and you can stay on that phone till you get to New York, then we should be able to have broadband coverage all across rural America in every part of our beautiful country. We once electrified rural America. Now let's make sure that we connect rural America with affordable, fast Internet. Everyone should have it. We can get it done. And I am glad to hear it being talked about today.

Thank you, Mr. Chairman.

Mr. BURGESS. The chair thanks the gentleman.

The chair can see a downside to you being on the telephone between Albuquerque and New York. But nevertheless, your comments are appreciated.

The chair recognizes the gentleman from Georgia, Mr. Carter, 5 minutes for questions, please.

Mr. CARTER. Thank you, Mr. Chairman. And thank all of you for being here. This is a very important program, certainly very important in my state. In the State of Georgia, SCHIP is the PeachCare program. We are very proud of it. It has been a very good program that has benefited many, many recipients.

I want to ask you, I will start with you, Ms. Snyder, and then, Mr. Holmes, I will also want you to address this, but I know that, in my district alone, we have got six federally funded health centers, and they serve over 55,000 patients. Very, very important. One of the things that we require, the Federal statute requires, is

that states reimburse these federally qualified health centers and rural health centers using prospective payment system. And there have been groups who said this could be done better. And let me quote real quick. The National Association of Medicaid Directors has said: This distinct reimbursement system limits Medicaid's ability to use the full range of value-based purchasing strategies in this care delivery setting, including models that incorporate financial risk. It also prevents many states from comprehensively transforming the healthcare system across all providers. The directors have said states need to be allowed to align value-based purchasing approaches.

How do you feel about that? Ms. Snyder, what do you think?

Ms. SNYDER. Congressman Carter, I am happy to answer question to the degree that I can.

What I can tell you is that the State in Texas is well aware of the requirement around a prospective payment system and very committed to working with all of our managed care and provider partners in the advancement of value-based purchasing initiatives. Unfortunately, I cannot answer specific questions in regard to FQHC reimbursement at this time, because the state is in the midst of active litigation on the matter.

Mr. CARTER. Oh, do tell about that.

Ms. SNYDER. I wish I could, but I can't.

Mr. CARTER. OK. We will give you a pass.

Mr. Holmes?

Mr. HOLMES. Over the years, payment methodologies have changed across all provider types, whether it has been a cost-based payment, whether it is a discounted fee-for-service payment, or whether it is prospective payment system payment. FQHCs are currently reimbursed under an FQHC prospective payment methodology for both Medicare and Medicaid.

A couple of years ago, Medicare updated their payment methodology. And I think it is important to note that Medicare, in that payment methodology update, retained the payment-per-visit methodology where a bundled set of services is reimbursed under that methodology.

We are looking at a change to value-based purchasing for all provider types. I think the question that comes in with value-based purchasing is how do you determine value? We have seen, in Minnesota, for instance, we have clinical outcome disclosures for outcomes of care for all medical groups. And the medical groups will range from Mayo Clinic down to the smallest safety net provider. And there are different ratings for optimum care and for diabetic care or optimum cardiovascular care.

But what concerns me about value-based payments is whether or not that value truly reflects the skill and the care of the provider or if it reflects the patient population that provider served. If I was going to a value-based system, I would wonder whether or not the best value is perceived in the suburban areas where there are high levels of income, there are high levels of poverty—or low levels of poverty and high education. I think we have to be careful that value does not reflect our patient populations but more accurately reflects the care that is delivered by the provider.

Mr. CARTER. OK. All right. Very quickly. I have just a few seconds left. But I want to ask you, Mr. Holmes, if you have experienced the 340B program? Do you all use that at all and what has been the impact on your systems there?

Mr. HOLMES. We use the 340B program. We have some savings under 340B. In turn, we use those savings to pay for some of our care coordinators and some of our patient assisters where we can align our patients into the pharmaceutical manufacturers patient assistance programs, because free is better than discounted.

Mr. CARTER. OK. Ms. Snyder, you all use 340B?

Ms. SNYDER. We do.

Mr. CARTER. And the impact?

Ms. SNYDER. I think it is a very valuable tool, in terms of influencing reimbursement in regard to pharmaceuticals.

Mr. CARTER. OK. And what do you use the savings for? Can you identify it specifically?

Ms. SNYDER. Yes. I would be unable to identify it specifically. But certainly, I think we are always looking at opportunities to maximize savings that we are seeing in our system through various means, including—

Mr. CARTER. OK. Well, we are looking at that closely on this committee—

Ms. SNYDER. OK.

Mr. CARTER [continuing]. And on the O&I Committee. So be prepared on that. OK?

Ms. SNYDER. Absolutely.

Mr. CARTER. All right. Thank you.

Mr. Chairman, I yield back.

Mr. BURGESS. The gentleman's time has expired. The chair thanks the gentleman.

The chair recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions, please.

Ms. CASTOR. Thank you very much, Mr. Chairman. And thank you to our witnesses and the role that you all have played with your organizations and hitting this historic mark of 95 percent of America's kids with health coverage now. And it certainly isn't the time to go backwards. We need your expertise in how we maintain that level. And anyone who cares about making sure kids are on a pathway to success in life really need to focus on this devastating TrumpCare bill and the most radical change to health services for kids under Medicaid in the 50-year history.

At the same time, we do need to reauthorize the Children's Health Insurance Program. And there are a few portions of it that I think are vital to maintaining that 95 percent an upwards coverage rate. One of them is the enhanced 23 percent bump. I have heard some people say that the 23 percent bump in the match did nothing to improve children's coverage. Well, I can tell you, coming from the State of Florida, and this happened in many other states last year, we were able to eliminate the 5-year Medicaid CHIP waiting period for children by using that bump up. It has been a major win for children and families.

In Florida, approximately 17,000 children were now able to come onto the rolls. I know in Arizona they were able to lift their enroll-

ment freeze in CHIP, in KidCare, allowing 30,000 kids to receive healthcare coverage.

Ms. Mann, how important is it, as part of the reauthorization, to maintain the 23 percent match, or bump up?

Ms. MANN. I think, as you note, it really has triggered in a number of states. And the National Academy of State Health Policy did a report talking to CHIP directors about the impact. But also, as Ms. Snyder said, it really is integrated into state budgets. And a new Kaiser survey of state budgets done by Health Management shows that 26 states are experiencing budget cuts. So I think if we pull those dollars out from the CHIP program, we will definitely see repercussions. And as I noted before, I think it is very much tied to the maintenance of effort—

Ms. CASTOR. Exactly. That was my next question, because I have heard folks say that that maintenance of effort that has been in place for 7 or so years and then was extended, in a bipartisan way, in the MACRA, some folks say that has limited state flexibility and innovation, and it should be allowed to expire. But, boy, that maintenance of effort has been vital to the continuity of care.

So is that as it is important? Do the 23 percent go hand-in-hand?

Ms. MANN. They go hand-in-hand. You could have a maintenance of effort requirement continuing to protect children's coverage and pull the money out from states, but I think there would be a lot of unhappy states with that arrangement. They really do go hand in hand. And I think even more now than 2 years ago, in terms of the stability of coverage is just critically important for children.

Ms. CASTOR. So if we didn't do that as part of the reauthorization, do you think we would see the return of waiting lists and lost coverage for kids?

Ms. MANN. I think we would. We definitely would see a pullback.

Ms. CASTOR. One of my great fears, and I know it has been intimated that, way back in the 1990s, Bill Clinton and the Democrats fooled around with block grants. And I can tell you, right now, this is very dangerous to the ability of our kids to be successful in life when you move this direction. And I am particularly frightened for my home State of Florida, because Florida spends about \$1,880 per child Medicaid enrollee. It is the lowest rate in the country, Ms. Mann. If we went to Medicaid caps, it appears that that would lock in Florida's low spending rate. But we are a high growth state, and our needs change over time.

What would happen to our state's ability to take care of kids and the elderly and people with disabilities?

Ms. MANN. I think Florida is a good example of many states' experience where they would be what is referred to as a relatively low spending state. They would be locked into those dollars, modified only by a small trend rate over time. And if they chose to add benefits, if they chose to put different care management in to help kids with asthma, kids with diabetes, they would either have to do that at state dollars or by cutting something else in the program.

Ms. CASTOR. Like education or—

Ms. MANN. As you know, in Florida there is not a lot of give—

Ms. CASTOR. I mean, where would we go? Would it be folks in nursing homes? They are very expensive. Or would it be special needs kids or children's hospitals?

Ms. MANN. Absolutely. And nationwide, we spend about a third of our dollars on long-term services and supports for the elderly, for people with disabilities. Populations will be vying for those limited dollars just to be able to keep steady, never mind lose ground.

Ms. CASTOR. Thank you for helping to explain what is at stake. Thank you very much.

I yield back.

Mr. BURGESS. The chair thanks the gentlelady. The gentlelady yields back.

The chair recognizes the gentleman from Oregon, Dr. Schrader, 5 minutes for questions, please.

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

Mr. Holmes, I would love to get into a discussion with you on value based. You may have some good points if it was still a silo-based delivery system in modern medicine. But I point out, in the ACA, there were some risk adjustments to take some of that issue away. And in Oregon, most of our physicians, nurse practitioners in Medicaid/CHIP arena now use coordinated care organizations. We get bundled payments so that it is not just the doctor being responsible for the outcome. But you had a social worker, a dentist, mental health provider. And, frankly, they take it upon themselves to make sure they have ultimate success. But I won't belabor that point. That is another discussion.

What percentage of your community health centers' budget comes from Medicaid?

Mr. HOLMES. Nationally, it is just under 50 percent.

Mr. SCHRADER. OK. So that is a pretty big number. The plans we have heard from our Republican colleagues would pretty much devastate the funding for community health centers, because it would be tough to make up that 50 percent.

What would happen to your expansion if the Republican plans went into effective and you were cut significantly, and particularly if you have any rural areas?

Mr. HOLMES. Certainly, if we have an immediate reduction, it places us in a difficult position. We have 10 different medical and dental delivery sites in nine different communities. There is no way for us to be able to sustain all of those sites with a significant reduction in resources. That means we are faced with which sites do we close, which staff do we lay off, how do we reconfigure our providers. And it all affects access to care for our patients.

Mr. SCHRADER. All right. Thank you.

Ms. Mann, I guess I will preface my comment. I am like a lot of my Republican colleagues, I have got huge swaths of rural Oregon in my district. And so I am a little surprised, because 25 percent—well, no, actually, half of the kids in rural Oregon get their healthcare through Medicaid. It is so critical to the success and health of these communities. It is a key portion. The rural hospitals are a key component and portion of our economic growth in employment in these communities.

So I am very concerned about how these reductions in Medicaid reimbursement, certainly over the long haul, will affect them. Can you talk a little bit more about what might happen in rural areas if the Medicaid expansions roll back like we are talking about?

Ms. MANN. I think one of the things we have been talking about so far in this hearing about ways to modernize our system of delivering care, ways to integrate behavioral health and physical health, ways to bring in telehealth, changing care practices, expanding our electronic health records, those all require investments. And so the first thing that will go will be any of those investments. And states will be scrambling to bring their spending down below the caps that are set by the Federal Government if the bill passes just because any dollar spent over that cap will be wholly state dollars, and any Federal dollars brought down over the cap will be clawed back the next year and really harm the state.

So we will not see investments for sure, but we will likely see reductions in funding for community providers and other specialty providers that allow that fragile fabric of access in rural areas to be able to work.

Mr. SCHRADER. All right. Thank you.

Ms. Snyder, you talk about the reduction in uninsured rate for kids, I think 16 to 6 in Texas and stuff. What will happen to that uninsured rate in Texas if some of the Republican healthcare plans go through as currently envisioned? Will it go up or down?

Ms. SNYDER. So what I can tell you is the CHIP program, clearly, in Texas precedes the advent of the ACA, the AHCA, or the Senate proposal that was advanced yesterday. The CHIP program in Texas is highly successful. As I mentioned, it has resulted in a reduction in the percentage of—

Mr. SCHRADER. What about the Medicaid piece? If the Medicaid reimbursement for Texas is cut as proposed, is your children's uninsured rate going to go up or down?

Ms. SNYDER. So we are, right now, looking at the implications of the legislation that has been proposed on the House side, as well as the proposal that was advanced yesterday, to determine how that is going to impact the state. What I will tell you, as a state—

Mr. SCHRADER. You are not sure quite yet?

Ms. SNYDER. We are still looking into that, yes.

Mr. SCHRADER. All right. Well, I appreciate that, and that is a good answer, given where you all are coming from. And I feel sorry for a lot of your providers. I know rural hospitals in your state, in many states, that did not do the expansion are facing some pretty tough times.

I think there is some middle ground here, to be quite honest with you. I too am in favor of making sure that Medicaid is put on a budget, but a budget that is realistic and doesn't result in tons of uninsured children, children that we should not be balancing the budget of this country on. I worry about that. But I look forward to work with my Republican colleagues to fix this system overall.

And I yield back.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for questions, please.

Ms. ESHOO. Thank you, Mr. Chairman. And thank you to the witnesses.

I just want to start out by speaking about what is racing through me throughout this hearing, and that is that I have lived my life for my children. And I think everyone here has as well. We are talking about something that couldn't be more sacred: our children, my children, your children, the children of our Nation.

And I really am overwhelmingly sad by what is happening. I can't believe that this is taking place in our country. There is some sort of conflation that is going on here today. It is important for us, obviously, to reauthorize the CHIP program and the other, and with all of everything that should be a part of it. But to have the evisceration of Medicaid as the top issue, top line headline of today that is going on in the Congress, what are we doing?

Children need patriots in the Congress. I don't know what has happened to the Republican party. I don't recognize it. Republicans that are in my district don't support any of this. And a strong CHIP program depends on a strong Medicaid program. So there is like a pretend thing going on here. CHIP this, CHIP that. CHIP, CHIP, CHIP. What about the chipping away at or the destruction of Medicaid? Does anyone here think that we are going to be able to care for, provide what our children need in our country if we rip away \$834 billion out of Medicaid for tax cuts that were taking care of them?

There are myths that are swimming around. The myth that 23 percent bump in the ACA did nothing to improve children's coverage. Since the enactment of the enhanced 23 percent bump and the matching payments for CHIP, the states have used those additional dollars to improve the care and expand coverage for kids in our country. There is a myth that CHIP is the primary insurer of low-income children in the United States. Medicaid is the primary insurer of low-income children in the United States.

So, yes, CHIP is important, but let's not let all these myths creep in around it. This is a shameful thing that is taking place in our country. It really is a shameful thing, and it is hurtful. What is going to happen to children that are disabled? Anyone examined their conscience on that?

So I would like to go to Ms. Mann and ask you to expand on the issue of disabled children. It is one thing for children to get the basic care that we all provided for our children. I think these families that have disabled children are among the most courageous people in our country in what they need to deal with. They get up earlier in the morning because they have a lot of things to do for that child. It costs more money, more doctors, more complications in their lives, more complexities. And they try to balance their affections too, because the other little ones may end up feeling that this one other child is getting more attention from the parents. This is what takes place in people's lives every single day across our country.

And we are sitting here in some insulated, air-conditioned, green-painted room as if this one thing that we are going to reauthorize, and we should, is just going to take care of everything, and that anyone that is involved in it and votes for it has absolution. They don't, in my view.

So, Ms. Mann, would you just say a few words about disabled children and these programs that are knitted together.

Ms. MANN. Yes. Certainly. Thank you for your comments. So Medicaid has many different eligibility pathways, and there are many different definitions of what is a disabled child. There is a category in the Medicaid program that if you have been determined disabled by the Social Security Administration of the state, then you automatically get Medicaid. In that circumstance, there are about 1.9 million children around the country who fit in that category. And based on that medical necessity standard that we talked about before, they get the care that they need, and they get the kind of care that really is not otherwise available in the commercial market. And some of them get special waiver service. They will get respite care for that caregiver who, as you say, is going 20 hours a day in terms of taking care of their child. They will get a wheelchair refitted as they age and as they grow. So it is a very important program.

And then there are other kids within the other categories of the Medicaid program. They may be foster care kids, they may be just low-income kids. They might not have a disability that meets that level of disability, that gets them into the category of disabled, but they are kids with very significant healthcare needs. And they too have their needs met very strongly by the Medicaid program, which is, I think, why you see those statements from organizations like Family Voices, Parents of Kids with Special Healthcare Needs.

Ms. ESHOO. Thank you so much.

Mr. BURGESS. The chair thanks the gentlelady. The gentlelady's time has expired.

The chair recognizes the gentleman from Texas, vice chairman of the full committee, Mr. Barton, 5 minutes for questions, please.

Mr. BARTON. Thank you, Mr. Chairman. I apologize. I, after votes, took a group of Members and staffers out to the hospital to see Matt Mika, one of the individuals that was shot in the incident last week at the congressional Republican baseball practice. So I am a little bit late getting back.

I think it is obvious—

Ms. DEGETTE. How is he doing? Give us a report.

Mr. BARTON. He is up and—

Mr. BURGESS. Do not violate HIPAA, come on. This is a Federal—yes.

Mr. BARTON. He is doing very well, Diane. I can't go into details, apparently. But he is excited, and hopefully he is going to be out of the hospital within a week.

Mr. GREEN. Did the chairman invoke HIPAA?

Mr. BARTON. Yes, I am not a doctor. I can just tell you what I saw. OK? I saw a breathing, happy young man who is wearing the cap of his employer, which I am not going to publicize. But they sell a lot of chicken and they are headquartered near Arkansas.

Now, to the purpose of this hearing, Mr. Chairman, we want to talk about CHIP reauthorization and community health centers. And I think the last CHIP reauthorization I was one of the chief cosponsors of. So we are obviously for CHIP and the community health centers. My family foundation has bought a building in my hometown and donated it to the Hope Clinic, which is a community health center for Ellis County, and the Nel Barton annex is providing services for low-income citizens in Ennis, Texas, and is

doing very, very well. And so we are strong supporters of the community health centers and SCHIP.

I have two questions that I have been asked to ask our distinguished panel. This one is for Ms. Snyder and Mr. Holmes. This committee earlier this year passed a bill to charge millionaires, people who have won the lottery, a little bit more if, in fact, they have come into some extra money. To put it in perspective, this policy change would mean millionaire Medicaid beneficiaries would only pay approximately \$70 more each month. That would save apparently several billion dollars.

Would you two support making millionaires on Medicare to pay their fair share to help pay to extend the SCHIP and the health center funds? That was supposed to have been asked by Mr. Walden, but he is not here to ask it.

Ms. Snyder.

Ms. SNYDER. Congressman Barton, I am happy to answer the question. As I have mentioned in my testimony earlier and in some of my responses over the course of the hearing, in Texas, we are very much in support of personal responsibility and infusing a level of personal responsibility into the programs that we administer. Certainly, this, I think, is a good example of an opportunity to infuse that personal responsibility into one of our programs in a way that is commensurate. Ultimately, we hope, with the earnings, that each of those individuals is lucky enough to be a beneficiary of lottery winnings is able to draw down as income.

So we would support a measure such as that and would support that it ultimately reflect the earnings in a way that holds individuals accountable.

Mr. BARTON. Mr. Holmes.

Mr. HOLMES. Certainly, the expenditures of the Federal Government are important to its people. It is also important to where those expenditures are directed. We have common things that we need to do as far as defense, but we also need to look at the care of our most vulnerable populations. And in order to do that, we need money. That money is coming from the taxpayers. And we have to make sure that it is a fair system and that it is a system that has good return.

I will say, from a health center perspective, we are concerned about the return on investment that the taxpayer is making in health centers and that we use those dollars wisely to lessen the burden on the taxpayer, and that we show a return for those dollars in the savings and the Medicaid programs and the Medicare programs and throughout all of our patient population.

Mr. BARTON. My time has expired, Mr. Chairman. I will submit the other question for the record.

I do want to say that we are working on a bipartisan basis. We have a bill called the ACE Kids Act. And we had it in the last Congress with over 200 cosponsors. Ms. Castor, who just left, Mr. Green, I think everybody in the room right now who is a Member was a cosponsor in the last Congress and hopefully will be in this Congress. We are going to reintroduce that very quickly.

But it is a bill for these special needs children that have complex medical conditions to create a medical home so that their care can be coordinated with Medicaid across state lines. And it is a vol-

untary optional program for the states to participate in. But if they choose to participate, it apparently is a piece of legislation that will make the care much better and also save money for the taxpayers. And we hope to reintroduce that bill in the very, very near future. And we have a commitment to have a hearing on it. And hopefully, we are going to have a commitment to move that bill.

With that, I yield back.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentlelady from Colorado, Ms. DeGette, 5 minutes for questions, please.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

We have been talking a lot today about—at least on this side of the aisle—our concerns about what this TrumpCare bill would do to Medicaid and how it would interface with the CHIP program, because CHIP is something that we have all agreed is important for the children of this country, but it really does ride on the foundation of Medicaid. I want to talk a little bit about that.

The \$840 billion cut to Medicaid and converse of the program into a per-capita cut, under TrumpCare, it would then be combined with President Trump's budget, which cuts CHIP funding by \$3.4 billion by eliminating this so-called 23-point bump. So Medicaid covers 37 million children, and nearly 9 million additional are covered under CHIP. I am trying to figure out what would happen if both the TrumpCare cuts to Medicaid and the budget cuts to CHIP went through.

Ms. Mann, can you discuss, from your knowledge, how these proposed Medicaid cuts and the CHIP proposal under the Trump budget would affect children in the states?

Ms. MANN. Certainly. Thank you for your question. The House provision around setting caps for the program would fundamentally change the commitment that the Federal Government makes to the children, to people with disabilities, to parents, to pregnant women, to people, elderly, who are served by that Medicaid program. And they would force states to have to significantly reduce their spending in order to stay within the caps, unless they were going to spend only their state-only dollars.

And so the kinds of things that states would end up doing, no doubt reluctantly, would be things that would reduce access to care, things that would potentially look at some of these specialized programs for kids with brain injury and special healthcare needs, pull out funding around children's school-based services and early intervention care. A number of different ramifications we think that that would have.

In addition, it would pull out the funding for the expansion population. And this often talks about the so-called childless adults in the expansion population—I say so-called, because I would be a childless adult. My children are grown. I am not a childless adult. But many of those individuals covered under the expansion are parents.

Ms. DEGETTE. Right.

Ms. MANN. And children do better when their parents are healthy. So between those cuts and the budget cuts, I think we would see a really devastating change for children's coverage.

Ms. DEGETTE. Let me follow up and ask you, do you think of the children who would lose their insurance or lose some of those specialized benefits under the cuts, could they be covered by CHIP?

Ms. MANN. CHIP is not designed, both in its financing and in its benefit structure, to pick up those children.

Ms. DEGETTE. To pick up those kids. That is right.

Ms. MANN. And if you are pulling the 23 percentage points away from CHIP, we are going to see a ratcheting down of CHIP.

Ms. DEGETTE. But CHIP is really designed to be in addition to Medicaid.

Ms. MANN. That is right.

Ms. DEGETTE. It is not as a substitute.

Ms. MANN. It needs the foundation of Medicaid in order to operate well.

Ms. DEGETTE. Now, the administration has said they might allow states to lower the bar on Medicaid benefits, cost sharing, and other attributes. And I think you alluded to this, but if those programmatic changes go into effect, then how is that going to impact kids in light of the proposed cuts?

Ms. MANN. Well, there are many ways in which whether it is increased cost sharing and premiums for children and families at very low incomes, we talked about lottery winners, but most of the children on Medicaid have incomes below the poverty line. For a family of three, that is about \$1,700 a month to support three people every month for rent, food, utilities, all that they need. So those kinds of responsibilities may be hard for families to bear.

In addition, if there are reductions in the benefits. If there are waivers to EPSDT and kids can't get dental services or kids can't get transportation. We have talked about some of the problems that children face in rural areas. They need help getting transportation to medical care. So those are all of the kinds of ways besides just absolutely cutting a group of children who are high-needs children off the program that states may have to turn to under caps and further budget cuts.

Ms. DEGETTE. And states have their own set of budget issues too. In my state, we have a constitutional prohibition against raising taxes without a vote. So it is not like states have huge pools of money they are going to pour into this.

Thank you so much, and I yield back.

Mr. BURGESS. The chair thanks the gentlelady. The gentlelady yields back.

The chair recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for your questions, please.

Mr. SHIMKUS. Thank you, Mr. Chairman. I'm sorry I wasn't here. I was with Coach Barton as we went up to the hospital. So I haven't been able to follow all the activities that have been going on in the hearing.

And I think it is safe to say, bipartisanwise, that we support the Medicaid program and we support CHIP. So the real debate, from what I am gathering, is, you know, tied into whatever the Senate is doing, whatever we did. So let me just ask a question. Does anyone at the panel know our national debt?

Mr. Holmes, do you know how much our national debt is?

Mr. HOLMES. I believe that it is close to \$20 trillion.

Mr. SHIMKUS. Ms. Snyder?

Ms. SNYDER. That is my understanding as well.

Mr. SHIMKUS. Ms. Mann?

Ms. MANN. Nineteen point six, I think. And a little over 13 is public.

Mr. SHIMKUS. And what is debt? When we say that, what is that? Is it safe to say it is our promises to pay future services either—because we know what drives our national debt. It is the mandatory spending programs. People don't like to say this, but it is just true. It is Medicare, Medicaid, Social Security, and our interest payments.

I will point everybody up to the pie chart, which has been—I use this a gazillion times. So that is 2015 spending. And when we find on our budget, we are fighting that blue area, which is the discretionary. And we are going to be going through that. Does anyone reject that pie chart as being an accurate depiction of our Federal spending?

No. OK. I am seeing everybody believing that what we put up there is accurate.

So in the red, we have automatic spending and Social Security, Medicare, Medicaid, which means we are not engaged in determining those costs. They are automatic, other mandatory interest payment. And the blue is what we call discretionary spending.

So go to the next chart. So this is what has happened in our Nation since 1965. As you see that the mandatory spending continues to grow, squeezing out the discretionary budget, which are things like defense, education, HHS, Department of Energy, roads, bridges, infrastructure, and the like. And so if left unchecked, in 2026, we continue to start having big problems. And that is why we discuss it.

We don't discuss the debate on mandatory spending out of a desire to be mean, vindictive. We actually discuss this to save our country. Admiral Mullen said in testimony before the Armed Services Committee, our debt is our national threat. The threat to our country relies in that depiction there.

So what we did in our healthcare bill—and I am not sure what my colleagues on the other side ended up saying, but the fact is we have Medicaid spending and we have a percentage of growth, per capita growth. So as much as they want to say it is a cut, over the years, it has increased Medicaid spending at a slower rate than what would happen if you left it automatic. That is the reality of the state.

So if someone is something you are cutting Medicaid, in real dollars, they are not telling the truth. It is an inaccurate depiction of what we have done. And my guess is that is what has been going on today in the hearing. Where we are trying to get control of the threat to our Nation, which is our national debt, and we are trying to provide to our providers a stable funding stream that grows and let them, through the Medicaid program in the state, manage how best to provide for their citizens in the states. Empowering governors, who are actually closer, so it just impels me to raise that.

And my time is almost over. But I would just end on this. This is from a report, and I can provide it to the minority. I am not asking for it to be submitted into the record. But current projections

bear no resemblance to a picture in which people historically dependent on Medicaid would lose their benefits. To the contrary, CMS estimates that Medicaid enrollment would stay roughly constant at current levels under the AHCA, while still be being substantially higher than projected before the Affordable Care Act was passed. Indeed, CMS finds that many states would still cover some of the ACA expansion population, even if lawmakers do away with the ACA's inflated Federal matching payment rate. This would mean expanded coverage relative to pre-ACA levels, while also being equitable for the ACA.

And my time has expired, and I yield back.

Mr. BURGESS. The chair thanks the gentleman. The gentleman's time has expired. The gentleman yields back.

The chair recognizes the gentleman from California, Mr. Cárdenas, 5 minutes for questions, please.

Mr. CÁRDENAS. Thank you, Mr. Chairman. I appreciate the opportunity to hear from the witnesses and also the opinions of our colleagues.

Unfortunately, my colleague, Mr. Shimkus, his time was expired, but I would like at least one of the witnesses to take an opportunity to respond to the narrative that we just heard for the last 5-plus minutes.

Ms. Mann, would you like to maybe enlighten us a little bit about the juxtaposition between the argument that was just made on expenditures versus healthcare?

Ms. MANN. Sure. I will take a stab at that. Thank you.

Let me say a couple of things. One is that the Medicaid reductions in spending in the bill largely are not being used to reduce the deficit. They are largely being used to finance new tax cuts in the bill. So the connection there is not as strong as it might otherwise seem.

But I think the bigger issue in terms of the healthcare debate is there is no dispute, I think, among anyone, healthcare policy experts, hospital administrators, consumers, state Medicaid agencies, that we need to do what we can to bring down healthcare costs. And that has been, I think, what people have been engaged in, particularly in the last 4 or 5 years, the integration of behavioral health, the physical health, the care management, the telehealth. Those are all mechanisms to deliver better care and to do that in a way that lowers cost.

And what won't work is if you simply take one part of the healthcare system, the largest source of coverage for the lowest income people, and just say, on that program, we are going to put a cap, because that doesn't change the cost. That doesn't change the healthcare needs. It is a tougher job to do that.

Mr. CÁRDENAS. In the long run, what you just described, if you just take away dollars and reduce benefits of being able to see a doctor or getting healthcare, in the long run, doesn't that set us on a trajectory to increase cost and reduce the health level of Americans?

Ms. MANN. I think that is absolutely right. When people don't get care at the right time at the right place, they go to emergency rooms, they have more inpatient admissions.

Mr. CÁRDENAS. That is preventative care, which, “A stitch in time saves nine.” I love that. When I was a kid, I hated hearing that, but now that I am adult, gosh, makes a lot of sense, especially as a policymaker.

Ms. Snyder, taking a swath of money, like \$1 trillion away from our American healthcare system, and then—I don’t know if you agree with me, but having less people having direct access to care, doesn’t that create—in the long run, we put ourselves on charting the course of, oops, now per person long term we are probably spending more for healthcare and maybe not even having better care, just more emergency care, more last-minute care.

Ms. SNYDER. So what I would say is I think the CHIP program actually provides us with a great opportunity to look at a program that does infuse some of those critical concepts into the program framework that can help to drive down costs. Those include state administrative flexibility, the inclusion of personal responsibility—

Mr. CÁRDENAS. Yes, but with all due respect, state flexibility is something that is thrown around a lot. But if you have more flexibility and a heck of a lot less money or resources to provide care for your state constituents, your people who live in your state, can that contribute to, oops, we are now setting ourself on a course where less care in time early on, less preventative care means that, oops, we are now snowballing for different reasons and having more expenditure need on care in the long run?

Ms. SNYDER. So I think that is a great question, and I think—

Mr. CÁRDENAS. Well, what is the answer? Is that an accurate narrative or I am just not seeing it right?

Ms. SNYDER. What I would say is it is incumbent upon states, and it is going to be more crucial than ever that states—

Mr. CÁRDENAS. I used to be a state legislator. I used to be the budget chairman. So I know what it is like to make those tough decisions, saying we have all the things that we love to do but just not enough money to do it. And then when the Feds go around saying we are going to block grant you, and all of a sudden we went from taking off a 0 of how much money the Feds give us, then we say, oh, my gosh, that didn’t reduce the need to provide for our constituents. All it meant is we have less money to do it with.

Ms. SNYDER. And I believe that is the case. And so what it is going to really call on us to do is to critically evaluate the data that we have on hand and ensuring that we are making informed and smart decisions—

Mr. CÁRDENAS. Sure. But with all due respect, if I were a single mother with two children and people are telling me, reevaluate your family situation, and I have no healthcare coverage for my children, that analysis ain’t going to do my diddly when my son gets really sick and gets a fever, and I don’t have a clinic to go to, and I don’t have coverage, and I am not part of CHIP anymore because I am on a waiting list, or I don’t have Medicaid anymore because I am on a waiting list for my state.

And then all of a sudden, guess what I am going to do as that single mom? I am going to end up in the emergency room. And, gosh, darn it, I think it is going to cost the state more. It is going

to cost that hospital more. It is going to tax them. It is not going to help my challenge.

For Heaven's sakes, if my child has a fever because he has a more serious condition, and if I would have taken him to a doctor 2 years ago, they would have found it early, and all of a sudden now my child has fourth stage something else. Oh, believe me, we are going in the wrong direction.

And I appreciate your generosity, Mr. Chairman, for allowing some of us to go over our time on both sides of the aisle. Thank you. I am out of time.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentleman from New York, Mr. Engel, 5 minutes for questions, please.

Mr. ENGEL. Thank you very much, Mr. Chairman.

I want to make a statement and then I have a couple of questions for Ms. Mann.

Let me say at the outset that I strongly support CHIP, the Children's Health Insurance Program, and our Nation's community health centers. I was very proud to support the Medicare Access and CHIP Reauthorization Act back in 2015, and it most recently extended those two vital programs.

I would like to point out, though, that those reauthorizations passed the House in March of 2015 and was signed into law by mid-April, and yet here we are at the end of June without a plan to fund programs set to expire in September. It is certainly not right.

And in reality, our timeline is even tighter than that. Months before their funds are depleted, some states must start the process of shutting their CHIP programs down. And that means that if Congress doesn't act fast, it is entirely possible that children will see their coverage disrupted, and I think Mr. Cárdenas pointed that out.

So why hasn't Congress acted yet? Why didn't we vote to extend funding for CHIP and community health centers in March as we did in 2015? And the answer is that TrumpCare monopolized the House's time and prevented us from doing all these important things.

And that is not the only thing that TrumpCare has endangered. TrumpCare will cut and cap care for the 37.1 million children on Medicaid. And on top of that, TrumpCare's radical restructuring of Medicaid has dangerous implications for the CHIP program. A strong CHIP program depends on a strong Medicaid program. They work in concert to afford children comprehensive coverage.

How? First of all, more than half of children with CHIP are actually enrolled in expanding Medicaid coverage that is financed by CHIP. These programs also work together to meet the needs of different populations of kids since Medicaid covers benefits that other insurers do not.

CHIP reauthorization is vitally important for America's kids. I don't dispute it. My Democratic colleagues don't dispute it. But in a discussion on this topic—a discussion on this topic can occur in a vacuum. If TrumpCare becomes law and Republicans therefore

succeed decimating Medicaid, there is no way to go around it. Children will be much worse off.

I want to talk about President Trump's budget, which unfortunately exacerbates the problems that TrumpCare creates for kids. While we should enact a full, long-term extension of CHIP, this budget proposes harmful changes to the program.

What does it do? It will abolish the enhanced Federal funding match that states get now. It will overturn the requirement that states maintain children's current eligibility levels, turning back the clock on historic coverage improvements, and cut off support for CHIP kids above 250 percent of the Federal poverty level.

I want to talk more about this last point, because right now, 24 states have income eligibility for Medicaid and CHIP and are greater than 250 percent of the Federal poverty level. This includes my State of New York. We are a high cost-of-living state. So what you buy in New York, you buy a lot less for the same money than you do in other states. It is ridiculous to penalize states like mine. The administration wants to cut off Federal dollars, give nearly half of all states the flexibility to cover children above 250 percent of the Federal poverty level.

We hear a lot about states' rights, and yet we want to take away the flexibility that states have, the programs that states deem are important for them. We want to tell them, the Federal Government, what they can and cannot do. So much for states' rights.

If this cut takes effect, I have to imagine that states will have no choice but to restrict eligibility for the CHIP program, thus cutting off care for children who have CHIP coverage today. So it is bad enough that we won't be helping children who need this coverage; it will be throwing children off who have it today.

So let me ask you, Ms. Mann, since this provision would affect my district, where one-third of children are covered by Medicaid or CHIP, I am extremely concerned about its potential effects. Can you tell us what we can expect to happen if Federal support for CHIP kids above 250 percent of the Federal poverty level is cut off?

Ms. MANN. Thank you for the question. You are absolutely right. We have about 24 states that cover children at some income levels above 250 percent of the poverty line.

Most of the children actually in the program, 97 percent, have incomes below 250 percent of the poverty line. But those states that have increased their eligibility levels have made a determination, have exercised their safe flexibility because of cost in that state, because of market conditions in the state, for various reasons of concern for the kids in their states have decided that having CHIP as an option for those children is really important.

And I should say, New York, like every other state that covers children at higher income levels, requires the families to pay a portion for their care, so there is premiums and the premiums slide in accordance with the income.

If in a state like New York with high healthcare costs and high premiums for other kinds of coverage have to end their coverage, go down to 250 percent of poverty, those children will be scrambling for other kinds of care. They will pay higher cost. Their benefits won't be as pediatric focused as they are in the New York CHIP program. And many of them, because of what is called the

family glitch, won't be able to qualify for subsidies in the marketplace.

Mr. ENGEL. Well, I had a couple of more questions, but you have really answered them about how this in turn would effect coverage levels——

Mr. BURGESS. That is good, because your time has expired. So the gentleman yields back, and the chair thanks the gentleman for his participation.

I want to recognize myself for questions. The chair would point out that the chair did delay his questions until the end to allow all other members to ask their questions and then accommodate their travel plans, if they had them. I may not use the entire 5 minutes, because this has been a very robust and insightful discussion.

We do have a task ahead of us, which is the funding for the State Children's Health Insurance Program, which concludes on September 30 of this year, the end of the fiscal year. That, of course, was a fiscal cliff that was set in motion under the Affordable Care Act, when the Affordable Care Act passed and was signed into law in 2010, as CHIP was reauthorized to the end of fiscal year 2019, funded only until the end of fiscal year 2015. Your chairman, as part of the SGR Repeal, managed to get 2 years of funding until fiscal year 2017, and that is the task that is ahead of us at this time.

So, Ms. Snyder, I need to ask you what is just a very practical and Texas-focused question, but since the majority of the dais members now are from Texas, it will be appropriate. You said in your testimony, what you provided us in your testimony, that Texas has just concluded its legislative session. Is that correct?

Ms. SNYDER. Exactly.

Mr. BURGESS. And Texas, the legislative session is every 2 years. So your budget is now set until the next legislative session in 2019. Is that correct?

Ms. SNYDER. That is correct.

Mr. BURGESS. And there were some assumptions made by the finance committees that are there in the Texas House and Texas Senate, the budget committees in the House and Senate, there were some assumptions made that the funding for State Children's Health Insurance Program would, in fact, continue until 2019. Is that correct?

Ms. SNYDER. Yes, with the 23 percent additional bump in——

Mr. BURGESS. So changes that we make now come after the fact for what your state Senators and state representatives assume to be what was going to be available for them to include in their budget, and any changes we make now would have a significant effect on the state budget that has already been passed and I believe signed into law. Is that correct?

Ms. SNYDER. Exactly, an \$800 million impact over the biennium.

Mr. BURGESS. So I understand the importance of getting this done. And let me just also say that under current law, under the Affordable Care Act, under current law, something happens to disproportionate share funding in Texas. Doesn't it?

Ms. SNYDER. Yes.

Mr. BURGESS. What is that that happens to disproportionate share funding? They have funds that go to hospitals that see a dis-

proportionate share of Medicaid, low income, and uninsured. What happens to those funds in Texas?

Ms. SNYDER. Can I ask you to clarify the question?

Mr. BURGESS. What happens under current law, under the Affordable Care Act, so-called DSH funds, the disproportionate share funds, those additional funds paid to hospitals, paid to institutions to see a disproportionate share of Medicaid low-income and uninsured, what happens to those funds at the end of this fiscal year?

Ms. SNYDER. And I am sorry, I don't know the answer to the question.

Mr. BURGESS. Well, I know the answer.

Ms. SNYDER. And I apologize.

Mr. SHIMKUS. I know the answer too.

Mr. BURGESS. And I will be glad to share it with the committee. Those funds, under current law, under the Affordable Care Act—of course, everyone is going to be lying down the allegiant fields of ObamaCare. There is going to be no need to provide additional funding to those hospitals because everybody has got this wonderful health insurance that was provided under the ACA.

But under current law, Texas is going to lose those funds in October of this year, and that was an effort—we did try to correct that in the bill that passed through this committee in a 28-hour markup and passed on the floor of the House the first part of May. And I know my state counterparts were very interested that we take care of that discrepancy, and I think that we have.

Let me just ask you, because I have run a little bit long with that, we all want our dollars to be spent appropriately. And Medicaid has a history. Sometimes dollars aren't always spent appropriately. But over and above the dollars being spent appropriately, if a patient is eligible for Medicaid, but they also have a commercial insurance, another third party that is supposed to be liable for their medical care, sometimes the path of least resistance is just to bill the Medicaid system, and that seems to be a quicker way of collecting the money.

But one of the things that we have been working on is to enhance the ability to collect the third-party liability, if there is coverage that is actually owed by another payer, a commercial insurer. So what has your experience been in managing potential overpayments within the state related to third-party liability?

Ms. SNYDER. So we are very committed in the State of Texas to ensuring, when there is another payer source, that we are capitalizing on that payer source and that Medicaid remains the payer of last resort.

We have efforts underway, both within the Medicaid program and in conjunction with our inspector general, to ensure that we are systematically drawing on the funding that is available from those other payer sources. It is one of our priority projects every year, understanding that that Medicaid impact is the payer last resort.

Mr. BURGESS. Very good. Well, we will have legislation coming on that, and I appreciate your input on that.

Mr. Holmes, let me just ask you. I certainly appreciate what you do and what other people involved in community health centers and federally qualified health centers provide. When a patient sees

a physician or a nurse practitioner at a federally qualified health center who is covered by Medicaid, is the rate reimbursed by Medicaid the same as it would be by a physician practicing in private practice in the same town?

Mr. HOLMES. It is not, in most cases. Health centers are paid under a PPS system, and it is a bundled set of services for the Medicaid patient. And it is based on payment methodology that was passed through Congress many years ago. And that is different than a discounted fee for service payment arrangement that currently exists with a number of other Medicaid providers.

Mr. BURGESS. And that would be the provider out in private practice?

Mr. HOLMES. That is correct, unless those providers are in a capitation system or in some type of ACO.

Mr. BURGESS. Be careful. We have heard that "capitation" is a bad word this morning.

Mr. HOLMES. It is a method of payment where you are paid on a per-member per-month basis. And for that per-member per-month basis, you are delivering the scope of care within that agreement.

Mr. BURGESS. And another aspect of the difference between a doctor in private practice and a doctor working in a federally qualified health center is the liability question. Is that not correct?

Mr. HOLMES. That is correct.

Mr. BURGESS. So a doctor in private practice has to carry medical liability insurance, which, as you know, in some areas, can be quite expensive. But in a federally qualified health center that cost is ameliorated by participation in the Federal Tort Claims Act. Is that correct?

Mr. HOLMES. That is correct. And it was under Congress' direction to include health center physicians and providers in FTCA, because they felt it was a method to save healthcare dollars.

Mr. BURGESS. And I don't disagree with that. In fact, probably when Gene Green was in the State House in the early 1990s, our state legislature provided doctors who did a certain percentage of Medicaid in their practice the first \$100,000 in liability coverage. That didn't last, and I don't know why. It was probably too expensive as a state program.

But if we want to encourage the number of providers to see patients who are covered by Medicaid, that seemed to me to be a very forward-leaning aspect of what they did back in the early 1990s. So I want to thank my colleague from Texas. I am sure he was the main driver of that liability assistance when it occurred.

Well, I want to thank all of our witnesses. Seeing no other members wishing to ask questions, I do want to thank the witnesses for being here.

We received outside feedback from a number of organizations on these bills, so I would like to submit statements from the following for the record: the American Academy of Dermatology Association; America's Essential Hospitals; American Academy of Family Physicians; AHIP; the Healthcare Leadership Council; our House colleagues from Minnesota; a CHIP letter from 1,200 local state and national organizations. So without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. GREEN. Mr. Chairman, I won't ask for the 4 minutes extra you have on your 5 minutes, but—

Mr. BURGESS. No, sir, I accrued all of the extra minutes I gave on your side and utilized them for our side, because I knew my questions would be most important.

Mr. GREEN. Well, I appreciate your activity, but that was taken at the end. All I want to do is—give me 1 minute.

Mr. BURGESS. The gentleman is recognized.

Mr. GREEN. First of all, I was in the legislature in 1991, and I am not sure but—after that I ran for Congress. But the State of Texas is going to be in special session. Is that not correct?

Ms. SNYDER. That is correct.

Mr. GREEN. In the next few weeks. Having been there and done that, nobody likes special sessions in summer.

But the other issue is, Texas did not expand Medicaid. Is that correct?

Ms. SNYDER. That is correct.

Mr. GREEN. OK. And the other issue is third-party coverage. That is not unusual, because if you have an auto accident, the hospital has—in Texas, I assume everywhere else—has a right to put a hospital lien on that, whatever you win from your lawsuits. So I don't have any problem with Texas doing that under Medicaid, so that is pretty common.

But that is not going to solve our problem with Medicaid in our terrible program we have in Texas. And even there, when Democrats were in the majority, Texas has always have been very conservative. Our Medicaid program is nothing compared to some others.

And, in fact, I will give one example. After Katrina, the Houston area received a quarter of a million people. We brought them in under our Medicaid system, although the state legislature was out of session. We were able to get Federal money to do the state match for those folks, and over a period of time, they either went back to Louisiana or they became Texan. And that is when I found out that Louisiana actually gets 75 percent Federal reimbursement, and Texas receives 67 percent. And I would hope maybe our subcommittee could look at that and see why is it more expensive than Louisiana.

Mr. BURGESS. Will the gentleman yield?

Mr. GREEN. I would be glad to.

Mr. BURGESS. I do not know all of the intricacies of the formula that CMS uses to calculate, but it is based on the average state income as well and probably reflects that average state income in Texas is somewhat greater than the average state income in the State of Louisiana. And that is probably a fiscal fact for which we should both be extremely grateful and thank our lucky stars that we live in Texas.

Mr. SHIMKUS. Would the gentleman yield?

Illinois is a 50/50 state, so I just want you to put that on the record.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back.

Let me just continue on the unanimous consent requests that I was doing. I also want to ask unanimous consent to submit for the record copies of the Congressional Record volume 141, issue 207, Friday, December 22, 1965, where Senator Patty Murray introduced to the record over in the Senate a letter to President Clinton asking for the participation in a per-capita cap arrangement.

Mr. GREEN. 1995.

Mr. BURGESS. Did I say 1995?

Mr. GREEN. You said 1965.

Mr. BURGESS. 1965. 1995. Time flies.

I also want to submit for the record a New York Times editorial from 1997, February of 1997, called "Making the Budget Bearable," where they point out that the President offers an important reform of Medicaid proposing to control future spending by placing a cap on the amount of Federal spending per enrollee and allowing states to place enrollees in managed care without going through the frustrating process of begging for Washington's approval.

Without objection, so ordered. Those things will be entered into the record.

Mr. BURGESS. Pursuant to committee rules, I remind members they have 10 business days to submit additional questions for the record. I ask that witnesses submit their responses within 10 business days upon a receipt of those questions.

Without objection, the subcommittee is adjourned.

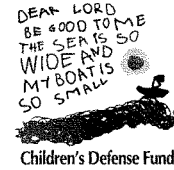
Mr. GREEN. Mr. Chairman, we could be here all day, but I also wanted to remind you, in 1995, I think the Senate Republicans wanted an individual mandate.

Mr. BURGESS. That was actually in response to a request for a block grant.

The subcommittee stands adjourned.

[Whereupon, at 1:14 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



June 14, 2017

Statement of the Children's Community Urging Congress to Act Quickly on a Strong, Five-Year Extension of Funding for the Children's Health Insurance Program

As advocates for children and pregnant women, **today we call on Congress to take immediate action to stabilize CHIP in its current form and enact a five-year extension of CHIP funding.** Congress should protect the gains in children's health coverage that have resulted in more than 95 percent of all children in America being enrolled in some form of insurance coverage. Together, Medicaid and the Children's Health Insurance Program (CHIP) are an integral part of this success and we urge Congress to ensure that coverage for children and pregnant women provided through Medicaid and CHIP is protected and not disrupted in any upcoming legislation.

Our organizations are deeply distressed about the devastating consequences for children and pregnant women that would result from drastic cuts to Medicaid or restructuring Medicaid into a per capita cap or block grant. Today, 37 million children get health coverage, including important health services in schools, through Medicaid. Medicaid covers roughly half of all births in this country, including the majority of care provided for preterm and low birthweight infants. Any proposal that imposes deep cuts to Medicaid or turns Medicaid into a per capita cap or block grant would have a significant impact on the health and well-being of half of our nation's children and pregnant women. Congress should abide by a "do no harm" principle when it comes to coverage for children and pregnant women.

As the House Energy and Commerce Subcommittee on Health meets today for a hearing "to Examine Extending Funding for Health Programs Strengthening the Safety Net," our organizations are focused on the future of CHIP. We call on Congress in the strongest possible terms to take immediate action to fully extend CHIP in its current form for five years.

CHIP is a 20-year old bipartisan health coverage program for children in working families that enjoys near-universal support in Congress and in statehouses across the nation. Senators,

representatives, and governors all recognize the importance of CHIP in providing affordable, pediatric-specific coverage to almost 9 million children in low-income working families who cannot afford private coverage or lack access to employer-based coverage. CHIP also provides quality, affordable care to pregnant women in 19 states, allowing them to obtain the care they need to have healthy pregnancies and give birth to healthy infants.

Despite its enormous success, CHIP's funding is set to expire on September 30, 2017 and states are just weeks away from setting in motion processes to establish waiting lists and send out disenrollment notices to families. Once undertaken, these actions will have an immediate effect, creating chaos in program administration and confusion for families. This is a fiscally irresponsible and eminently avoidable problem.

Extending CHIP is particularly important in light of the ongoing debate on and uncertainty regarding the future of the Affordable Care Act (ACA), Medicaid, and the stability of the individual insurance markets. With state budgets already set for the coming year, states are counting on CHIP to continue in its current form. Changes to CHIP's structure – including changes to the Maintenance of Effort or the enhanced CHIP matching rate – would cause significant disruption in children's coverage and leave states with critical shortfalls in their budgets. Given CHIP's track record of success, now is not the time to make changes to CHIP that would cause harm to children.

CHIP was a smart, bipartisan solution to a real problem facing American families when it was adopted in 1997 and its importance and impact in securing a healthy future for children in low-income families has only increased. Today, we stand united in urging Congress to ensure that their actions match their words in protecting and preserving the health and well-being of all of America's children and pregnant women. As Congress works to reform our nation's health care systems, a primary goal should be to improve health coverage for children, but at a minimum, no child should be left worse off. To this end, a long-term extension of federal funding to sustain existing CHIP programs is a necessary first step.

Contact: Ari Goldberg, VP Communications, First Focus, 240-678-9102,
agoldberg@firstfocus.org

#KeepKidsCovered
#DoNoHarm



Statement for the Record
House Energy and Commerce Subcommittee on Health
Examining the Extension of Safety Net Health Programs
 June 23, 2017

Presented by
North American Society for Pediatric
Gastroenterology, Hepatology and Nutrition

On behalf of the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (NASPGHAN), we urge Congress to enact a long-term funding extension of the Children's Health Insurance Program (CHIP) as quickly as possible. CHIP funding is currently set to expire on September 30, 2017. Swift action on a CHIP funding extension bill would provide much-needed certainty to states and families and ensure that health coverage for the 8.9 million children who rely on CHIP will not be disrupted.

NASPGHAN is an organization comprised of 1,800 members who have specialized training and expertise in caring for children with disorders of the digestive system, liver and nutrition. As we have experienced first-hand, CHIP plans provide critical access to child-specific pediatric subspecialists. Unlike many private insurance plans, which are based on the health needs of adults, CHIP offers insurance with age-appropriate benefits that is affordable for middle-income families.

CHIP has strong bipartisan roots and was developed as a state-federal partnership that gives governors broad flexibility to design programs targeting the needs of their pediatric population. The Society feels that an uncertain future of the CHIP program is a significant problem for states as they are already developing their budgets and negotiating contracts with insurers and providers.

For states to continue their CHIP programs without interruption, they must know that that federal support for CHIP will exist beyond September. If funding is not stabilized, states will have no choice but to begin planning for the impending funding shortfall, which could lead to drastic program cuts through enrollment caps, benefit reductions, reductions in eligibility, or provider payment cuts.

At a time when children's coverage rates have hit record highs – with more than 95 percent of our children enrolled in some type of health coverage – it would be devastating if states begin to dismantle their CHIP programs. Given the uncertainty in the insurance market and as Congress continues to look at broader health system reforms, it is important that CHIP remains a stable source of coverage for children.

Coverage provided through CHIP and Medicaid must be protected. As a Society that is dedicated to the health and well-being of children, we are hopeful that our nation's leaders can work together to continue the current CHIP policy that is working well for states and families. NASPGHAN members urge Congress to make swift action on a long-term CHIP funding extension an immediate priority.

Leading Children's Health Groups to House of Representatives: Keep Medicaid Strong

3/22/2017 American Health Care Act would jeopardize care for children and families

Washington, DC—The American Academy of Pediatrics, Children's Defense Fund, Children's Dental Health Project, Family Voices, First Focus Campaign for Children, March of Dimes and National Association of Pediatric Nurse Practitioners issue the following joint statement opposing the American Health Care Act's (AHCA) drastic changes to Medicaid and their detrimental impact on children and families:

"Our organizations represent children, pregnant women, families, children's health care providers and advocates across the country, and we speak with one voice today to urge the U.S. House of Representatives to keep Medicaid strong for children and vote 'no' on the AHCA. This bill ends the Medicaid program as we know it, jeopardizing coverage for the 72 million vulnerable Americans – primarily children, pregnant women, seniors and people with disabilities – who rely on Medicaid for their health care.

Children make up the single largest group of people who rely on Medicaid; nearly 36 million children receive Medicaid coverage, including children with special health care needs and those from low-income families. Medicaid also provides comprehensive prenatal care to pregnant women, allowing millions of pregnant women to have healthy pregnancies and helping millions of children get a healthy start. Unlike many private health insurance plans, Medicaid guarantees specific benefits designed especially for children. Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits are the definitive standard of pediatric care, covering an array of services like developmental, dental, vision and hearing screenings, and allowing health problems to be diagnosed and treated appropriately and as early as possible. Simply put: Medicaid works. In fact, children in Medicaid are more likely to get check-ups, miss less school, graduate and enter the workforce than their uninsured peers.

Medicaid is able to provide affordable, comprehensive care for every child because of the strength of Medicaid's state-federal partnership. The program already provides flexibility to states and allows each state to meet the needs of its Medicaid population when a natural disaster, public health crisis like the current opioid epidemic, or economic recession increases the number of people enrolled and the cost of providing services.

The AHCA includes harmful proposals to restructure Medicaid, and the changes to AHCA unveiled on Monday evening go from bad to worse, allowing even more damaging changes to the program. In addition to the bill's initial proposal to fund Medicaid through per capita caps, the amendments would allow states to choose a block grant model, which would eviscerate existing protections afforded to children and pregnant women in the Medicaid program. Comprehensive EPSDT benefits would no longer be required for children, allowing states to ration limited dollars by drastically cutting back pediatric services.

Block grants and per capita caps have a singular purpose, to reduce federal funding to states. In a bill that is supposed to be improving care for Americans, block grants and per capita caps shift costs from the federal government to the states, putting pressure on states to come up with the resources to cover their Medicaid patients when federal funds run out and costs inevitably rise. These drastic changes would place politicians, rather than health care providers, in charge of health care for children, pregnant women and families. Whether a life-saving childhood vaccination, a wheelchair or a hearing aid, politicians should not be the ones determining who gets what coverage, which providers offer those services, and what families must pay.

The AHCA does not make coverage more affordable for families. In fact, it makes it harder for families to afford premiums in the individual market and phases out the option for states to expand Medicaid to cover more low-income adults, which has

6/23/2017

Leading Children's Health Groups to House of Representatives: Keep Medicaid Strong

led to tremendous cost savings for states and better health outcomes for families across the country. Having healthy parents means children are healthier, too. Stopping Medicaid expansion, restructuring Medicaid financing, and opening the door to harsh new requirements for Medicaid enrollees, as the AHCA proposes, are not only bad for state budgets, they are harmful to child health.

The AHCA's provision allowing states to deny Medicaid coverage unless mothers and fathers are working is especially onerous. This provision would mean that a married mother of an infant could be required to return to work 60 days after giving birth in order to keep her Medicaid coverage. Maintaining health coverage for mothers after birth is essential for infants' healthy development. Among adults with Medicaid coverage, about 80% are in working families; this proposal is not only short-sighted and dangerous, it offers a solution to a problem that does not exist.

In short, our organizations are united in opposition to any threat to Medicaid that would jeopardize the gains we've made in children's coverage and dismantle a pillar program that millions of families rely on. More children are insured today than at any time in American history; the AHCA will reverse that progress. We urge Congress to oppose the AHCA and to instead pursue policies that prioritize children and keep Medicaid strong."

Earlier today, many of our organizations joined a letter with more than 400 organizations dedicated to improving the well-being of children from all 50 states and the District of Columbia to urge Congress to keep the unique needs of children and their parents front and center as they consider any changes to the nation's health care system.

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About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 66,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults. For more information, visit www.aap.org and follow us on Twitter @AmerAcadPeds.

About the Children's Defense Fund

The Children's Defense Fund Leave No Child Behind® mission is to ensure every child a Healthy Start, a Head Start, a Fair Start, a Safe Start and a Moral Start in life and successful passage to adulthood with the help of caring families and communities.

About the Children's Dental Health Project

The Children's Dental Health Project (CDHP) is an independent nonprofit that creates and advances innovative policy solutions so that no child suffers from tooth decay. Based in Washington, D.C., CDHP is driven by the vision of all children achieving optimal oral health in order to reach their full potential. We use data measurement and analysis to advance models that incentivize oral health, not just payment for treating the symptoms of dental disease. CDHP seeks to lead the way toward a health care system that is truly inclusive of oral health, from payment to care delivery. Learn more about CDHP at www.cdhp.org.

About Family Voices

Family Voices is a national, nonprofit, family-led organization promoting quality health care for all children and youth, particularly those with special health care needs. Working with family leaders and professional partners at the local, state, regional, and national levels since 1992, Family Voices has brought a respected family perspective to improving health care programs and policies and ensuring that health care systems include, listen to, and honor the voices of families.

American Academy of Dermatology Association
Statement for the Record
House Committee on Energy and Commerce
Subcommittee on Health
Hearing: "Examining the Extension of Safety Net Health Programs"
June 14, 2017

Chairman Burgess and Ranking Member Green, on behalf of the American Academy of Dermatology Association (Academy), which represents more than 13,500 dermatologists nationwide, thank you for your leadership in convening the hearing entitled "Examining the Extension of Safety Net Health Programs." The Academy is pleased to submit the following statement for your consideration.

The Academy appreciates your leadership in holding this hearing to examine the extension of several important health care safety net programs, including the Children's Health Insurance Program (CHIP), Federally Qualified Health Centers (FQHCs) and the Community Health Center Fund (CHCF). Dermatologists are the only residency-trained physicians fully educated in the science of cutaneous medicine and surgery, including more than 3,000 unique skin disorders ranging in complexity and commonality. At any given time, 1 in 3 Americans suffers from a skin disease, including non-melanoma skin cancer, melanoma, and psoriasis. Preserving and improving access to the quality care provided by dermatologists for all Americans is important in managing these conditions.

In light of the Subcommittee's hearing, the Academy would like to highlight the important role that the Community Health Center Fund (CHCF) has played in improving access to care for patients through community health centers (CHCs). CHCs provide access to much needed health care services for low income patients, serving over 25 million patients, including 7.5 million children and 1.2 million homeless patients, each year.¹ CHCs also provide significant savings to our health care system by providing preventive services and by helping patients manage chronic disease. Without an extension of the CHCF this year, CHCs would face a destabilizing 70% reduction in funding. Without this funding, several thousand centers would be forced to close, leaving an estimated 9 million patients without access to necessary care.

The Academy is committed to ensuring that every patient has access to safe and effective dermatologic care. To that end, dermatologists provide in-person and consulting services to CHC patients through in-person treatment; through telemedicine and teledermatology services, including store-and-forward technologies; and through clinics and patient referrals under the Extension for Community Healthcare Outcomes (ECHO) program. In these ways, CHCs help provide patients in underserved areas with access to important specialty

¹ American Health Centers 2017 Fact Sheet



American Academy of Dermatology Association
"Excellence in Dermatology"

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American Academy of Dermatology Association
Statement for the Record
June 14, 2017
Page 2 of 2

care, such as dermatology. Currently, only select CHCs offer telemedicine and teledermatology services for patients; but with additional funding, these services could be expanded, further building on the mission of CHCs and increasing access to care for patients who might otherwise wait much longer to access the care they need. In addition, expanding access to such services could help reduce wait times and unnecessary referrals for in-person visits. For example, the previously mentioned ECHO program, which several dermatologists engage in today, allows for dermatologists to use live video conferencing to train primary care providers, including those at CHCs, to identify skin diseases. Furthermore, by connecting primary care physicians and specialists, the ECHO program has been shown to reduce costs through further educating primary care providers about specialty care and treatment which results in a reduction of unnecessary referrals.

Increased funding has the potential to build on past successes such as these and improve access to care. Furthermore, without continued funding for CHCs, low income patients would lose access to not only primary care but to essential specialty services, including care for serious skin diseases, which will ultimately result in increased costs to the entire health care system.

Again, the Academy appreciates the Subcommittee's effort to address the extension of funding for these vital safety net programs. Please feel contact Christine O'Connor, the Academy's Associate Director of Congressional Policy, at coconnor@aad.org or (202) 609-6330 if you have any questions or if we can provide additional information.



AMERICA'S
ESSENTIAL
HOSPITALS

Statement for the Record
Committee on Energy and Commerce
Subcommittee on Health

Examining the Extension of Safety-Net Health Programs
June 14, 2017

Thank you for the opportunity to submit a statement for today's hearing on funding for programs vital to our nation's health care safety net. America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including low-income working Americans and others who face financial hardships. Our more than 300 members serve as reliable sources of care for individuals and communities, providing primary care through trauma care, disaster response, health professionals training, research, public health programs, and other services. America's Essential Hospitals is pleased the committee wants to ensure the health care safety net remains intact.

The Children's Health Insurance Program (CHIP) and federally qualified health centers (FQHCs) are both critical to providing coverage and access to care for people who might otherwise have few or no options. We are pleased the committee is actively working to extend funding for these critical programs. They deserve your prompt attention.

For millions of low-income Americans, the safety net provides choices for affordable care—not only at FQHCs but also at many essential hospitals and children's hospitals. Due to their patient populations, these hospitals often face significant financial challenges compared with other hospitals. The nation's essential hospitals:

- operate with no margin, on average;
- provide 18.3 percent of all uncompensated care nationally, or about \$7.8 billion dollars;
- care for a population that is half uninsured or Medicaid patients; and
- train nearly seven times as many medical and dental residents as other U.S. teaching hospitals.

essentialhospitals.org

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To keep their doors open and continue providing care, these hospitals rely on Medicaid disproportionate share hospital (DSH) payments.

Under the Affordable Care Act (ACA), Medicaid DSH payment cuts were scheduled to begin in 2014. But for more than four years, a bipartisan Congress has delayed the cuts, recognizing the threat they pose to the stability of patients and essential hospitals. In fact, the original House majority proposal to repeal and replace the ACA included a full repeal of Medicaid DSH cuts across all states—a reflection of lawmakers' concern.

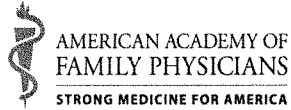
The most recent delay of the Medicaid DSH cuts came in the 2015 Medicare Access and CHIP Reauthorization Act (MACRA), which delayed the cuts in fiscal year (FY) 2017 by “rebasin” the cuts to extend them by a year, to 2025.

But like funding extensions for CHIP and FQHCs in MACRA, the DSH payment cut delay is set to expire on September 30 of this year. DSH cuts would start October 1 with a \$2 billion reduction in FY 2018 and increase by \$1 billion annually through 2024, ending with an \$8 billion cut. If the cuts take effect, DSH hospitals would see massive funding shortfalls at a time when the health care safety net faces other dire funding threats.

So, as Congress continues to consider broader health care reform legislation, the imminent threat of DSH cuts remains.

We believe it is critical to support safety-net programs collectively, to provide struggling Americans and underserved communities with a wider net. We respectfully request that, along with funding extensions for CHIP and FQHCs, Medicaid DSH cuts are delayed as quickly as possible and for the duration of time remaining until all stakeholders can work together for a more sustainable solution.

Thank you for your prompt attention to this vital issue.



**Statement of
American Academy of Family Physicians
Submitted for the Record**

**House Energy and Commerce Committee
Health Subcommittee**

**Examining the Extension of Safety Net Health
Programs**

June 14, 2017

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On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, thank you for the opportunity to submit testimony for the record to the US House Energy and Commerce Committee Health Subcommittee regarding the continuation of the Children's Health Insurance Program (CHIP).

Congress Should Swiftly Approve a Long-Term Extension of CHIP Funding.

The AAFP urges Congress to swiftly approve a bipartisan long-term extension of CHIP, in order to promote stability and health security for 8.9 million low-income children¹ and their families. Time is of the essence in completing this work in order to ensure continuous access to primary and preventive services for this vulnerable population, protect progress in public health and allow States to adequately plan.

The AAFP has supported CHIP since its inception in 1997, and during each subsequent reauthorization and extension of funding (2007, 2009, and 2015), as a way to extend health coverage to uninsured children whose families do not meet eligibility requirements for Medicaid. Since the enactment of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), in April 2015, the AAFP has reiterated support for CHIP funding beyond the current end-date of September 30, 2017—through letters to this Committee and to Congressional Leadership. As a medical specialty, family medicine is committed to the success of all health insurance programs financed with public dollars, including CHIP. AAFP member data indicates that over two thirds of AAFP members accept new Medicaid patients.² Although the AAFP does not collect member survey data on CHIP participation, we know (due to the close connection between Medicaid and CHIP—including the fact that some states operate combined Medicaid / CHIP programs—and the fact that family physicians perform so many pediatric services) that family physicians are helping to carry out Congress's intent behind CHIP: treating low-income children, many of whom would be uninsured without the program.

Family physicians play an important role in addressing American children's health needs. According to the AAFP's latest member census, published December 31, 2016, over 80 percent of AAFP members care for adolescents, and 73 percent care for infants and children.³ Other AAFP member survey data reflect that about 20 percent of AAFP's members deliver babies as part of their practice, with roughly 6 percent delivering more than 30 babies in a recent calendar year.⁴ Of AAFP active members with full hospital

¹ Centers for Medicare and Medicaid Services, 2016 Enrollment Report, available at <https://www.medicare.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf>.

² AAFP, 2015 Practice Profile Survey (excerpt), available at <http://www.aafp.org/about/the-aafp/family-medicine-facts/table-12.html>.

³ AAFP Member Census (Dec. 31, 2016), available at <http://www.aafp.org/about/the-aafp/family-medicine-facts/table-13.html>.

⁴ AAFP, 2015 Practice Profile Survey (July 15, 2016).

privileges, 70 percent provide newborn care in the hospital, and 64 percent provide pediatric care in the hospital.⁵ This is consistent with family medicine's traditional role of practicing in the entire scope of the physician license in order to meet the needs of the community in which the family physician practices. A family physician who serves a small rural community without a pediatrician, for example, will often perform most or all pediatric care for that community.

The AAFP also supports health care for all, consistent with the public-health mission of the specialty of family medicine. The AAFP promotes health care for all in the form of "a primary care benefit design featuring the patient-centered medical home, and a payment system to support it," for everyone in the United States.⁶ AAFP believes that all Americans should have access to primary-care services (e.g. in the case of infants and children, immunizations and other evidence-based preventive services, prenatal care, and well-child care), without patient cost sharing. The AAFP believes that universal health care also should include services outside the medical home (e.g. hospitalizations) with reasonable and appropriate cost sharing allowed, but with protections from financial hardship. Supporting universal access to care is also consistent with the "triple aim" of improving patient experience, improving population health, and lowering the total cost of health care in the United States. Having both health insurance and a usual source of care (e.g., through an ongoing relationship with a family physician) contributes to better health outcomes, reduced disparities along socioeconomic lines, and reduced costs.⁷

The AAFP urges Congress to pass a "clean" extension of CHIP with a minimum of unnecessary policy changes. Family physicians and their practices thrive on stability in the insurance market. Unlike Medicare and Medicaid, which provide stable and reliable federal funding under current law, CHIP funding is contingent upon Congressional action at regular intervals. Given the importance of the program to almost 9 million children from low-income families, the AAFP urges the Committee to swiftly extend and stabilize the program on a long-term basis.

⁵ *Id.*

⁶ AAFP, Health Care For All (2014), *available at* <http://www.aafp.org/about/policies/all/health-care-for-all.html>.

⁷ See, e.g., The Robert Graham Center, The Importance of Having Health Insurance and a Usual Source of Care, *Am. Fam. Physician* (Sept. 15, 2004), *available at* <http://www.aafp.org/afp/2004/0915/p1035.html>.

Congress Should Also Provide Long-Term Support for Graduate Medical Education Through Continued Funding of the Teaching Health Center Program and Community Health Centers.

As an additional note, the AAFP would like to emphasize to the Committee the importance of providing long-term support for the Teaching Health Center Graduate Medical Education (THCGME) program, which will also expire on September 30, 2017, absent Congressional intervention. THCGME is a successful primary-care training program, currently financing training for 742 medical and dental residents in community-based ambulatory settings. Residents in the THCGME program train exclusively in primary-care specialties.

Of relevance to the legislative process surrounding CHIP, two-thirds of the THCGME residents are training in family medicine or pediatrics.⁸ The THCGME program, administered by the Health Resources and Services Administration (HRSA), accounts for less than one percent of the annual federal spending devoted to graduate medical education, yet it is the only GME program that is devoted entirely to training primary-care physicians and dentists. Residents in the program train in community health centers (including federally qualified health centers), and tend to be concentrated in rural and underserved areas that need access to more providers, particularly primary-care physicians. American Medical Association Physician Masterfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location.⁹ By comparison, fewer than 5 percent of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas.¹⁰ Thus, the most effective way to encourage family and other primary-care physicians to practice in rural and underserved areas is not to recruit them from remote academic medical centers but instead to train them in these underserved areas.

Community health centers (CHCs) play an important role in primary care graduate medical education as well. The nation's 9,800 centers provide care for 25 million patients, 71 percent of whom are low-income.¹¹ CHC facilities, along with other safety

⁸ Health Resources and Services Administration, Teaching Health Center Graduate Medical Education Program, Academic Year 2014-2015, *available at* <https://bhwh.hrsa.gov/sites/default/files/bhwh/nchwa/teaching-health-center-graduate-highlights.pdf>.

⁹ E. Blake Fagan, M.D., et al., Family Medicine Graduate Proximity to Their Site of Training, *Family Medicine*, Vol. 47, No. 2, at 126 (Feb. 2015).

¹⁰ Candice Chen, M.D., MPH, et al., Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions, *Academic Medicine*, Vol. 88, No. 9, p. 1269 (Sept. 2013).

¹¹ National Association of Community Health Centers, About Our Health Centers, *available at* <http://www.nachc.org/about-our-health-centers/>

net providers, are valuable training settings for THCGME residents who care for patients like those they are likely to treat in primary care outpatient settings. Residents who train in CHCs also have the unique opportunity to be trained in delivery system models using electronic health records, providing culturally competent care, and following care coordination protocols.¹² Some are also able to operate in environments where they are trained in mental health, drug and substance use treatment, and chronic pain management.¹³ We know that residents who train in underserved communities are likely to continue practicing in those same environments.¹⁴

¹² Candice Chen, Frederick Chen, and Fitzhugh Mullan. Teaching Health Centers: A New Paradigm in Graduate Medical Education." *Academic Medicine: Journal of the Association of American Medical Colleges* 87.12 (2012): 1752–1756. PMC. available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3761371/>

¹³ David Mitchell, Residency Directors Tout Benefits of Teaching Health Center GME Program, AAFP News, (September 6, 2013), available at <http://www.aafp.org/news/education-professional-development/20130906thcroundtable.html>

¹⁴ Elizabeth Brown, MD, and Kathleen Klink, MD, FFAFP, Teaching Health Center GME Funding Instability Threatens Program Viability, *Am Fam Physician*. (Feb. 2015);91(3):168-170. Available at <http://www.aafp.org/afp/2015/0201/p168.html>



STATEMENT FOR THE RECORD

**Submitted to the
House Energy and Commerce Committee
Subcommittee on Health**

The Children's Health Insurance Program

June 14, 2017

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
Suite 500, South Building
Washington, D.C. 20004

America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

We appreciate the committee's interest in the Children's Health Insurance Program (CHIP) and other safety net health programs. CHIP serves as a vitally important safety net for more than 8 million children whose families have modest incomes. They depend on CHIP every day, and without the coverage and access to care it provides, many might fall through the cracks. We applaud the committee's interest in examining CHIP and ensuring that the program continues its mission of providing high quality health coverage to children.

AHIP's members are strongly committed to meeting the health care needs of children enrolled in CHIP and ensuring it remains an efficient, effective program.

Many states rely on health plans to serve their CHIP populations. In fact, 80 percent of children covered by stand-alone CHIP programs are enrolled in health plans. Health plans have a proven track record of success in providing high quality, affordable, patient-centered coverage with a strong emphasis on primary care for children. Many CHIP health plans have implemented innovative education and outreach initiatives to ensure that children receive complete physical examinations, hearing and vision checkups, dental care, immunizations, and other health care services they need to stay healthy. The delivery of these crucial primary care services is an important factor in promoting good health among children.

The value of CHIP coverage is clearly indicated by research showing that children with public health coverage (including CHIP or Medicaid) are more likely – when compared to uninsured children – to have a usual source of care (97% vs. 73%), receive a well-child check-up (85% vs. 56%), and see a doctor for specialty care (13% vs. 7%) over a 12-month period. The same analysis found that children with CHIP or Medicaid coverage are less likely to delay or forgo medical care due to cost concerns, less likely to go more than two years without seeing a doctor,

and less likely to have dental needs that are not addressed due to cost concerns.¹ Additional research has demonstrated that CHIP and Medicaid coverage has helped achieve reductions in both avoidable hospitalizations and child mortality,² and that improved health among children enrolled in CHIP and Medicaid programs “translates into gains in school performance and educational attainment over the longer term, with potentially positive implications for both individual economic well-being and productivity in the overall economy.”³

We Strongly Support a Five-Year Extension of Federal CHIP Funding

AHIP and our member plans urge Congress to authorize a five-year extension of federal funding for CHIP, as recommended by the Medicaid and CHIP Payment and Access Commission (MACPAC).

During this time of transition for our nation’s health care system – with the potential for major changes emerging from the congressional debate on repealing and replacing the Affordable Care Act (ACA) – it is more important than ever to maintain CHIP as a strong, stable, and dependable coverage option for America’s children. CHIP has been essential in reducing the rate of uninsured children from 13.9 percent in 1997 to 4.5 percent in 2015.⁴ This is a remarkable achievement, particularly in light of the success CHIP has demonstrated, as noted above, in improving health outcomes for children. By adopting MACPAC’s recommendation to extend federal CHIP funding through 2022, Congress can sustain this progress and ensure the continuation of health coverage for children who rely on CHIP.

As the committee knows, the current authorization for federal CHIP funding is scheduled to expire on September 30, 2017. It is critically important for Congress to approve a five-year funding extension in a timely fashion – not only to provide peace of mind to families that are served by CHIP, but also to ensure that states can plan ahead and make budget decisions for the new fiscal year.

¹ Kaiser Commission on Medicaid and the Uninsured, “Children’s Health Coverage: The Role of Medicaid and CHIP and Issues for the Future,” June 2016.

² Embry Howell and Genevieve Kenney, “The Impact of the Medicaid/CHIP Expansions on Children: A Synthesis of the Evidence,” *Medical Care Research and Review* 69(4), August 2012.

³ Kaiser Commission on Medicaid and the Uninsured, “The Impact of the Children’s Health Insurance Program (CHIP): What Does the Research Tell Us?” June 2014.

⁴ Medicaid and CHIP Payment and Access Commission, “Recommendations for the Future of CHIP and Children’s Coverage,” January 2017.

Without an extension of federal CHIP funding, MACPAC has projected that four states and the District of Columbia would exhaust their existing federal CHIP allotments in October-December 2017. Another 29 states would deplete their federal funds in January-March 2018, and 16 states would run out of funds in April-June 2018. All states are projected to exhaust their federal CHIP funds at some point in fiscal year 2018 if funding is not extended. The consequences for every state would be significant.

Under the ACA's maintenance of effort requirement, states must maintain – through September 30, 2019 – their eligibility standards and processes for children in Medicaid and CHIP that were in place in 2010. However, states that operate a separate CHIP program are allowed to end coverage when federal funding runs out. States operating CHIP through an expansion of Medicaid must continue providing coverage through fiscal year 2019, but they would receive the lower Medicaid match rate instead of the enhanced CHIP match rate.

While the impact would vary from state to state, there is no question that the loss of federal CHIP funding would be devastating for many CHIP enrollees and their families. In 2015, MACPAC estimated that 3.7 million children would lose their CHIP coverage if funding expired and that 1.1 million of these children would become uninsured. That would mean poorer health, higher utilization of emergency rooms, and more uncompensated care for rural hospitals across the country. Of the remaining children, MACPAC estimates that 1.4 million would obtain subsidized coverage through the ACA's Exchanges and 1.2 million would obtain coverage through a parent's employer-sponsored insurance.⁴

MACPAC data show that CHIP coverage is significantly more affordable for families than commercial coverage. The average out-of-pocket cost for families with a child enrolled in CHIP is \$158 per year, including premiums and cost sharing. By comparison, the average out-of-pocket cost for a child enrolled in subsidized Exchange coverage would be \$1,073 for the second lowest cost silver plan.⁵ Moreover, costs would be much higher for a child that has an acute health event or a chronic condition, putting coverage out of reach for some families. In light of these findings, we believe it is very clear that CHIP coverage remains the best option for families with modest incomes who are seeking affordable care for their children.

⁵ Medicaid and CHIP Payment and Access Commission, "Chapter 5: Design Considerations for the Future of Children's Coverage: Focus on Affordability," Report to the Congress on Medicaid and CHIP, March 2016.

We appreciate that members of the committee, both Republicans and Democrats, have expressed support for continuing to provide federal funding for CHIP. This committee played a leadership role in advancing the previous extension of federal CHIP funding, which was approved with strong bipartisan support – including the votes of 92 senators – as part of the “Medicare Access and CHIP Reauthorization Act of 2015.”

We thank you for your past support of CHIP and strongly encourage you to take action, as soon as possible, on MACPAC’s recommendation for a five-year extension of federal CHIP funding.



June 14, 2017

The Honorable Michael C. Burgess, M.D.
 Chairman
 Subcommittee on Health
 Committee on Energy and Commerce
 U.S. House of Representatives
 Washington, D.C. 20515

Dear Chairman Burgess:

Thank you for your leadership of the Subcommittee on Health and your commitment to ensuring the healthcare safety net helps low-income individuals achieve better health outcomes. As the Subcommittee prepares to hold a hearing on this critical topic, the Healthcare Leadership Council (HLC) welcomes the opportunity to share our thoughts with you.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century health system that makes affordable, high quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, pharmacies, post-acute care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach. Safety net programs like the State Children's Health Insurance Program (SCHIP) and Federally Qualified Health Centers (FQHCs) are a critical part of our country's healthcare infrastructure, and HLC urges Congress to maintain support for our most vulnerable citizens by continuing to fund these programs.

SCHIP

SCHIP plays an important role in providing health coverage for children in families with low and moderate incomes. SCHIP has expanded children's eligibility for coverage and has encouraged participation by simplifying enrollment and renewal. Along with other factors, SCHIP has led to a steep decline in the number of uninsured children, from 10 million in 1997 (when the program was enacted) to 3.3 million in 2015.

HLC strongly believes that keeping children healthy by giving them access to care is essential to the wellbeing of our society. By diagnosing and treating problems at an early age, we can ensure that children will grow into healthy and productive adults. HLC members are at the forefront of developing and providing these health solutions to children, and we are grateful that the Subcommittee is looking at ways to ensure that SCHIP remains on a sound fiscal footing. Without congressional action to extend the

program's funding beyond September 30, states will soon exhaust their SCHIP funds. In this time of limited state resources and tight budgets, without federal assistance states will have to remove children from SCHIP. Many of these children will not be eligible for Medicaid nor will their parents be able to afford a private insurance plan. The children will then become uninsured and will have to go without necessary doctor visits, prescriptions, and other healthcare services. They will not be able to access preventive care and instead will have to be treated in emergency rooms and other high-cost settings. To avoid this costly situation and protect children's access to healthcare, HLC asks Congress to extend SCHIP funding.

HLC also supports giving states flexibility in administering their SCHIP program. For example, states can reduce their costs by making SCHIP a wraparound option for children who are eligible for the program but who have private insurance through their parents. This option would fill in the gaps in what the private plan covers and would also cover the cost-sharing expenses of the private plan. States should also be given incentives for managing their program effectively and streamlining the enrollment process.

FQHCs

FQHCs are our nation's largest source of comprehensive primary care for the medically underserved. They provide care to over 25 million people in more than 9,000 rural and urban communities across America. These centers provide medical, dental, mental health, reproductive care, and other important healthcare services. This care is high quality, cost effective, and accessible. Furthermore, the centers serve as critical economic engines that benefit local economies.

HLC supports continued funding of the FQHCs to ensure that the safety net is preserved and that our country's health is improved with adequate access to care. Without action before the end of this fiscal year, FQHCs will face a 70% cut in funding on October 1, which will result in an estimated 9 million patients losing access to care. We ask that Congress extend the Community Health Center Fund (CHCF). Without this support, many centers will have to close and their patients will have limited access to care. They will instead turn to the emergency room or other high-cost settings.

Thank you again for your work on these important issues. HLC looks forward to continuing to collaborate with you. If you have any questions, please do not hesitate to contact Debbie Witchev at (202) 449-3435.

Sincerely,



Mary R. Grealy
President

Congress of the United States
Washington, DC 20515

June 23, 2017

Chairman Michael Burgess Energy and Commerce Subcommittee on Health 2125 Rayburn House Office Building Washington DC, 20515	Ranking Member Gene Green Energy and Commerce Subcommittee on Health 2125 Rayburn House Office Building Washington DC, 20515
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Dear Chairman Burgess and Ranking Member Green:

We write to you today in support of the community health center (CHC) program and thank you for conducting a timely hearing on extending health center funding.

As you are aware, health center funding will decrease nearly 70% starting on October 1st, 2017 if we do not act to extend their "Section 330" funding. At the hearing, you will hear from a fellow Minnesotan, Mr. Michael Holmes, who has been invited by the Subcommittee to testify on the "primary care cliff" health centers face. Mr. Holmes is CEO of Scenic Rivers Health Services based in Cook, Minnesota. He leads an organization tasked with caring for over 12,000 patients at a number of medical and dental clinics located throughout rural northern Minnesota.

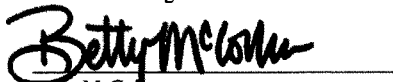
In our conversations with Minnesota's health centers, they have shared with us that if we do not address this funding cliff by October 1st, the State's 17 CHCs serving 181,000 low-income Minnesotans will lose nearly \$27 million of their overall revenue. Individual health centers would see an average drop of 15% in funding. Such a decrease would cause CHCs in Minnesota and other health centers in the United States to dramatically scale back services, if not close sites altogether. Ultimately, this loss of revenue jeopardizes access to primary care services for low-income Minnesotans across the state – not only in rural areas such as Cook, but also in the Twin Cities Metro, where residents face challenges accessing primary care services.

In short, by extending Section 330 funding, health centers will be able to continue their mission of providing primary care while saving precious state and federal resources. We ask that you act favorably on this important issue of health center funding and the "primary care cliff."

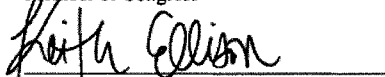
Sincerely,



Richard M. Nolan
Member of Congress



Betty McCollum
Member of Congress



Keith Ellison
Member of Congress



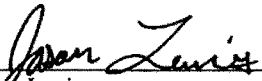
Tom Emmer
Member of Congress



Timothy J. Walz
Member of Congress



Collin Peterson
Member of Congress



Jason Lewis
Member of Congress



Erik Paulsen
Member of Congress

June 12, 2017

The Honorable Mitch McConnell
United States Senate
Washington, DC 20510

The Honorable Orrin Hatch
United States Senate
Washington, DC 20510

The Honorable Chuck Schumer
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
United States Senate
Washington, DC 20510

The Honorable Paul Ryan
United States House of Representatives
Washington, DC 20515

The Honorable Greg Walden
United States House of Representatives
Washington, DC 20515

The Honorable Nancy Pelosi
United States House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
United States House of Representatives
Washington, DC 20515

Dear Majority Leader McConnell, Minority Leader Schumer, Speaker Ryan, Minority Leader Pelosi, Chairman Hatch, Ranking Member Wyden, Chairman Walden and Ranking Member Pallone:

As leading national, state, tribal, and local organizations concerned about the health and well-being of America's children and pregnant women, we are writing to urge you to turn your attention as quickly as possible to enacting a long-term funding extension of the Children's Health Insurance Program (CHIP). CHIP funding is currently set to expire on September 30, 2017. Swift action on a CHIP funding extension bill would provide much-needed certainty to states and families and ensure that health coverage for the 8.9 million children who rely on CHIP will not be disrupted. Congress last extended CHIP as part of the Medicare and CHIP Reauthorization Act of 2015 (MACRA), legislation that passed with overwhelming bipartisan majorities. A longterm CHIP funding extension bill would not only avert a coverage crisis for children, families, and states, it would also provide an opportunity for Members and Senators on both sides of the aisle to work together toward the collective goal of protecting children's coverage. To be clear, states are already crafting their FY 2018 budgets and lack of timely congressional action will soon cause states to begin the process of disenrolling children from coverage.

For two decades, CHIP has been an essential source of children's coverage, ensuring access to high-quality, affordable, pediatric-appropriate health care for children in working families whose parents earn too much to qualify for Medicaid but too little to purchase private health insurance on their own. It has strong bipartisan roots and was developed as a state-federal partnership that gives governors broad flexibility to design their programs to target the needs of their child populations.

CHIP is a model program that has played a critical role in reducing the number of uninsured children by more than 68 percent, from nearly 15 percent in 1997 to a record of less than five percent in 2015, while improving health outcomes and access to care for children and pregnant women. If Congress fails to act in a timely manner, the 8.9 million children enrolled in CHIP will be at risk of losing their health coverage. It is worth noting that the children who stand to lose CHIP

would likely have no other affordable coverage option available to them. The resulting increase in the rate of uninsured children would be an enormous step backwards.

CHIP's uncertain funding future is a significant problem for states as they are already developing their FY 2018 budgets and negotiating contracts with insurers and providers. In order for states to continue their CHIP programs without interruption, they must know as soon as possible that federal support for CHIP will exist beyond September 30, 2017, when CHIP funding is set to expire. If funding is not stabilized quickly, states will have no choice but to begin planning for the impending funding shortfall, which will require drastic program cuts through enrollment caps, benefit reductions, reductions in eligibility, or provider payments cuts. At a time when children's coverage rates have hit record highs – with more than 95 percent of our children enrolled in some type of health coverage – it would be devastating if states begin to dismantle their CHIP programs.

Given the uncertainty in the insurance market and as Congress continues to look at broader health system reforms, it is important that CHIP remains a stable source of coverage for children. Coverage provided through CHIP and Medicaid must be protected. As advocates who are concerned about the health and well-being of children, we are hopeful that our nation's leaders can work together to continue the current CHIP policy that is working well for states and families. We urge Congress to make swift action on a long-term CHIP funding extension an immediate priority.

Sincerely,

NATIONAL ORGANIZATIONS

First Focus	American Academy of Nursing
1,000 Days	American Academy of Pediatric Dentistry
9to5, National Association of Working Women	American Academy of Pediatrics
A Father's Walk	American Association for Community Dental Programs
AASA, The School Superintendents Association	American Association for Dental Research
Academic Pediatric Association	American Association of Birth Centers
Academy of Nutrition and Dietetics	American Association of Child & Adolescent Psychiatry
ACCSES	American Association of Poison Control Centers
AFL-CIO	American Association on Health and Disability
African American Health Alliance	American Cancer Society Cancer Action Network
AFSCME	American College of Allergy, Asthma and Immunology
AIDS Alliance for Women, Infants, Children, Youth, & Families	American College of Cardiology
Alabaster	American College of Physicians
Allergy and Asthma Foundation of America	American College of Surgeons
Allergy & Asthma Network	American Congress of Obstetricians and Gynecologists
Alliance for Strong Families and Communities	
America's Essential Hospitals	
America's Promise Alliance	
American Academy of Family Physicians	

American Dental Association	Children's Dental Health Project
American Dental Hygienists' Association	Children's Environmental Health Network
American Diabetes Association	Children's Health Fund
American Federation of Teachers	Children's Health Watch, Boston Medical Center
American Foundation for the Blind	Children's Home Society of America
American Heart Association	Children's Hospital Association
American Lung Association	Children's Leadership Council
American Medical Association	Children's Mental Health Network
American Network of Oral Health Coalitions	Children's Rights
American Pediatric Society	CHRISTUS Health
American Pediatric Surgery Association	Coalition on Human Needs
American Psychological Association	Commissioned Officers Association of the U.S. Public Health Service, Inc. (COA)
American Public Health Association	Communities In Schools
Asian & Pacific Islander American Health Forum	Community Catalyst
Assistive Technology Law Center	Consortium for Children
Association for Community Affiliated Plans	Consumer Advisory Council
Association of Asian Pacific Community Health Organizations (AAPCHO)	Council of Administrators of Special Education
Association of Clinicians for the Underserved	Cystic Fibrosis Foundation
Association of Educational Service Agencies (AESA)	Daughters of Charity USA
Association of Maternal & Child Health Programs	Delta Dental Plans Association
Association of Medical School Pediatric Department Chairs	Democrats Abroad
Association of School Business Officials International (ASBO)	Dental Trade Alliance
Association of University Centers on Disabilities (AUCD)	DentaQuest
Augustinian Friars	Division for Early Childhood of the Council for Exceptional Children (DEC)
Bazelon Center for Mental Health Law	Doctors for America
Birth Defects Research & Education Foundation	Doctors for Global Health
Brain Injury Association of America	Early Care and Education Consortium
Bread for the World	Earth Evolution
Catholic Health Association of the United States	Easterseals
Center for Autism and Related Disorders	Endocrine Society
Center for Global Policy Solutions	Epilepsy Foundation
Center for Law and Social Policy (CLASP)	Every Child Matters
Center for Medicare Advocacy	EveryLife Foundation for Rare Diseases
Center for the Study of Social Policy	Families USA
Centering Healthcare Institute	Family Focused Treatment Association
Child Care Aware of America	Family Promise
Child Welfare League of America	Family-Run Executive Director Leadership Association
Children's Advocacy Institute	Family Voices
Children's Defense Fund	First Five Years Fund
	Forum for Youth Investment
	Franciscan Action Network
	Futures Without Violence
	Girls Inc.

Global Alliance for Behavioral Health and Social Justice	National Association for Children's Behavioral Health
Global Healthy Living Foundation	National Association of Community Health Centers
Global Justice Institute, Metropolitan Community Churches	National Association of Counsel for Children
Green & Healthy Homes Initiative	National Association of Counties
Hadassah, The Women's Zionist Organization of America, Inc.	National Association of County and City Health Officials
Health Resources in Action	National Association of County Behavioral Health & Developmental Disability Directors
HealthConnect One	National Association of County Human Services Administrators
Healthy Schools Campaign	National Association of Dental Plans
Healthy Schools Network	National Association of Pediatric Nurse Practitioners
Healthy Teen Network	National Association of School Nurses
Hemophilia Federation of America	National Association of Social Workers
High Flight Arts and Letters	National Association of State Directors of Special Education
HIV Medicine Association	National Association of State Head Injury Administrators
Home Instruction for Parents of Preschool Youngsters, HIPPIY	National Association of State Mental Health Program Directors
Holy Spirit Missionary Sisters - JPIC - USA	National Birth Equity Collaborative
Human Facets International	National Black Child Development Institute
Huntington's Disease Society of America	National Black Justice Coalition
IDEA Infant Toddler Coordinators Association	National Center for Healthy Housing
Immune Deficiency Foundation	National Center for Law and Economic Justice
Immunization Action Coalition	National Center for Transgender Equality
Institute for Child Success	National Center on Adoption and Permanency
Juvenile Law Center	National Coalition on Health Care
Kaiser Permanente	National Committee for Quality Assurance
Lakemary Center	National Council for Behavioral Health
League of Women Voters of the United States	National Council of La Raza
Learning Disabilities Association of America	National Council on Alcoholism and Drug Dependence
Leukemia & Lymphoma Society	National Disability Rights Network
LIFT	National Education Association
Lupus and Allied Diseases Association, Inc.	National Family Planning & Reproductive Health Association
Lutheran Services in America	National Foster Parent Association
March of Dimes	National Health Law Program
Medicaid Medicare CHIP Services Dental Association (MSDA)	National Hispanic Medical Association
Mended Little Hearts	National Immigration Law Center
Methodist Federation for Social Action	National Indian Child Welfare Association
MomsRising	
National Advocacy Center of the Sisters of the Good Shepherd	
National Alliance for Medicaid in Education	
National Alliance of Children's Trust and Prevention Funds	
National Alliance on Mental Illness	
National Association for Bilingual Education	

National Institute for Children's Health Quality (NICHQ)	Redstone Global Center for Prevention and Wellness
National Institute for Reproductive Health	RESULTS
National Network for Youth	Rights4Girls
National Organization for Rare Disorders (NORD)	Sisters of Charity Ministry Foundation
National Partnership for Women & Families	School Social Work Association of America
National Physicians Alliance	School-Based Health Alliance
National Prevention Science Coalition	SchoolHouse Connection
National Respite Coalition	Seedco
National Rural Education Advocacy Collaborative	Service Employees International Union (SEIU)
National Rural Education Association	Show of Hands: Our Children, Our Future
National School Boards Association	Shriners Hospitals for Children
National Urban League	Sisters of Charity of Nazareth Congregational Leadership
National WIC Association	Sisters of Charity, BVM
National Women's Law Center	Sisters of Mercy South Central Community
National Women's Health Network	Sisters of Mercy U.S. Province
Nemours Children's Health System	Sisters of St. Joseph of Carondelet
Network for Public Education	Society for Maternal-Fetal Medicine
NETWORK Lobby for Catholic Social Justice	Society for Pediatric Research
Non-Profit Evolution, Inc.	Society for Public Health Education
North American Society for Pediatric Gastroenterology, Hepatology and Nutrition	Society of St. Vincent de Paul
Nurse-Family Partnership	Society of State Leaders of Health and Physical Education
Nursing Students for Sexual and Reproductive Health	SparkAction
Oral Health America	Spina Bifida Association
Parent Watch	St Mary's Conference of Society of St. Vincent de Paul
Parents as Teachers	Stuart Center
Partnership for America's Children	TASH
Passport To Languages	The AIDS Institute
Pediatric Policy Council	The Arc of the United States
PICO Center for Health Organizing	The Cave Institute
PICO National Network	The Children's Cause for Cancer Advocacy
PolicyLab at the Children's Hospital of Philadelphia	The Hemophilia Alliance
Prevent Child Abuse America/ Healthy Families America	The National Alliance to Advance Adolescent Health
Project Inform	The National Campaign to Prevent Teen and Unplanned Pregnancy
Provincial Council Clerics of St. Viator	The National Crittenton Foundation
Public Advocacy for Kids	The Praxis Project
Racial and Ethnic Health Disparities Coalition	The Remmer Family Foundation, Inc.
Raineth Housing	The Sargent Shriver National Center on Poverty Law
Raising Women's Voices for the Health Care We Need	The Trevor Project
	Treatment Communities of America
	Trust for America's Health

U.S. Breastfeeding Committee
 U.S. Pain Foundation
 United Church of Christ
 United Food and Commercial Workers
 International Union
 United Methodist Church - General Board of
 Church and Society
 United Way Worldwide
 What to Expect Foundation
 Women's International League for Peace &
 Freedom
 Wyman Center, Inc.
 Young Invincibles
 Youth MOVE National
 YWCA USA
 ZERO TO THREE

STATE, TERRITORY AND LOCAL ORGANIZATIONS

Alabama

Alabama Chapter-American Academy of
 Pediatrics
 American Lung Association in Alabama
 Children's Policy Cooperative of Jefferson
 County
 Epilepsy Foundation of Alabama
 Envision 2020
 Lakeshore Foundation
 United Way of Southwest Alabama
 University of South Alabama Children's and
 Women's Hospital
 VOICES for Alabama's Children

Alaska

American Academy of Pediatrics-Alaska
 Chapter
 American Lung Association in Alaska
 Stone Soup Group
 United Way of Anchorage

Arizona

American Lung Association in Arizona
 Arizona Academy of Family Physicians
 Arizona Chapter of the American Academy of
 Pediatrics
 Arizona Dental Hygienists' Association
 Concilio Latino de Salud

Epilepsy Foundation of Arizona
 Maricopa County Oral Health Leaders
 Advocates and Resources Coalition
 National Association of Pediatric Nurse
 Practitioners Arizona Chapter
 Pan Asian Community Alliance
 Phoenix Children's Hospital
 The Mindfulness Education Exchange
 United Way of Northern Arizona
 United Way of Tucson and Southern Arizona
 Valley of the Sun United Way
 West Valley Neighborhoods Coalition

Arkansas

American Lung Association in Arkansas
 Arkansas Advocates for Children and Families
 Arkansas Chapter, American Academy of
 Pediatrics
 Arkansas Children's Hospital
 Arkansas Poison and Drug Information
 Center
 Project Hope Teen Pregnancy Prevention
 Project
 United Way of the Ouachitas

California

Alameda Health Consortium
 American Academy of Pediatrics, California
 American Academy of Pediatrics, CA Chapter
 3
 American Academy of Pediatrics - Orange
 County Chapter
 American Lung Association in California
 Arrowhead United Way
 Asian Americans Advancing Justice - Los
 Angeles
 Asian Law Alliance
 California Academy of Family Physicians
 California Children's Hospital Association
 California Coverage and Health Initiatives
 (CCHI)
 California Dental Association
 California Health Advocates
 California Pan-Ethnic Health Network
 (CPEHN)
 California Poison Control System
 California School-Based Health Alliance
 California School Nurses Organization

California State Association of Counties
 California WIC Association
 Cavityfree SF Collaborative
 Children Now
 Children's Defense Fund - California
 Children's Hospital Los Angeles
 CHOC Children's at Mission Hospital
 Coalition for Humane Immigrant Rights
 (CHIRLA)
 Community Health Centers of the Central
 Coast
 Community Health Councils
 Community Resources for Independent
 Living (CRIL)
 County Welfare Directors Association of
 California
 Epilepsy California
 Epilepsy Foundation of Greater Los Angeles
 Family Care Network, Inc.
 First 5 Association of California
 First 5 LA
 First 5 Santa Cruz County
 First 5 Sonoma County
 Give for a Smile
 Hemet Unified School District
 Jewish Family Service of San Diego
 Kids in Common
 Lincoln
 Loma Linda University Children's Hospital
 Lucile Packard Children's Hospital Stanford
 Making Change For Children
 Maternal and Child Health Access
 Miller Children's and Women's Hospital Long
 Beach
 National Association of Pediatric Nurse
 Practitioners -- Orange County, California
 Chapter
 National Association of Pediatric Nurse
 Practitioners -- San Francisco Bay Area
 Chapter
 Orange County United Way
 Partnership for the Children of San Luis
 Obispo County
 PICO California
 Placer Independent Resource Services
 Public Health Advocates
 Rady Children's Hospital - San Diego
 Reach Out

Shriners Hospitals for Children Northern
 California
 Silicon Valley Leadership Group
 The Children's Partnership
 The Los Angeles Trust for Children's Health
 United Way Bay Area
 United Way Fresno Madera Counties
 United Way of Kern County
 United Way of Northern California
 United Way of San Luis Obispo County
 United Way of Stanislaus County
 United Way of Ventura County
 United Ways of California
 UCSF Benioff Children's - Oakland
 Valley Children's Healthcare
 Western Center on Law & Poverty

Colorado

All Kids Covered Colorado
 American Academy of Pediatrics - Colorado
 Chapter
 American Lung Association in Colorado
 Center for Health Progress
 Children's Hospital Colorado
 Colorado Academy of Family Physicians
 Colorado Children's Campaign
 Colorado Consumer Health Initiative
 Colorado Cross-Disability Coalition
 Colorado Dental Association
 Colorado Organization for Latina
 Opportunity and Reproductive Rights
 Epilepsy Foundation of Colorado
 Focus Points Family Resource Center
 Mental Health Colorado
 One Colorado
 Oral Health Colorado
 Posada
 St. Vrain Valley Schools
 The Consortium

Connecticut

American Lung Association in Connecticut
 Connecticut Association for Human Services
 Connecticut Children's Medical Center
 Connecticut Voices for Children
 Greater Hartford Legal Aid
 National Association of Social Workers, CT
 Chapter

Unitarian Society of New Haven
 United Way of Connecticut
 United Way of Western CT
 Yale New Haven Children's Hospital

Delaware

American Lung Association in Delaware
 Delaware Ecumenical Council on Children
 and Families
 Delaware Oral Health Coalition
 Epilepsy Foundation of Delaware
 Medical Society of Delaware
 Nemours Children's Health System

District of Columbia

American Lung Association in District of
 Columbia
 Children's National Health System
 D.C. Hunger Solutions
 La Clínica del Pueblo
 The HSC Health Care System
 United Way of the National Capital Area

Florida

American Lung Association in Florida
 Catalyst Miami
 Democratic Women's Club of Florida
 Epilepsy Foundation of Florida
 Farmworker Association of Florida, Inc
 Florida Association of Children's Hospitals
 Florida Chapter of the American Academy of
 Pediatrics, Inc.
 Florida Dental Association
 Healthy Start Coalition
 Heart of Florida United Way
 Holy Cross Hospital, Inc.
 Immokalee Multicultural Multipurpose
 Community Action Agency
 Johns Hopkins All Children's Hospital
 Oral Health Florida
 Shriners Hospitals for Children – Tampa
 St. Joseph's Children's Hospital of Tampa
 Suncoast Health Council, Inc.
 The Children's Campaign
 United Way of Broward County
 United Way of Florida
 United Way of Miami-Dade
 United Way South Sarasota County

United Way Suncoast
 Voices for Florida
 Wolfson Children's Hospital

Georgia

American Lung Association in Georgia
 Children's Healthcare of Atlanta
 Easterseals Southern Georgia, Inc.
 Georgia Academy of Family Physicians
 Georgia Chapter-American Academy of
 Pediatrics
 Georgia Dental Association
 Georgia Watch
 Georgians for a Healthy Future
 Parent to Parent of Georgia
 St. Vincent de Paul Georgia
 United Way of Greater Atlanta
 United Way of Northeast Georgia
 Voices for Georgia's Children

Hawaii

American Lung Association in Hawaii
 Assistive Technology Resource Centers of
 Hawaii
 Big Brothers Big Sisters Hawaii
 Child & Family Service
 Epilepsy Foundation of Hawaii
 Feeding Hawaii Together
 Habilitat, Inc.
 Hawaii Children's Action Network
 Hawaii Dental Association
 Hawaii Public Health Institute
 Healthy Mothers Healthy Babies Coalition of
 Hawaii
 Ho'ola Na Pua
 Kapi'olani Medical Center for Women &
 Children
 Life Foundation
 Mental Health America of Hawaii
 Parents And Children Together
 People Attentive to Children (PATCH)
 Shriners Hospitals for Children Honolulu
 Susan G. Komen Hawaii

Idaho

American Lung Association in Idaho
 Idaho Chapter of the American Academy of
 Pediatrics

Idaho Oral Health Alliance
 Idaho Parents Unlimited
 Idaho Voices for Children
 SelectHealth
 St. Luke's Health System

Illinois

American Lung Association in Illinois
 Ann & Robert H. Lurie Children's Hospital of Chicago
 Chicago Women's AIDS Project
 Child Care Association of Illinois
 Comer Children's Hospital, University of Chicago Medicine
 Epilepsy Foundation of Greater Chicago
 Epilepsy Foundation of Greater Southern Illinois
 Epilepsy Foundation of North Central Illinois, Iowa, & Nebraska
 Erikson Institute
 Ever Thrive Illinois
 Fox Valley Citizens for Peace & Justice
 Illinois Academy of Family Physicians
 Illinois Chapter, American Academy of Pediatrics
 Illinois Coalition for Immigrant and Refugee Rights
 La Rabida Children's Hospital
 Legal Council for Health Justice
 Ounce of Prevention Fund
 Park Ridge Housing Initiative
 Project IRENE
 Shriners Hospital for Children Chicago
 The Alliance
 United Way of Illinois
 United Way of Lake County
 United Way of Metropolitan Chicago

Indiana

American Lung Association in Indiana
 Cardinal Services, Inc. of Indiana
 Covering Kids and Families of Indiana
 DJ Center for Youth, Inc
 Epilepsy Foundation of Indiana
 Family and Children's Ministries, Disciples Home Missions, Christian Church (Disciples of Christ)
 Family Voices Indiana

Indiana Association of United Ways
 Indiana Chapter of the American Academy of Pediatrics
 Indiana Dental Association
 Indiana Oral Health Coalition
 Indiana Resource Center for Families with Special Needs
 Indiana Small and Rural Schools Association
 Indianapolis Public Schools
 Lake Area United Way
 National Association of Social Workers, Indiana
 Opportunity Enterprises Inc.
 Passages, Inc.
 Prevent Child Abuse Indiana, a Division of The Villages
 Riley Hospital for Children at Indiana University Health
 The Phoenix Institute
 United Way of Madison County, Indiana

Iowa

Access for Special Kids (ASK) Resource Center, Inc.
 American Lung Association in Iowa
 Blank Children's Hospital
 Child and Family Policy Center
 ChildServe
 Congregation of the Humility of Mary, Leadership Team
 Epilepsy Foundation of North Central Illinois, Iowa, & Nebraska
 Iowa Chapter American Academy of Pediatrics
 Iowa Public Health Association
 National Association of Pediatric Nurse Practitioners -- Iowa Chapter
 Prevent Child Abuse Iowa
 United Way of Johnson & Washington Counties
 United Ways of Iowa
 University of Iowa Health Care

Kansas

Achievement Services for Northeast Kansas, Inc.
 American Lung Association in Kansas

Children's Alliance of Kansas
 Community Developmental Disability
 Organization (CDDO) of Butler County
 Community Health Council
 Developmental Services of Jackson County
 Developmental Services of Northwest Kansas
 Doniphan County Services and Workskills
 InterHab
 Junior League of Wichita
 Kansas Academy of Family Physicians
 Kansas Action for Children
 Kansas Chapter, American Academy of
 Pediatrics
 Mosaic
 New Beginnings Enterprises, Inc.
 Oral Health Kansas, Inc.
 Rogers Family Dentistry
 TARC, Inc

Kentucky

American Lung Association in Kentucky
 Bon Secours Kentucky Health System
 Covering Kentucky Kids and Families
 Epilepsy Foundation of Kentuckiana
 Family & Children's Place
 Kentucky Dental Association
 Kentucky Equal Justice Center
 Kentucky Youth Advocates
 Metro United Way
 Norton Healthcare
 Our Lady of Bellefonte Hospital
 Shriners Hospitals for Children - Lexington
 United Way of Greater Cincinnati - Northern
 Kentucky

Louisiana

American Lung Association in Louisiana
 First Christian Church of Greater New
 Orleans
 Health and Education Alliance of Louisiana
 Kingsley House
 Louisiana Association of United Ways
 Louisiana Budget Project
 Louisiana Chapter of the American Academy
 of Pediatrics
 Louisiana Democracy Project
 Louisiana Dental Association

Louisiana Partnership for Children and
 Families
 Shriners Hospitals for Children--Shreveport
 Stone Creek Nursery & Landscapes
 United Way of Northwest Louisiana
 United Way of Southeast Louisiana

Maine

American Lung Association in Maine
 Community Concepts Inc
 Families And Children Together
 Maine Chapter, American Academy of
 Pediatrics
 Maine Children's Alliance
 Maine Public Health Association
 MaineHealth
 The Diaper Fund
 United Way of Greater Portland
 United Way of Mid-Maine
 United Way of the Tri-Valley Area
 United Way of York County Maine

Maryland

Addiction Connections Resource
 Advocates for Children and Youth
 American Lung Association in Maryland
 CASA
 Consumer Health First
 Epilepsy Foundation Chesapeake Region
 Johns Hopkins Children's Center
 Maryland Academy of Family Physicians
 Maryland Center on Economic Policy
 Maryland Chapter, American Academy of
 Pediatrics
 Maryland Dental Action Coalition
 Maryland Family Network
 Maryland Hunger Solutions
 Maryland National Organization for Women
 MD Coalition of Families
 Mt. Washington Pediatric Hospital
 National Association of Pediatric Nurse
 Practitioners -- Maryland Chesapeake
 Chapter
 National Organization for Women,
 Montgomery County, MD, Chapter
 PeterCares House
 Public Justice Center
 Washington County NOW

Massachusetts

American Lung Association in Massachusetts
 Association for Behavioral Healthcare
 Boston Children's Hospital
 Brookline Department of Diversity, Inclusion,
 and Community Relations
 Community Action Committee of Cape Cod
 & Islands
 Epilepsy Foundation New England
 Federation for Children with Special Needs
 Floating Hospital for Children at Tufts
 Medical Center
 Franciscan Children's
 Health Care For All
 Massachusetts Chapter of the American
 Academy of Pediatrics
 Massachusetts Immigrant & Refugee
 Advocacy Coalition
 Massachusetts Law Reform Institute, Inc
 Massachusetts Medical Society
 Massachusetts Organization of Educational
 Collaboratives
 Mercy LIFE
 Shriners Hospitals for Children – Boston
 Shriner's Hospitals for Children - Springfield
 United Way of Franklin County
 United Way of Massachusetts Bay and
 Merrimack Valley
 Watertown Citizens for Peace, Justice and the
 Environment

Michigan

Advocates for Benzie County
 Alcona Citizens for Health, Inc.,
 Allegan County United Way
 American Lung Association in Michigan
 Baldwin Family Health Care
 Capital Area Community Services, Inc., Head
 Start and Early Childhood Programs
 Char-Em United Way
 Cherry Health
 Children's Hospital of Michigan
 Epilepsy Foundation of Michigan
 Great Start Collaborative of Traverse Bay
 Groundcover News
 Kent County Oral Health Coalition
 Leelanau Children's Center
 MI Chapter American Academy of Pediatrics

Michigan Academy of Family Physicians
 Michigan Association of Intermediate School
 Administrators
 Michigan Association of School
 Administrators
 Michigan Association of United Ways
 Michigan Council for Maternal and Child
 Health
 Michigan Dental Association
 Michigan Health & Hospital Association
 Michigan League for Public Policy
 Michigan Oral Health Coalition
 Moveon.org - Michigan
 Munson Healthcare
 Shiawassee United Way
 StarrVista
 The Leelanau Early Childhood Development
 Commission's Parenting Communities
 Program
 TrueNorth Community Services
 United Health Organization
 United Way for Southeastern Michigan
 United Way of Delta County
 United Way of Manistee County
 United Way Montcalm-Ionia Counties
 United Way of Washtenaw County
 University of Michigan, C.S. Mott Children's
 Hospital, Michigan Medicine
 Washtenaw County Public Health
 Washtenaw Health Plan

Minnesota

40outofPoverty
 American Lung Association in Minnesota
 AspireMN
 Children's Defense Fund-Minnesota
 Children's Minnesota
 Gillette Children's Specialty Healthcare
 Greater Friendship Missionary Baptist Church
 Impetus - Let's Get Started LLC
 Minnesota Chapter of the American Academy
 of Pediatrics
 Minnesota Head Start Association, Inc.
 Sherburne County Area United Way
 Shriners Hospitals for Children - Twin Cities
 University of Minnesota Masonic Children's
 Hospital

Mississippi

American Lung Association in Mississippi
 Children's Defense Fund - Southern Region
 Mississippi Chapter, American Academy of
 Pediatrics
 Mississippi Human Services Coalition
 Southern Rural Black Women's Initiative for
 Economic and Social Justice

Missouri

A Red Circle
 Almost Home
 American Lung Association in Missouri
 Behavioral Health Response, Inc.
 Bilingual International Assistant Services
 Capital Area Missouri NOW
 Child Care Aware of Missouri
 Children's Haven of Southwest Missouri, Inc.
 Children's Mercy Kansas City
 Empower Missouri
 Generate Health
 Howell County Health Department
 Judevine Center for Autism
 Kids In The Middle
 LUME Institute
 Lydia's House, Inc.
 Missouri Chapter of the American Academy
 of Pediatrics
 Missouri Children's Leadership Council
 Missouri Coalition for Oral Health
 Missouri Coalition of Children's Agencies
 Missouri Developmental Disabilities Council
 Missouri Health Care for All
 Missouri Hospital Association
 Missouri KIDS COUNT
 Missouri Kids First
 Missouri Parents as Teachers Association
 NAMI St. Louis
 No Kid Hungry Missouri
 Nurses for Newborns
 Places for People, Inc.
 Presbyterian Children's Homes and Services
 Provident, Inc.
 Safe Connections
 Saint Louis University Department of
 Pediatrics
 Saint Vincent Home for Children
 Shriners Hospitals for Children - St. Louis

SSM Health Cardinal Glennon Children's
 Hospital
 St. Louis Center for Family Development
 St. Louis Children's Hospital
 St. Louis County Children's Service Fund
 St. Martha's Hall
 The Family and Community Trust
 United 4 Children
 Vision for Children at Risk

Montana

American Lung Association in Montana
 Montana Academy of Family Physicians
 Montana Chapter of the American Academy
 of Pediatrics
 Montana Dental Association
 Montana Small Schools Alliance
 Rocky Mountain Hemophilia & Bleeding
 Disorders Association
 Western Native Voice

Nebraska

American Lung Association in Nebraska
 Children's Hospital and Medical Center
 Epilepsy Foundation Foundation of North
 Central Illinois, Iowa, & Nebraska
 Nebraska Appleseed
 Nebraska Foster and Adoptive Parent
 Association
 Sisters of Mercy West Midwest Justice Team
 Voices for Children in Nebraska

Nevada

Acting in Community Together Organizing
 Northern Nevada (ACTIONN)
 American Academy of Pediatrics, Nevada
 Chapter
 American Lung Association in Nevada
 Children's Advocacy Alliance
 Epilepsy Foundation of Nevada
 Immunize Nevada
 Family TIES of Nevada
 Nevada Primary Care Association
 Positively Kids
 Service Employees International Union
 Nevada Local 1107 (SEIU)

New Hampshire

American Lung Association in New Hampshire
 Children's Hospital at Dartmouth-Hitchcock
 Granite State Diabetes Educators, Inc.

New Jersey

Advocates for Children of New Jersey
 American Lung Association in New Jersey
 Caregivers of New Jersey
 Children's Specialized Hospital
 Coalition of Mental Health Consumer Organizations
 Coastal Habitat for Humanity
 Epilepsy Foundation of New Jersey
 Family Voices New Jersey
 Hackensack Meridian Health
 Jewish Federation of Ocean County
 K. Hovnanian Children's Hospital
 Lunch Break
 New Jersey Association of Mental Health and Addiction Agencies, Inc.
 New Jersey Chapter, American Academy of Pediatrics
 New Jersey Citizen Action
 New Jersey Tenants Organization
 Northern New Jersey Chapter, National Organization for Women
 Ocean County YMCA, Inc.
 RESULTS Central New Jersey
 Rutgers Center on Law, Inequality and Metropolitan Equity
 St. Francis Center, LBICC, Inc.
 Statewide Parent Advocacy Network
 The Children's Home Society of New Jersey
 The Hope Center at The House of Hope of Ocean County, Inc.
 Union County Peace Council
 United Way of Central Jersey
 United Way of Greater Philadelphia and Southern New Jersey
 United Way of Hunterdon County
 United Way of Monmouth and Ocean Counties
 United Way of Northern New Jersey
 United Way of Passaic County

New Mexico

All Faiths Children's Advocacy Center
 American Lung Association in New Mexico
 Community Action Agency of Southern New Mexico
 Health Action New Mexico
 High Plains Regional Education Cooperative
 Interfaith Worker Justice - New Mexico
 National Association of Social Workers - New Mexico
 New Mexico Academy of Family Physicians
 New Mexico Pediatric Society
 New Mexico Voices for Children
 RESULTS Santa Fe

New York

Acacia Network
 African Services Committee
 Albany Behavioral Health Services
 American Academy of Pediatrics, New York State
 American Lung Association in New York
 Association of Perinatal Networks
 Blythedale Children's Hospital
 Brooklyn Center for Independence of the Disabled
 Buffalo Prenatal Perinatal Network
 Catholic Charities of Chemung/Schuyler Counties, NY
 Center for Independence of the Disabled, NY
 Center for Research on Physical Activity, Sport & Health at D'Youville College
 Child Care Council, Inc.
 Child Care Resources of Rockland, Inc.
 Children's Defense Fund--New York
 Citizens' Committee for Children of New York, Inc.
 Claire Heureuse Community Center, Inc
 Community Resource Exchange
 Community Service Center of Greater Williamsburg
 Concerned Citizens For Change
 Dental Hygienists' Association of the State of New York
 Early Childhood Development Initiative
 Elmcot Youth and Adult Activities
 Empire Justice Center
 EPIC Long Island, Inc.

Epilepsy Foundation of Metropolitan New York
 Every Child Matters Coalition
 Families Together in New York State
 Family & Children's Service of Niagara
 Federation of Protestant Welfare Agencies
 Greater New York Labor Religion Coalition
 Health and Welfare Council of Long Island
 Health Care For All New York
 Independence
 Make The Road New York
 Metro New York Health Care for All
 Mohawk Valley Perinatal Network
 Mothers & Babies Perinatal Network of SCNY, Inc
 Mount Sinai Kravis Children's Hospital
 National Association of Pediatric Nurse Practitioners -- E-Chapter
 National Association of Pediatric Nurse Practitioners -- Greater New York Chapter
 New York Immigration Coalition
 New York Legal Assistance Group
 New York -- Presbyterian
 New York State Coalition for Children's Behavioral Health
 New York State Council for Community Behavioral Healthcare
 New Yorkers for Accessible Health Coverage
 North Country Prenatal Perinatal Council, Inc
 OneGroup-Benefits Advisory Service
 Oxford Family Group Day Care
 Prevent Child Abuse New York
 Quality Consortium
 Recovery Coaching Services of NY
 Rochester Childfirst Network
 Rockland Immigration Coalition
 Rural Schools Association of New York State
 Schenectady Inner City Ministry
 Schuyler Center for Analysis and Advocacy
 The Alcoholism and Substance Abuse Providers of New York State (ASAP)
 The Children's Agenda
 United Way of Buffalo & Erie County
 United Way of the Southern Tier, Inc.
 Violence Intervention Program
 Vocal Voters of Rockland
 West Side Campaign Against Hunger
 Westchester Children's Association

YWCA of the Greater Capital Region

North Carolina

American Lung Association in North Carolina
 Epilepsy Foundation of North Carolina
 Goldsboro Pediatrics, PA
 Jewish Family Services of Greater Charlotte
 Legal Services of Southern Piedmont
 National Association of Pediatric Nurse Practitioners - Charlotte, North Carolina Chapter
 National Association of Social Workers, North Carolina Chapter
 NC Child
 North Carolina Justice Center
 The National Alliance on Mental Illness North Carolina
 United Way of Moore County
 United Way of North Carolina
 Wayne Initiative for School Health
 Working America North Carolina

North Dakota

American Lung Association in North Dakota
 North Dakota Dental Association
 United Way of Grand Forks, East Grand Forks & Area

Ohio

Achievement Centers for Children
 Akron Children's Hospital
 American Lung Association in Ohio
 American Sickle Cell Anemia Association
 Art House, Inc.
 Asian American Community Services
 Asian Services In Action
 Center for Closing the Health Gap
 Children's Defense Fund-Ohio
 Cincinnati Children's Hospital Medical Center
 Cleveland Clinic Children's
 Cleveland Tenants Organization
 Community Assisted Restoration Services
 Community of Faith
 Contact Center
 Dayton Children's Hospital
 Family Connections of Northeast Ohio
 Family Promise of Greater Cleveland
 First Presbyterian Church

Friendly Inn Settlement, Inc
 Grace United Church of Christ
 Juvenile Justice Coalition (Ohio)
 Kings Local Food Pantry
 Lutheran Metropolitan Ministry
 Meigs County Health Department
 National Association of Pediatric Nurse
 Practitioners -- Ohio Chapter
 Nationwide Children's Hospital
 Needy Basket of Southern Miami County, Inc.
 Ohio Academy of Family Physicians
 Ohio Association of Community Health
 Centers
 Ohio Chapter, American Academy of
 Pediatrics
 Ohio Children's Hospital Association
 Ohio Family Care Association
 Ohio United Way
 Pathways of Central Ohio
 Positive Education Program
 ProgressOhio
 ProMedica Toledo Children's Hospital
 Providence House, Inc. - Crisis Nursery
 Rainey Institute
 Results Columbus
 Schubert Center for Child Studies
 SEM Food Pantry
 Shriners Hospital for Children Cincinnati
 Sisters of Charity of St. Augustine
 Society of St Vincent De Paul, Diocesan
 Council of Columbus
 Somali Community Association of Ohio
 South Community Inc.
 Talbert House
 The Achievement Centers for Children
 The Ohio Council of Behavioral Health &
 Family Services Providers
 United Way of Central Ohio
 United Way of Greater Cincinnati
 United Way of Greater Cleveland
 United Way of Greater Stark County
 United Way of Hocking County
 United Way of Summit County
 Universal Health Care Action Network of
 Ohio
 University Hospitals Rainbow Babies &
 Children's Hospital
 Valley Voices United for Change

Voices for Ohio's Children
 West Side Catholic Center
 Westland Ecumenical Community Food
 Pantry

Oklahoma

American Lung Association in Oklahoma
 Epilepsy Foundation of Oklahoma
 Oklahoma Chapter of the American Academy
 of Pediatrics
 Oklahoma Dental Association
 United Way of Central Oklahoma

Oregon

American Lung Association in Oregon
 Children First for Oregon
 Children's Institute
 National Association of Pediatric Nurse
 Practitioners -- Oregon Chapter
 Oregon Pediatric Society
 Oregon Poison Center
 The Family Place Therapeutic Services Inc.
 United Way of Columbia County

Pennsylvania

AIDS Resource
 All About Children Pediatric Partners, PC
 Allies for Children
 Amarcord
 American Lung Association in Pennsylvania
 Bhutanese Community Association of
 Pittsburgh
 Bucks County Medical Society
 Bucks County Women's Advocacy Coalition
 Catholic Social Services
 Centre County United Way
 Centro Nueva Creación
 Children's Hospital of Philadelphia
 Children's Hospital of Pittsburgh of UPMC
 Clinton County Housing Coalition
 Coalition of African Communities
 Community Action Partnership
 Consumer Health Coalition
 Epic Health Services
 Epilepsy Foundation Eastern PA
 Epilepsy Foundation Western/Central
 Pennsylvania
 Family Promise of Harrisburg Capital Region

Family Service Association of Bucks County
 Family Services of Western Pennsylvania
 GRANDS AS PARENTS INC
 Health Care Access
 HIAS Pennsylvania
 Keystone Progress
 Maternity Care Coalition
 Mental Health Association in PA
 Mental Health Association of Southeastern
 PA
 Montgomery County Community Action
 Development Commission
 National Association of Pediatric Nurse
 Practitioners - Pennsylvania-Delaware Valley
 Chapter
 New Start Medical
 Pediatric Dental Associates, LTD
 Pediatric Palliative Care Coalition
 Penn State Health Children's Hospital
 Pennsylvania Association of Community
 Health Centers
 Pennsylvania Association of School Nurses
 and Practitioners
 Pennsylvania Catholic Health Association
 Pennsylvania Chapter of the American
 Academy of Pediatrics
 Pennsylvania Coalition for Oral Health
 Pennsylvania Council of Churches
 Pennsylvania Dental Association
 Pennsylvania Health Access Network
 Pennsylvania Health Funders Collaborative
 Pennsylvania Health Law Project
 Pennsylvania Partnerships for Children
 Pittsburgh Association for the Education of
 Young Children (PAEYC)
 Public Citizens for Children and Youth
 Reclaim Philadelphia
 Shriners Hospitals for Children – Erie
 Shriners Hospitals for Children – Philadelphia
 Sickle Cell Disease Association of America,
 Philadelphia/Delaware Valley Chapter
 Southeastern Pennsylvania Oral Surgery
 Special Smiles, LTD
 Survivors, Inc.
 The Sisters of St. Francis of Philadelphia
 Unitarian Universalist Pennsylvania
 Legislative Advocacy Network
 United Methodist Advocacy in Pennsylvania

United Way of Adams County
 United Way of Beaver County
 United Way of Butler County
 United Way of Chester County
 United Way of Greater Hazleton
 United Way of Greater Philadelphia and
 Southern New Jersey
 United Way of Monroe County
 United Way of Susquehanna County
 United Way of the Titusville Region
 United Way of Western Crawford County
 United Way of Wyoming Valley
 United Way of York County, PA
 West Chester Food Cupboard
 Western Pennsylvania Diaper Bank
 Women's Law Project
 YWCA Greater Pittsburgh

Puerto Rico

Colegio de Cirujanos Dentistas de Puerto Rico

Rhode Island

Adoption Rhode Island
 American Lung Association in Rhode Island
 Rhode Island KIDS COUNT

South Carolina

Access Family Services
 American Lung Association in South Carolina
 Bible Way Community Learning Center
 Black River United Way
 Children's Hospital Greenville Health System
 Medical University of South Carolina
 Children's Hospital
 National Association of Pediatric Nurse
 Practitioners -- South Carolina Chapter
 Palmetto Association for Children and
 Families
 Palmetto Project
 SC Appleseed Legal Justice Center
 SC Dental Association
 Shriners Hospitals for Children - Greenville
 South Carolina Chapter of the American
 Academy of Pediatrics
 South Carolina Children's Hospital
 Collaborative
 Southern Georgetown Leadership Group

Still Learning, Inc
 United Way Association of South Carolina
 United Way of Aiken County
 United Way of Greenville County
 United Way of Hartsville SC
 United Way of Pickens County
 United Way of the Midlands
 Youth Collaboratives of Georgetown County

South Dakota

American Lung Association in South Dakota
 National Association of Social Workers,
 South Dakota Chapter
 South Dakota Chapter American Academy of
 Pediatrics

Tennessee

American Lung Association in Tennessee
 Black Children's Institute of Tennessee
 Children's Hospital Alliance of Tennessee
 East Tennessee Children's Hospital
 Epilepsy Foundation of East Tennessee
 Le Bonheur Children's Hospital
 Mental Health America of Middle Tennessee
 Monroe Carell Jr. Children's Hospital at
 Vanderbilt
 Niswonger Children's Hospital
 Tennessee Academy of Family Physicians
 Tennessee Chapter of the American Academy
 of Pediatrics
 Tennessee Justice Center
 United Ways of Tennessee

Texas

American Lung Association in Texas
 Bread Fellowship
 Children's Defense Fund - Texas
 Children's Health System of Texas
 Children's Hospital Association of Texas
 Children's Hospital of San Antonio
 Clarity Child Guidance Center
 Coalition of Texans with Disabilities
 Cook Children's Health Care System
 Dell Children's Medical Center of Central
 Texas
 Driscoll Children's Hospital
 Epilepsy Foundation Central & South Texas

Epilepsy Foundation Texas -
 Houston/Dallas-Fort Worth/West Texas
 Get Up Project
 Healthy Futures of Texas
 Houston Women March
 Insure-A-kid
 Mental Health America of Greater Houston
 Methodist Healthcare Ministries of South
 Texas, Inc.
 National Association of Pediatric Nurse
 Practitioners -- Austin, Texas Chapter
 National Association of Pediatric Nurse
 Practitioners -- Greater Texas Chapter
 National Association of Social Workers -
 Texas Chapter
 PediPlace
 Shriners Hospitals for Children Galveston
 Shriners Hospitals for Children - Houston
 Teaching Hospitals of Texas
 Texans Care for Children
 Texas Academy of Pediatric Dentistry
 Texas Association of Charitable Clinics
 Texas Association of Community Health
 Centers
 Texas Children's Hospital
 Texas Dental Association
 Texas Doctors for Social Responsibility
 Texas Foster Family Association
 Texas Kids Can't Wait
 Texas Medical Association
 Texas Pediatric Society - Texas Chapter of the
 American Academy of Pediatrics
 Texas Rural Education Association
 Texas Scottish Rite Hospital for Children
 Trinity Lutheran Church
 Unitarian Universalist Fellowship of Hidalgo
 County
 United Way of Brazoria County
 United Way of Central Texas
 United Way of Greater Houston
 United Way of Metropolitan Dallas
 United Way of Tarrant County
 United Way of the Coastal Bend
 United Ways of Texas
 Voices for Children of San Antonio

Utah

American Lung Association in Utah

Disabled Rights Action Committee
 Epilepsy Foundation of Utah
 Intermountain Healthcare
 Primary Children's Hospital
 SelectHealth
 Shriners Hospital - Salt Lake City
 United Way of Cache Valley
 United Way of Northern Utah
 United Way of Salt Lake
 Utah Health Policy Project
 Voices for Utah Children

Vermont

Addison County Community Trust
 Addison County Transit Resources
 American Academy of Pediatrics Vermont Chapter
 American Lung Association in Vermont
 Disability Rights Vermont
 Epilepsy Foundation of Vermont
 Green Mountain United Way
 Mary Johnson Children's Center
 United Way of Addison County
 United Way of Lamoille County
 United Way of Windham County
 United Ways of Vermont/Vermont 211
 Vermont Adult Learning
 Vermont Coalition for Disability Rights
 Vermont Family Network
 Vermont Federation of Families for Children's Mental Health

Virginia

American Lung Association in Virginia
 Blue Ridge Independent Living Center
 Children's Hospital of Richmond at Virginia Commonwealth University
 Cornerstones, Inc.
 Department of Community and Human Services, City of Alexandria
 Epilepsy Foundation of Virginia
 Inova Children's Hospital
 Jackson-Feild Behavioral Health Services
 Prevent Child Abuse Virginia
 Rappahannock United Way
 Social Action Linking Together (SALT)
 United Way of the National Capital Area

Virginia Chapter, American Academy of Pediatrics
 Virginia Coalition of Latino Organizations
 Virginia Oral Health Coalition
 Virginia Parents as Teachers State Office-CHIP of Virginia
 Virginia Society of Pediatric Dentistry
 Voices for Virginia's Children

Washington

American Lung Association in Washington
 Anti-Hunger & Nutrition Coalition
 Children's Alliance
 Community Health Network of Washington
 Community Health Plan of Washington
 Conscious Talk Radio
 Epilepsy Foundation Northwest
 Hope Sparks
 Muslim County Resource Center - Islamic Civic Engagement
 National Association of Pediatric Nurse Practitioners
 North Mason Coalition of Churches & Community
 Northwest Harvest
 Northwest Health Law Advocates
 Ocean Beach Hospital and Medical Clinics
 OneAmerica
 Partners for Our Children
 Sea Mar Community Health Center
 Seattle Children's Hospital
 Shriners Hospitals for Children - Spokane
 Triumph Treatment Services
 United Way of Island County
 United Way of Snohomish County
 Washington Academy of Family Physicians
 Washington Association of Community & Migrant Health Centers
 Washington Chapter of the American Academy of Pediatrics
 Washington Community Action Network
 Washington Dental Service Foundation
 Washington Healthcare Access Alliance
 Washington Rural Health Association
 Washington State Labor Council, AFL-CIO

West Virginia

American Lung Association in West Virginia

Hoops Family Children's Hospital at Cabell
 Huntington Hospital
 TEAM for West Virginia Children
 West Virginia Chapter, American Academy of
 Pediatrics
 West Virginia Dental Association
 West Virginia Oral Health Coalition
 West Virginians for Affordable Health Care

Wisconsin

American Lung Association in Wisconsin
 Children's Hospital of Wisconsin
 Community Advocates, Inc.
 End Domestic Abuse WI
 Epilepsy Foundation Heart of Wisconsin
 Epilepsy Foundation of Western Wisconsin
 Great Rivers United Way
 Marshfield Clinic Health System
 Marshfield Community Development
 Authority
 Mental Health America of WI
 National Association of Social Workers-
 Wisconsin Chapter
 United Way of Sheboygan County
 United Way of Wisconsin
 Wisconsin Alliance for Women's Health
 Wisconsin Chapter of the American Academy
 of Pediatrics
 Wisconsin Council on Children and Families
 Wisconsin Faith Voices for Justice
 Wisconsin Family Ties, Inc.
 Wisconsin Oral Health Coalition
 Wisconsin Rural Schools Alliance

Wyoming

American Lung Association in Wyoming
 UPLIFT
 Wyoming Dental Association

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 225-2927
Minority (202) 225-3641

July 7, 2017

Mr. Michael Holmes
CEO
Scenic Rivers Health Services
20 5th Street, S.E.
Cook, MN 55723

Dear Mr. Holmes:

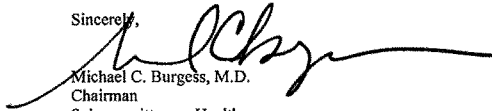
Thank you for appearing before the Subcommittee on Health on June 23, 2017, to testify at the hearing entitled "Examining the Extension of Safety Net Health Programs."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on July 21, 2017. Your responses should be mailed to Jay Gulshen, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to jay.gulshen@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment



Cook Area Health Services, Inc.

☐ 135 Pine Tree Dr.
PO Box 135
Bigfork, MN 56628
Ph: 218-743-3232
Fx: 218-743-4223

July 20, 2017

☐ 410 Second St. NW
PO Box 218
Big Falls, MN 56627
Ph: 218-276-2403
Fx: 218-276-2456

Michael C. Burgess, MD
Chairman
Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

☒ 20 Fifth St. SE
Cook, MN 55723
Fx: 218-666-5099
MEDICAL
Ph: 218-666-5941
DENTAL
Ph: 218-666-5958

RE: Hearing Entitled "Examining the Extension of Safety net Health Programs"

Dear Chairman Burgess:

MEDICAL
☐ 126 W Seventh Ave.
PO Box 426
Floodwood, MN 55736
Ph: 218-476-2221
Fx: 218-476-2965

Thank you for the opportunity to deliver testimony before the Subcommittee on Health on June 23, 2017.

In response to your letter dated July 7, 2017 and pursuant to the Rules of the Committee on Energy and Commerce, I am providing responses to the additional questions from the Members.

DENTAL
☐ 601 Hwy 73
PO Box 46
Floodwood, MN 55736
Ph: 218-476-2969
Fx: 218-476-1599

Please contact me if you require additional information.

Sincerely,

Michael A. Holmes
CEO

☐ 12052 Main St.
PO Box 66
Northome, MN 56661
Ph: 218-897-5222
Fx: 218-897-5226

Cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Questions for the Record – Michael Holmes

The Honorable Michael C. Burgess

- 1. The Community Health Center Program's annual funding has more than tripled between FY2002 and FY2016, largely due to increases in the Community Health Center Fund. The grants have been used for broad purposes, and the types of grant-supported program activities have expanded and changed over time. Since the establishment of the Community Health Center Fund in 2011, in general, how have these grant funds been used? How have new investments changed over time?**

The Community Health Center Fund has been essential in helping health centers meet the health needs for over 25 million individuals and expand the range of services provided at community health centers. Specifically, the funding provided through the Community Health Center Fund has gone toward 1,110 new access points (new facilities where individuals can access care); 1,138 awards to community health centers to make capital improvements, facility upgrades, and site expansions; and also allowed all community health centers to offer expanded services like dental, behavioral health, substance abuse or mental health services that weren't offered as widely before the creation of the Community Health Center Fund. Finally, the grants provided via the Community Health Center Fund have helped health centers around the nation lower the cost of delivering care and drive innovation through delivery system reform, quality improvement and health information technology (HIT) utilization. In short, the grants provided via the Community Health Center Fund help health centers expand access, lower cost, and improve the quality of health care delivered at CHCs. Over time, this focus has broadened from capital and new access point awards, to incorporate more investments in expanded services, quality and health IT.

- 2. In rural communities like the ones I represent, Federally Qualified Health Centers are a critical piece of the delivery system, and so are Critical Access Hospitals. How do you partner with the Critical Access Hospitals in your area, and is there more potential for better collaboration between the two nationwide?**

Our health center was started with assistance from a small hospital long before the critical access hospital designation. Our first new access point expansion was added with collaboration of another critical access hospital. Today, our physicians staff the emergency rooms under agreements with two hospitals. Our patients use the hospital's laboratory & imaging services. The hospitals also operate labs in three of our other clinic sites. The Bigfork Valley Hospital retail pharmacy is our 340B contract pharmacy. The hospitals participate in physician recruitment with us and share in the cost of recruitment incentives for new physicians. One of the hospitals built a new clinic for us in their facility and we are leasing it at market rate. They are currently expanding that space to add more exam rooms for our two new physicians joining us this fall. There is always potential for new partnerships between health centers and critical access hospitals. We have always taken the approach of doing what's best for our patients and what is the best way to deliver care in their areas. Our patients are hospital patients and hospital patients are our patients. As the healthcare delivery system changes there will be new partnership opportunities with the development of accountable care organizations and whatever the future of health care reform may bring.

3. **In Texas, Federally Qualified Health Centers serve a large proportion of both the Medicaid and the CHIP populations. Can you give any specific examples of productive collaboration between the CHIP/Medicaid program and health centers?**

While I am sure there are many examples of this kind of collaboration across the country, we are not currently engaged in any specific effort at my health center that I can highlight for you at this time. Nationally, health centers are deeply involved with state Medicaid programs in many states as they collaboratively explore payment and delivery system reform efforts. A 2015 article in Health Affairs highlighted the increasing involvement of CHCs in safety net Accountable Care Organizations (ACOs), which are increasingly involved in Medicaid reform.

4. **You say in your testimony that health centers were a critical part of the response to public health threats like the Zika virus and the Flint water crisis. What role did community health centers play in responding to these crises and how was their response unique compared to other safety-net providers?**

Health centers are trusted community partners and serve as the source of primary and preventive care for over 25 million individuals throughout the nation, including some of the most vulnerable individuals and families. As such, they are often serving on the front lines during public health crises, providing needed and timely education, outreach, and access to care in their communities. Last year, Congress recognized the important role of health centers in responding to the Zika virus by providing \$40 million to health centers in Puerto Rico, American Samoa and the U.S. Virgin Islands to expand the availability of preventive and primary health care services to meet the immediate and anticipated Zika-related needs in these territories. These resources enabled health centers to expand their response efforts to continue providing high quality services, including outreach, education, and screening for underserved populations. In addition, earlier in the year, HHS made similar investments in health centers in Puerto Rico through \$5 million in funding alongside a similar investment of \$742,000 for health centers in American Samoa and the U.S. Virgin Islands.

During the Flint water crisis, two health centers in Flint each received \$250,000 from HHS to hire additional personnel and provide more lead testing, treatment, outreach, and education to meet the increased health needs of the people of Flint and the surrounding communities. This funding complimented and enhanced ongoing efforts by health centers to meet community needs around lead blood level testing, assistance obtaining bottled water, emotional support and tracking of blood levels of all children under age 6 who receive services at the health centers.

5. **One of the issues the Committee must consider is whether to retain the ACA's enhanced matching rate for CHIP. In MACRA, House Republicans agreed to the enhanced match as part of SGR repeal. Now CBO is telling us that spending money on CHIP over the next couple of years won't increase the number of children with health insurance. In fact, if we extend the program for two years with the enhanced match compared to without the enhanced match, we would be spending \$8 billion – and are not projected to increase the rate of children with insurance. So I would like to know – wouldn't you and other health centers prefer we use some of this money to extend health center funding, vs. just buy out state contributions?**

CHIP is an important source of coverage for children and families and I would not advocate for any policy that might undermine the program. Health centers are certainly facing a devastating funding cliff if Congress does not act by September 30, 2017, as is the CHIP program. I see these as complimentary but separate programs, each of which have longstanding bipartisan support and proven track records in improving access to quality healthcare. Both are worthy of Congress's continued investment.

6. Can you describe the patient population that typically seeks care at a community health center? How do these patients differ from other safety net providers?

Health center patients are among the nation's most vulnerable populations – people who even when insured, nonetheless remain isolated from traditional forms of medical care because of where they live, who they are, the language they speak, and their higher levels of complex health care needs. As a result, patients are disproportionately low income, uninsured or publicly insured, and minority.

By statute, all health centers are located in medically underserved areas or serve a medically underserved population as designated by HHS. Of the 25 million patients served at health centers nationwide, 7.6 million are children and over 300,000 are veterans. Over 70% of health center patients have incomes below 100% of the Federal Poverty Level (FPL) and if these individuals are uninsured they are charged no more than a nominal fee to access the full range of services provided by the health center. An additional 21% of health center patients have incomes between 101% - 200% FPL, and these individuals are charged base on a sliding fee scale. Nationally, health centers serve 1 in 3 people below the FPL, 1 in 5 uninsured persons and 1 in 6 Medicaid beneficiaries.. In order to serve the diverse needs of health center patients, health centers work in close collaboration with other safety net providers who provide needed specialty and other health care services for their patients.

7. Health centers serve nearly 8 million children - about one-third of patients of all patients seen. However, CHIP only represented about 1% of health centers' revenue for FY 2016. Is that because these children are enrolled in Medicaid?

According to the 2015 Uniform Data System (UDS) report (the most recent data publicly available at this time), the vast majority of children seen by health centers in 2015 were covered by Medicaid. Of the roughly 7.6 million children (0-17 years old) seen that year, 5.6 million were covered by Medicaid, including 146,000 CHIP enrollees who were folded in to their state's Medicaid program. Another 996,000 were uninsured and 870,000 were privately insured. Roughly 244,000 children on CHIP were seen by health centers during this time, making it an important source of coverage for families, but nowhere near as large a coverage source for health center patients as Medicaid. Additional information on the can be found at <https://bphc.hrsa.gov/uds/datacenter.aspx>

8. I understand that some 70% of Federally Qualified Health Centers are now certified as Patient-Centered Medical Homes. Can you speak to the importance of that designation, and overall to quality improvement efforts at your health center?

The PCMH designation provides a framework and numerous metrics by which a CHC (or other primary care provider) can benchmark its progress toward a unified goal of offering responsive, patient-centered and comprehensive care.

Several organizations, such as the National Committee for Quality Assurance (NCQA), the Joint Commission (TJC), and the Accreditation Association for Ambulatory Health Care (AAAHC), have taken the PCMH principles and operationally defined PCMH to support current implementation within primary healthcare systems. Some states have also developed their own PCMH programs (e.g., Minnesota, Oregon). Primary healthcare systems, including health centers, are utilizing these programs to formally demonstrate they are PCMHs to various stakeholders in the healthcare marketplace.

At our health center we have a robust quality improvement program. Our goal is to provide quality and compassionate care for every patient at every visit. We monitor and evaluate the quality and appropriateness of patient care. Our medical and dental providers, along with our Board of Directors, have instrumental roles in identifying specific goals for evaluation and analysis. Our goals are reviewed in terms of opportunity, potential for impact on patient outcomes and the ability to be specific, measurable, achievable, realistic and time framed. We believe in continuous quality improvement. We score our measures quarterly and compare our results over time. Not only do we evaluate our organization as a whole, but we evaluate each delivery site and each provider. Our current quality measures include ones for optimum diabetic care, optimum cardiovascular care, asthma care, opioid prescribing reduction, immunization rates and preventive disease management. In addition, we compare our results to other medical practices in Minnesota through Minnesota Community Measures. Through these processes we believe that we can deliver better care and improve the health of our patients.

9. **FQHCs are critical to Florida's safety net. During my tenure in Congress, I've helped raise awareness of their national importance and educated constituents on the services offered by community health centers in my district. Data from the last year on record, 2015, shows Florida has the 3rd largest network of community health centers serving 1.3 million Floridians over nearly 5 million visits each year. What is the average cost of care per patient versus other comparable provider settings? What is the national network size of community health centers? What is the scope of services provided?**

While it's difficult to make an apples-to-apples comparison of community health centers and other providers due to differences in patient mix, a recent study published in the American Journal of Public Health in 2016 found that community health center patients who are Medicaid enrollees have 24% lower health care spending compared to those treated at other primary care settings. This is a testament to the diligent work of practitioners at roughly 1,400 health center organizations at nearly 10,000 sites nationwide. It is not only primary care medical services that help attain these results, but also services in dental, behavioral health, substance abuse, pharmacy, vision care, nutrition, health education and obesity prevention. In total, these practitioners provide care for over 25 million patients.

10. **Can you speak to the quality and continuity of care received in community health centers? How does this compare with other care settings? Can you speak to the importance of having patient/consumer representation on each health center's board of directors? How does your**

board work in concert with the leadership and medical staff to ensure the health center is addressing the most pressing community needs?

Our health center physicians, physician assistants, nurse practitioners and dentists are the only providers in our communities. We see our patients not only in the clinic, but also in the emergency room, nursing home and hospital. We provide care to the entire community because there is no one else. When we refer patients for specialty care those patients come back to us. Our quality improvement plan contains clinical performance measures on diabetic, cardiovascular and asthma care along with depression screening targets and other measures. We not only track changes in our performance quarterly but we also compare ourselves to other community health centers. The State of Minnesota has mandatory clinical performance reporting and we compare our performance with all of the other medical practices in the state. Even though we serve a remote rural patient population with health disparities, we believe that our clinical performance is comparable to other group practices.

With a service area of 8300 square miles, it is extremely important for us to have community/consumer/patient involvement in what we do. We now have six medical clinics and four dental clinics. Each clinic has been added in response to consumer/patient needs brought to us by our board members. We just opened a new dental clinic in Bigfork, MN. One of the community's dentists closed his practice and left the area. The other announced his retirement. The community was very concerned about losing all access to dental care so they asked our Bigfork board members if we could help. Our board decided to add a new dental clinic for the community even though there were no additional federal resources. They helped the community secure a foundation grant to replace old & failing dental equipment. We this support we opened this clinic on July 3, 2017. Consumer input is extremely helpful in assessing and addressing community needs and to also provide a feedback mechanism to the community when some services are not viable.

- 11. As Vice-Chairman of the Committee on Veterans Affairs in addition to my role on this committee, I understand that Health Centers already provide quality care to more than 300,000 veterans across the country and are an important source of care for veterans in rural areas who may not be able to easily access a VA facility. Can you share with the Committee some of the ways in which health centers are working with the VA to address the health care needs of our nation's veterans? What more can be done to improve veteran's access to care at health centers?**

In our community health center sites, all of our physicians, dentists, nurse practitioners and physician assistants are enrolled providers in the Veterans Choice program. Last year more, than 800 of our 12,000 patients identified themselves as veterans and we have a veteran on our Board of Directors. We are strong believers in improving access to care for our veteran patients.

Nationally, health centers serve approximately 305,000 veterans. In 2015, nearly 9 in 10 health centers served veteran patients and offered a wide range of serves including dental, mental health, substance abuse, and enabling services.

Health centers work closely with the VA as part of the Veterans Choice Program. Notably, Federally Qualified Health Centers (FQHCs) are the only type of health care provider which is specifically named in the Veterans Choice Program statute as eligible to care for participating veterans (See Section 101(a)(1)(B)(ii)). This special attention suggests that Congress intended for FQHCs to play a

central role in assisting the VA to implement the program successfully. And health centers take this role seriously given that they may often be located in communities with many low-income veterans, but with few or no other care providers.

I also want to highlight that the Senate FY18 Milcon-VA Appropriations Subcommittee report included language to direct the VA to submit a report to both Houses of Congress regarding the role FQHCs play in providing veterans care through the Veterans Choice program and outlining opportunities for further collaboration. This again signals the important role of health centers in caring for our nation's veterans now and for the future.

- 12. I understand that according to the Public Health Service Act (PHSA) section 330 requires that a health center be located in an area designated as medically underserved or as serving a population designated as "Medically Underserved," however in Oklahoma we are still lacking providers and care, while other cities seem to have a large number of community health centers. Do you believe that HRSA is doing a good job at awarding the community health center grants according to need?**

I believe that HRSA is doing the best job that they can in awarding community health center grants according to need. It has been my experience over the past 38 years that there has been approximately a 50/50 rural/urban split in grant funding. Depending on funding opportunities and the directions by Congress, the statute allows for up to 60/40 rural/urban or up to 60/40 urban/rural. The Medically Underserved Designation is based upon the Population/Primary Care Physician Ratio, Percentage of Population with Incomes Less than 100% of Poverty, Percentage of Population Over the Age of 65 and the Infant Mortality Rate. I believe that this Medically Underserved Designation does not favor either urban or rural areas. There are 17,000 Health Professional Shortage Areas and over 4200 Medically Underserved Areas in the United States. I strongly believe that we still need more Community Health Centers to serve these shortage areas and populations.

- 13. Community Health Centers have seen a large uptick in funding since FY2011, especially in mandatory funding. In your opinion, how have health centers used this increase in funds?**

Congress' support for the Community Health Center Fund, which received a broad and bipartisan extension via MACRA in 2015, has allowed health centers across the country to expand the breadth of services they offer, upgrade and expand their facilities, hire additional practitioners, and open up additional sites to offer care to individuals in need. Due to the grants provided via the Community Health Center Fund, not only have millions of additional patients gained access to care, but patients at health centers around the nation are now able to access a broader range of services, including behavioral health and substance abuse treatment, dental and vision care, and nutrition education and obesity prevention. In 2016, over 1,300 health centers used grants from the Community Health Center Fund to invest in quality improvements, health information technology (HIT), and delivery system reforms that will help drive down the cost of delivering care and improve patient experiences at health centers.

- 14. What are some of the services that Community Health Centers provide that aren't covered under Medicare and Medicaid? What are ways that Community Health Centers can better leverage existing dollars to serve rural areas like Eastern Oklahoma?**

Health centers have been leaders in taking a patient-centered, holistic approach to patient care, dedicating time and resources to maximizing their patients' ability to fully access care. By designing systems of care that remove geographic, socioeconomic, linguistic, and cultural barriers to care while addressing social determinants of health, health centers are better able to improve health outcomes and lower costs, even when these services are not reimbursed by insurance. As such, community health centers provide a wide array of critical non-medical enabling services and social service interventions, many of which are not reimbursed by Medicaid or Medicare. Common examples include services like translation, interpretation, health education, and transportation, none of which are covered by Medicare, and only some of which are covered by certain state Medicaid programs that have elected to reimburse for optional services. Additionally, Medicare does not reimburse for dental services at all, and Medicaid coverage for adult dental services varies by state.

Telehealth is a clear example of a service that is currently only reimbursed by Medicare and Medicaid in a limited way, but could be expanded upon to help health centers better leverage existing dollars to serve rural areas. By supporting policies that improve utilization of telehealth, Congress could enable health centers to serve more patients in low cost settings and improve care coordination, patient compliance with care plans, and health outcomes, while at the same time overcoming challenges posed to health centers by critical workforce shortages.

15. Studies comparing health center patients with non-health center patients found that patients receiving most of their primary care in health centers experienced lower utilization and spending for care. How are health centers saving dollars in care delivery?

Several main items factor into the fact that the health center model generates lower overall utilization and spending in the health care system. First, health centers focus on prevention and wellness – often treating conditions before they become more acute and/or chronic, and thus preventing not only bad outcomes but higher costs. Second, the health center model encourages the integration of care, in recognition that physical health care services are only one piece of the puzzle when it comes to maintaining patient and population health. Behavioral health integration, in particular, helps address these issues in the context of primary care, before they can spiral out and become much more serious – and costly – conditions. Lastly, due to the unique governance structure of consumer-majority boards, each health center is designed to be responsive to the particular needs of its community. This responsiveness helps ensure patients access the right care, at the right time, in the right place, and in the most affordable setting possible.

16. According to HRSA, there are 10,760 Health Center Service Delivery Sites and 224 Health Center Look-Alike Service Delivery Sites. What is a health center program “look-alike” and how does it differ from a Health Center Program award recipient?

Health Center look-alikes operate and provide services consistent with Health Center Program requirements, but do not receive Health Center Program grant funding. They are, however, eligible to apply to the Centers for Medicare and Medicaid Services (CMS) for reimbursement under FQHC Medicare and Medicaid payment methodologies. Look-alikes are also eligible to purchase discounted drugs through the 340B Federal Drug Pricing Program, receive automatic Health Professional Shortage Area designation, and may access National Health Service Corps providers.

Look-alikes were established to maximize access to care for medically underserved populations and communities by allowing entities that do not receive Health Center Program funding to apply to become part of the Health Center Program. Both Health Center Program award recipients and look-alikes provide comprehensive primary health care services that are responsive to identified health care needs, provide services to all persons regardless of ability to pay, and must meet all Health Center Program requirements.

17. **As a former businessman, I often say, “In God We Trust, All Others Bring Data.” The data on CHIP shows there is much to commend the program. The program has help dramatically lower the number of children without health insurance. The program is more affordable for low-to-moderate-income children and their families than the Exchanges – yet there is reasonable cost-sharing. What I would like to know is how in what ways do you think CHIP has lessons we can learn from to help improve Medicaid? CHIP is a flexible program for states, great for patients and families, and high value for taxpayers. What do we do in CHIP – as part of the program design or benefits or tools for states – that we should carefully consider for helping improve Medicaid?**

This is a question that my co-panelists might be able to provide additional detail on, but from my perspective I would point to CHIP’s success in streamlining enrollment and renewals, practices that Medicaid subsequently adopted in most states. Furthermore, to your point, CHIP charges reasonable premiums and ensures affordable cost-sharing for visits to make sure families can continue to maintain and utilize their coverage. Another key success of the CHIP program is ensuring coverage for pediatric-focused provider networks and including pediatric expertise in program administration, both of which are essential for children covered by Medicaid as well.

The Honorable Larry Bucshon

1. **HRSA-funded health centers are evaluated on a set of performance measures emphasizing health outcomes and the value of care delivered. Grantees must establish quality and performance goals, and assess their progress through this process. How do health centers collect and report their data? With Medicaid being the largest source of health center revenue (42.2% for FY 2016) how can states and health centers work together to improve the consistency of data and quality reporting?**

Each year, Health Center Program grantees and look-alikes report on their performance using the measures defined in the Uniform Data System (UDS). The UDS offers a comprehensive look at a number of different measures and performance relative to national and individual health center goals. UDS data is posted online so that the public and the taxpayer can examine these results and statistics, and so that researchers can access the data for analysis. HRSA offers manuals, webinars, trainings online and at various state/regional/national meetings, and other technical assistance resources to assist health centers in collecting and submitting their data.

In terms of Medicaid, one of the biggest opportunities I see is for states, Medicaid managed care companies, and health centers to partner together with regard to data sharing. Without access to Medicaid MCO claims data, in many states health centers face a challenge in being able to statistically prove their value in terms of lowering system-wide costs.

The Honorable Tim Murphy

1. **Federal law allows states to establish alternative payment models for health centers as long as the both the state and health center agree on it and the alternative payment model revenue is at least what the prospective payment system would have been. How many states have created alternative payment models and how do these payment structures compare to the traditional prospective payment system in terms of outcomes and savings?**

As of 2016, 23 states were operating under Alternative Payment Models (APM) as allowed for under the FQHC Medicaid statute (SSA Sec. 1902(bb)). These models range from more traditional payment systems to value-based models incorporating capitation. Perhaps furthest along in testing the latter category of payment model is the state of Oregon, which began its APM in March of 2013 after getting approval the prior year. Begun as a pilot involving three health centers, the Oregon APM has since expanded to 17 health centers statewide, and is showing promising early results.

For more information on the Oregon APM, please visit: <http://www.nachc.org/wp-content/uploads/2016/12/Oregon-FQHC-APM-December-2017.pdf>

The Honorable Morgan Griffith

1. **I understand that according to the Public Health Service Act (PHSA) section 330 requires that a health center be located in an area designated as medically underserved or as serving a population designated as "Medically Underserved," however in Oklahoma we are still lacking providers and care, while other cities seem to have a large number of community health centers. Do you believe that HRSA is doing a good job at awarding the community health center grants according to need?**

I believe that HRSA is doing the best job that they can in awarding community health center grants according to need. It has been my experience over the past 38 years that there has been approximately a 50/50 rural/urban split in grant funding. Depending on funding opportunities and the directions by Congress, the statute allows for up to 60/40 rural/urban or up to 60/40 urban/rural. The Medically Underserved Designation is based upon the Population/Primary Care Physician Ratio, Percentage of Population with Incomes Less than 100% of Poverty, Percentage of Population Over the Age of 65 and the Infant Mortality Rate. I believe that this Medically Underserved Designation does not favor either urban or rural areas. There are 17,000 Health Professional Shortage Areas and over 4200 Medically Underserved Areas in the United States. I strongly believe that we still need more Community Health Centers to serve these shortage areas and populations.

- a. **Community Health Centers have seen a large uptick in funding since FY2011, especially in mandatory funding. In your opinion, how have health centers used these increased funds?**

Congress' support for the Community Health Center Fund, which received a broad and bipartisan extension via MACRA in 2015, has allowed health centers across the country to expand the breadth of services they offer, upgrade and expand their facilities, hire additional practitioners, and open up additional sites to offer care to individuals in need. Due to the grants provided via the Community Health Center Fund, not only have millions of additional patients gained access to care, but patients at health centers around the nation are now able to access a broader range of services, including

behavioral health and substance abuse treatment, dental and vision care, and nutrition education and obesity prevention. In 2016, over 1,300 health centers used grants from the Community Health Center Fund to invest in quality improvements, health information technology (HIT), and delivery system reforms that will help drive down the cost of delivering care and improve patient experiences at health centers.

b. What are some of the services that Community Health Centers provide that aren't covered under Medicare and Medicaid?

Health centers have been leaders in taking a patient-centered, holistic approach to patient care, dedicating time and resources to maximizing their patients' ability to fully access care. By designing systems of care that remove geographic, socioeconomic, linguistic, and cultural barriers to care while addressing social determinants of health, health centers are better able to improve health outcomes and lower costs, even when these services are not reimbursed by insurance. As such, community health centers provide a wide array of critical non-medical enabling services and social service interventions, many of which are not reimbursed by Medicaid or Medicare. Common examples include services like translation, interpretation, health education, and transportation, none of which are covered by Medicare, and only some of which are covered by certain state Medicaid programs that have elected to reimburse for optional services. Additionally, Medicare does not reimburse for dental services at all, and Medicaid coverage for adult dental services varies by state.

c. What are ways that Community Health Centers can better leverage existing dollars to serve rural areas like Eastern Oklahoma?

Telehealth is a clear example of a service that is currently only reimbursed by Medicare and Medicaid in a limited way, but could be expanded upon to help health centers better leverage existing dollars to serve rural areas. By supporting policies that improve utilization of telehealth, Congress could enable health centers to serve more patients in low cost settings and improve care coordination, patient compliance with care plans, and health outcomes, while at the same time overcoming challenges posed to health centers by critical workforce shortages.

The Honorable Gus Bilirakis

1. FQHCs are critical to Florida's safety net. During my tenure in Congress, I've helped raise awareness of their national importance and educated constituents on the services offered by community health centers in my district. Data from the last year on record, 2015, shows Florida has the 3rd largest network of community health centers serving 1.3 million Floridians over nearly 5 million visits each year.

a. What is the average cost of care per patient versus other comparable provider settings?

While it's difficult to make an apples-to-apples comparison of community health centers and other providers due to differences in patient mix, a recent study published in the

American Journal of Public Health in 2016 found that community health center patients who are Medicaid enrollees have 24% lower health care spending compared to those treated at other primary care settings. This is a testament to the diligent work of practitioners at roughly 1,400 health center organizations at nearly 10,000 sites nationwide.

2. What is the national network size of community health centers? What is the scope of services provided?

Nationally, more than 1,400 health center organizations operate roughly 10,400 locations, serving over 25 million patients. It is not only primary care medical services that help attain these results, but also services in dental, behavioral health, substance abuse, pharmacy, vision care, nutrition, health education and obesity prevention.

Can you speak to the quality and continuity of care received in community health centers?

- a. How does this compare with other care settings? b. Can you speak to the importance of having patient/consumer representation on each health center's board of directors? c. How does your board work in concert with the leadership and medical staff to ensure the health center is addressing the most pressing community needs?**

Our health center physicians, physician assistants, nurse practitioners and dentists are the only providers in our communities. We see our patients not only in the clinic, but also in the emergency room, nursing home and hospital. We provide care to the entire community because there is no one else. When we refer patients for specialty care those patients come back to us. Our quality improvement plan contains clinical performance measures on diabetic, cardiovascular and asthma care along with depression screening targets and other measures. We not only track changes in our performance quarterly but we also compare ourselves to other community health centers. The State of Minnesota has mandatory clinical performance reporting and we compare our performance with all of the other medical practices in the state. Even though we serve a remote rural patient population with health disparities, we believe that our clinical performance is comparable to other group practices.

With a service area of 8300 square miles, it is extremely important for us to have community/consumer/patient involvement in what we do. We now have six medical clinics and four dental clinics. Each clinic has been added in response to consumer/patient needs brought to us by our board members. We just opened a new dental clinic in Bigfork, MN. One of the community's dentists closed his practice and left the area. The other announced his retirement. The community was very concerned about losing all access to dental care so they asked our Bigfork board members if we could help. Our board decided to add a new dental clinic for the community even though there were no additional federal resources. They helped the community secure a foundation grant to replace old & failing dental equipment. We this support we opened this clinic on July 3, 2017. Consumer input is extremely helpful in assessing and addressing community needs and to also provide a feedback mechanism to the community when some services are not viable.

3. As Vice-Chairman of the Committee on Veterans Affairs in addition to my role on this committee, I understand that Health Centers already provide quality care to more than 300,000 veterans across the country and are an important source of care for veterans in rural areas who may not be able to easily access a VA facility.

- a. Can you share with the Committee some of the ways in which health centers are working with the VA to address the health care needs of our nation's veterans? b. What more can be done to improve veteran's access to care at health centers?

In our community health center sites, all of our physicians, dentists, nurse practitioners and physician assistants are enrolled providers in the Veterans Choice program. Last year more than 800 of our 12,000 patients identified themselves as veterans and we have a veteran on our Board of Directors. We are strong believers in improving access to care for our veteran patients.

Nationally, health centers serve approximately 305,000 veterans. In 2015, nearly 9 in 10 health centers served veteran patients and offered a wide range of services including dental, mental health, substance abuse, and enabling services.

Health centers work closely with the VA as part of the Veterans Choice Program. Notably, Federally Qualified Health Centers (FQHCs) are the only type of health care provider which is specifically named in the Veterans Choice Program statute as eligible to care for participating veterans (See Section 101(a)(1)(B)(ii)). This special attention suggests that Congress intended for FQHCs to play a central role in assisting the VA to implement the program successfully. And health centers take this role seriously given that they may often be located in communities with many low-income veterans, but with few or no other care providers.

I also want to highlight that the Senate FY18 Milcon-VA Appropriations Subcommittee report included language to direct the VA to submit a report to both Houses of Congress regarding the role FQHCs play in providing veterans care through the Veterans Choice program and outlining opportunities for further collaboration. This again signals the important role of health centers in caring for our nation's veterans now and for the future.

The Honorable Leonard Lance

1. Can you describe the patient population that typically seeks care at a community health center? How do these patients differ from other safety net providers?

Health center patients are among the nation's most vulnerable populations – people who even when insured, nonetheless remain isolated from traditional forms of medical care because of where they live, who they are, the language they speak, and their higher levels of complex health care needs. As a result, patients are disproportionately low income, uninsured or publicly insured, and minority.

By statute, all health centers are located in medically underserved areas or serve a medically underserved population as designated by HHS. Of the 25 million patients served at health centers nationwide, 7.6 million are children and over 300,000 are veterans. Over 70% of health

center patients have incomes below 100% of the Federal Poverty Level (FPL) and if these individuals are uninsured they are charged no more than a nominal fee to access the full range of services provided by the health center. An additional 21% of health center patients have incomes between 101% - 200% FPL, and these individuals are charged base on a sliding fee scale. Nationally, health centers serve 1 in 3 people below the FPL, 1 in 5 uninsured persons and 1 in 6 Medicaid beneficiaries.. In order to serve the diverse needs of health center patients, health centers work in close collaboration with other safety net providers who provide needed specialty and other health care services for their patients.

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS
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July 7, 2017

Ms. Jami Snyder
Associate Commissioner
Medicaid/CHIP Services
Health and Human Services Commission
4900 North Lamar Boulevard
Austin, TX 78751

Dear Ms. Snyder:

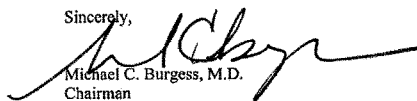
Thank you for appearing before the Subcommittee on Health on June 23, 2017, to testify at the hearing entitled "Examining the Extension of Safety Net Health Programs."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on July 21, 2017. Your responses should be mailed to Jay Gulshen, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to jay.gulshen@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

House Energy & Commerce Committee

Written Questions and Answers

Jami Snyder, Associate Commissioner, Texas Health and Human Services Commission

The Honorable Michael C. Burgess

1. In your testimony, you noted Texas has seen the overall uninsured rate for children below 200 percent of the federal poverty level drop to about 6 percent in 2015 – down from 18 percent in 1998. Congratulations on that. I understand Texas’s CHIP eligibility is about 200 percent. But some states in CHIP have eligibility above 300, 350, even 400 percent of the federal poverty level. The federal poverty level for a family of four in 2017 is \$24,600, so 300 percent of the federal poverty level is \$98,400. The median household income in the U.S. is just under \$54,000 according to Census data. So I am curious: do you think it is fair that taxpayer dollars are used to pay for health coverage for upper income children above 300, 350, or 400 percent of the federal poverty level?

Response: The annual income eligibility limit in Texas for Children’s Health Insurance Program (CHIP) participation is 201% percent of the federal poverty level (FPL), equating to \$48,852 a year for a family of four or \$4,071 a month. Texas is not among the states covering families with higher incomes in CHIP and the Texas Health and Human Services Commission takes no position regarding states that have elected to do so.

2. Texas has a stand-alone CHIP program, so there is a lot of flexibility under current law. Do you face any federal statutory or regulatory barriers in you CHIP program that you think the Committee should be aware of and potentially re-examine? What about on the Medicaid side – are there barriers to innovation in that critical program that the Committee to better understand?

Response: As noted in my testimony, the statutory and regulatory framework affords states considerable flexibility in designing and operating CHIP programs and has contributed to the success of the CHIP program in Texas. I have no recommendations related to the CHIP statutory framework.

In regard to Medicaid, current statutory requirements around cost-sharing (including premiums, deductibles, and copays) found in Sections 1916 and 1916A of the Social Security Act and 42 CFR Chapter 447 make it administratively complex for states to obtain federal approval and operationalize cost-sharing requirements for most Medicaid beneficiaries. In particular, existing law excludes certain Medicaid eligibility groups and limits copayment to nominal amounts. These regulations pose a barrier for Texas and other states interested in implementing commonsense cost-sharing mechanisms that would serve to increase the investment Medicaid beneficiaries have in their medical care.

- a. Follow-up: In the Medicaid program, one of the bills the Committee has been examining is the ACE Kids Act. We had a great bipartisan hearing last Congress and plan to reintroduce updated legislation within days. The goal is to help incentivize care coordination services for children with special medical needs in Medicaid. I

think we have a good bill that will work for Medicaid directors and stakeholders. Would you commit to looking at the new legislation and working to provide feedback to the Committee to inform our process moving forward?

Response: Texas is committed to examining financially responsible proposals that will provide the care necessary for children who need it.

3. A report last fall from the HHS Office of the Inspector General examined the Express Lane Eligibility program which lets states use data from other programs to determine eligibility for CHIP and Medicaid. The report examining CHIP spending in states with Express Lane found some of the spending on children was for children not eligible for CHIP. A sister report from the OIG reported that \$284 million taxpayer dollars, 20% of total Medicaid spending in ELE programs, was on potentially ineligible beneficiaries. If Congress were to extend Express Lane authority, what are some oversight recommendations or practices that you would think could help safeguard tax dollars so they only provide coverage for children who qualify?

Response: To date, Texas has not implemented the Express Lane Eligibility option and therefore does not have recommendations related to oversight of the program.

4. In your testimony, you noted that CHIP has allowed Texas to “design a system that aligns with the state’s philosophy of ensuring accountability and stewardship in the management of public funds and increasing personal responsibility for program participants.” You note that “federal CHIP regulations afford states flexibility to tailor their CHIP benefit package to meet the unique needs of the population served.” Can you give us some examples of how the flexibilities in CHIP have allowed Texas to provide high-quality care for children?

Response: As noted in my written testimony, federal CHIP regulations allow states to place reasonable limitations on the scope of services members may receive. For example, Texas imposes a \$20,000 annual cap on durable medical equipment. Texas’ CHIP program also has a \$564 limit on dental benefits per enrollment period, excluding emergency dental services. By way of comparison, such hard caps on services are not possible in the Medicaid program under federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, which mandate states cover all medically necessary Medicaid services for qualified children. Reasonable service limitations within CHIP, in contrast, allow states to more effectively operate the program within federal allotments and provide for more predictable budgeting. Such limitations also allow CHIP coverage to align more closely with benefit packages offered in the commercial market.

5. I understand many state fiscal years start July 1. And I understand Texas and many other states built their budgets around the 23 percent match. But this Committee is on record repealing it just last March— we did so in The Common Sense Savings Act of 2016. So why would you plan on retaining it? I know some states say they planned for current law, but how can you say that when, under current law, all CHIP funding expires? How is it fiscally responsible and fair to assume a higher match rate that means more federal spending, but doesn’t increase coverage for kids? We have lots of other important

extenders, and I think we need to consider not retaining the match to help pay for health centers and other priorities.

Response: The Common Sense Savings Act of 2016, (H.R. 4725, 114th Congress) would have repealed the Affordable Care Act provision which amended Title XXI of the Social Security Act to increase the CHIP Enhanced Federal Medical Assistance Percentage (E-FMAP) rate by 23 percent through September 2019. During the time the Texas Legislature was considering appropriations for the FY 2018-2019 biennium (January through May of 2017) the 23 percent provision was (and still is) in effect.

6. I have a question about the Pediatric Quality Measures program that has often been funded alongside CHIP. A March 2017 report by MACPAC stated that "current grantees "are assessing the feasibility and usability of the measures at the state, health plan, and provider levels." A HHS Secretary report on in 2015 noted that higher numbers of states are reporting on quality measures. Everyone on this committee believes quality is important and data is important. So my question is not one of value, but effect. What do states do with the pediatric quality data they report for this program? Do you know what CMS does with the quality measures that are reported?

Response: Texas uses this data for a number of its quality initiatives, including:

- The integration of quality metrics in MCO report cards which assist consumers in selecting the best health plan to meet their needs.
- The integration of key quality metrics in the state's Pay-for-Quality program, which places a percentage of the health plans' capitation at risk based on their performance on the identified metrics.

CMS makes available state-by-state results for these measures. CMS may use the measures for other purposes. I would recommend contacting CMS officials directly for additional insight.

7. The ACA created an enhanced matching rate (E-FMAP) of 23 percentage points (not to exceed 100%) for most CHIP expenditures from FY2016 through FY2019. Some have expressed concern that the elevated federal spending upsets the federal-state partnership that has historically characterized a successful SCHIP program. Others have noted that the elevated spending would cost federal taxpayers billions of additional dollars, but would result in no significant net increase in the number of children with health coverage. Certainly, retaining such a policy would increase the federal cost of extending SCHIP funding. Can you help the Committee understand why Texas found it appropriate to assume a higher matching rate and build your budget around it, when CHIP funding itself expires this Congress? As a conservative, that sounds like liberal math.

Response: In Texas, budgets are constructed in accordance with existing federal and state law. The state constitution requires the Texas Legislature to meet every two years for 140 days and produce a balanced budget during that period for the next two years. The regular session of the Texas Legislature concluded in May 2017. The state's budget for FY 2018 -2019 was approved during that session.

If the 23 percent E-FMAP for CHIP were to be repealed by Congress and the President during the FY 2018 - 2019 biennium, the state would act accordingly to reduce the impact to the state budget. If Congress decided not to reauthorize CHIP, under state law, CHIP would terminate in Texas (Texas Health & Safety Code, Chapter 62).

8. One of the things that health care research shows is that low-income families who may be marginally attached to the traditional workforce may have fluctuations in income that mean they move in and out of programs like Medicaid and CHIP. For example, how long is the average length a child is on the CHIP program in Texas? Can you talk about how CHIP provides a continuity of health coverage for such families?

Response: In Texas, the average length of time a child is on CHIP is fourteen months. Texas provides children with a continuous eligibility period, during which, income changes do not impact a child's eligibility.

- Children receiving Medicaid benefits receive six months continuous eligibility.
- Children receiving CHIP benefits receive twelve months continuous eligibility.
 - Households with incomes at or above 185 percent of the federal poverty level are subject to income re-verification at the sixth month of the twelve month certification period.

An increase in income can potentially impact CHIP eligibility. When income verifications are conducted after the Medicaid continuous eligibility period ends and indicate a change in program eligibility, Texas ensures a smooth transition of coverage between Medicaid and CHIP. In general, families with children who are no longer eligible for Medicaid but are eligible for CHIP are automatically enrolled into CHIP and provided a grace period to pay the CHIP enrollment fee, if required, to ensure continuity of coverage.

9. I want to ask you about a policy the Committee has examined in the past to close a loophole and reduce federal and state Medicaid spending – because this policy could potentially help offset extending CHIP funding. States are required to provide temporary Medicaid coverage to individuals who have not provided documentation of their citizenship or satisfactory immigration status. The policy idea would be to close the loophole in current practice by ensuring that federal taxpayer dollars in the Medicaid program only go to individuals who have proven they are citizens or are here legally in the U.S. This would save hundreds of millions of federal dollars – and cut state costs. Do you think this policy and policies like this that prioritize the most vulnerable and close loopholes are a reasonable way to help pay to extend CHIP funds?

Response: Under current law, as you note, Medicaid applicants are afforded a “reasonable opportunity” to provide proof of citizenship and can receive Medicaid benefits during that period if their application is otherwise deemed complete. Texas would support the tightening of this requirement.

10. Both the National Governors’ Association and MACPAC have recommended Congress extend CHIP funding for five years. Such an extension would be unprecedented in its duration, since it’s my understanding the historical record shows that longest period of

time that has passed without Congress providing additional funding or adjusting the funding formula is two years. But I think many in Congress could support a longer extension if the funding is appropriately offset. Neither NGA nor MACPAC endorsed policies to offset the more than \$7 billion in costs for a 5-year extension. Do you have any policies to cut costs and help pay for extension that you or other Medicaid directors would recommend? Do you think it's fair for the states to ask Congress to spend billions of dollars but not make any recommendations on offsets?

Response: I am aware that members of Congress and others have a variety of views regarding the CHIP reauthorization period. In his confirmation hearing on January 24, 2017, Secretary Price (then Representative Price) suggested that an eight-year reauthorization may be preferable to five years.

As I testified, Texas has implemented a variety of cost-savings initiatives in both CHIP and Medicaid. We remain committed to ensuring both programs are administered in an efficient and effective manner, understanding our obligation to both state and federal taxpayers.

11. As a former businessman, I often say, "In God We Trust, All Others Bring Data." The data on CHIP shows there is much to commend the program. The program has help dramatically lower the number of children without health insurance. The program is more affordable for low-to-moderate-income children and their families than the Exchanges – yet there is reasonable cost-sharing. What I would like to know is how in what ways do you think CHIP has lessons we can learn from to help improve Medicaid? CHIP is a flexible program for states, great for patients and families, and high value for taxpayers. What do we do in CHIP – as part of the program design or benefits or tools for states – that we should carefully consider for helping improve Medicaid?

Response: CHIP offers each state the administrative flexibility to design a program that meets the state's needs, the ability to infuse concepts of personal responsibility and accountability into the program's benefit design and the opportunity to pursue innovative strategies aimed at enhancing outcomes for beneficiaries. Understanding that the demographic composition of the Medicaid and CHIP populations differs notably and those differences must be taken into account, Texas would welcome modifications to regulatory requirements in the Medicaid program which offer similar flexibility, allowing for the development of a delivery system that meets the needs of Texans and aligns with core principles espoused by the state.

12. One of the committee's priorities has been to improve access to treatment for those struggling with opioid addiction. How has opioid epidemic impacted community health centers? Can you tell me what health centers are doing in this area, and how health center grants help expand this work?

Response: Various efforts have been initiated by public and private entities to support federally qualified health centers (FQHCs) in confronting the opioid epidemic. I would recommend contacting the National Association of Community Health Centers for more information on the FQHCs' success in addressing the needs of individuals struggling with opioid addiction.

13. In your testimony, you explained that in Texas, “all CHIP families make co-payments for office visits, prescription medications, inpatient hospital care, and non-emergent care provided in an emergency room setting.” I know fees and co-payments vary based on family income and the total amount a family is required to contribute out of pocket toward the cost of health care services is capped at five percent of family income. But what is the amount a family might reasonably be asked to pay, on average under CHIP?

Response: Co-pays range from \$0-\$35 for lower income families (up to and including 151 percent of the federal poverty level) to \$10-\$125 for higher income families (above 186 percent of the federal poverty level, up to and including 201 percent of the federal poverty level). There are no co-pays for preventive services or for CHIP perinatal members. Total cost-sharing (sum of enrollment fees and co-pays) is capped for each family at five percent of household income.

In fiscal year 2016, less than one-tenth of one percent of CHIP members reported meeting the five percent cap.

- a. Is \$1,230 about the maximum a family could be expected to pay if their income is about 100 percent of the federal poverty level?

Response: Since implementation of the ACA and changes to Medicaid eligibility levels, the lowest income level in CHIP is 133 percent of the federal poverty level (FPL). A family of two with an annual income of \$21,599 (133 percent of the federal poverty level) would pay no enrollment fee and copayments would be capped at \$1,080 per year. A family of one with an annual income of \$16,040 (133 percent of the federal poverty level) would pay no enrollment fee and copayments would be capped at \$802 per year.

- b. While I know there are strong differences of opinion on the ACA, I assume you would all agree with me that CHIP makes coverage more affordable for low-income families than many of the products commercially available?

Response: Enrollment fees for Texas CHIP are lower than subsidized premiums available through the federal health insurance exchange. Co-pays in Texas CHIP are also lower than state employee health plan co-pays. Furthermore, CHIP co-pays are capped at five percent of family income.

The Honorable Larry Bucshon

1. According to MACPAC data, in FY2013, almost 85 percent of children in separate CHIP coverage lived in households with one parent working. Do you happen to know what percentage of children in Texas’s CHIP program have at least one parent working?

Response: Texas does not have data available to determine the percentage of children in CHIP with at least one parent working.

- a. Follow-up: One idea I am interested in is making it easier for states to use premium assistance models to help take a defined amount of federal dollars and put folks in private coverage. Conceptually, it's a good public-private partnership. Can you help me understand what would be the policy or mechanical challenges to just letting a mom or dad take their child's CHIP dollars and buy into a family plan – either in the Exchanges or in employer-sponsored insurance?

Response: While there may be advantages to having families in CHIP purchase health insurance, states may face challenges in doing so, including:

- Costly systems and operational changes, necessary for the state to assess a family's allocated "CHIP dollars" in order to facilitate their ability to "buy into" a family plan while ensuring coverage commensurate with that offered under the program.
- Implementation of a comprehensive education and outreach campaign, aimed at supplying families with the knowledge needed to successfully purchase coverage through the Exchange or their employer.

It should be noted that Texas prohibits enrollment in CHIP if a child has private insurance coverage. As such, all CHIP enrolled members would be required to fully transition to private coverage, should the state elect to pursue that avenue.

The Honorable Tim Murphy

1. Mathematica analyzed the outreach and enrollment grants that have often been funded with CHIP. They found these grants "played an important role in supporting and supplementing state outreach efforts." However, there is limited data able to quantify just how successful these programs have been in terms of number enrolled. State officials gave support for extending the grants, stating they "had been particularly helpful in bolstering otherwise underfunded outreach efforts, and played a significant role in supporting and sustaining community-based groups involved in outreach." While the support of these grants is wide spread, and utilization is clear, why is it difficult to quantify on their ability to increase enrollment and retention in Medicaid and CHIP programs? We need to be data-driven in our policy making, so how should we think about extending funding where we have anecdotes instead of hard data?

Response: The overall impact of outreach and enrollment grants is difficult to quantify because grant activities constitute only one of many factors impacting outreach and retention. Increases in enrollment may be influenced by other variables such as changes in the economy. The implementation of the insurance marketplace under the Affordable Care Act also created a mechanism to test individuals for Medicaid and CHIP eligibility, which ultimately resulted in increased enrollment. Because outreach and enrollment grants were implemented over the course of the economic downturn and following passage of the Affordable Care Act, it is difficult to infer a direct causal relationship between the grant activity and enrollment and retention changes impacting CHIP.

The Honorable Morgan Griffith

1. I want to ask you about a policy the Committee has examined in the past to close a loophole and reduce federal and state Medicaid spending – because this policy could potentially help offset extending CHIP funding. States are required to provide temporary Medicaid coverage to individuals who have not provided documentation of their citizenship or satisfactory immigration status. The policy idea would be to close the loophole in current practice by ensuring that federal taxpayer dollars in the Medicaid program only go to individuals who have proven they are citizens or are here legally in the U.S. This would save hundreds of millions of federal dollars – and cut state costs. Do you think this policies and policies like this that prioritize the most vulnerable and close loopholes are a reasonable way to help pay to extend CHIP funds?

Response: Under current law, as you note, Medicaid applicants are afforded a “reasonable opportunity” to provide proof of citizenship and can receive Medicaid benefits during that period if their application is otherwise deemed complete. Texas would support the tightening of this requirement.

The Honorable Gus Bilirakis

1. How do you engage a patient population driving the majority of health costs whose health challenges are exacerbated by socio-economic status?

Response: As noted in my testimony, Texas CHIP has operated through a managed care model since its inception. One of the advantages of a managed care delivery system is the ability to increase access to and promote the utilization of primary care by assigning each member a primary care provider (PCP). Under the model, families are encouraged to engage with their PCP. In turn, the provider has the opportunity to intervene with families and potentially detect and ameliorate medical issues resulting from the inability to access related supports and services due to socio-economic status. A PCP can, for instance, more quickly identify that recurring, uncontrolled asthma symptoms are due to issues within a substandard housing complex, whereas such issues would not be identified through analysis of medical claims.

The managed care framework also relies heavily on effective service coordination. Because MCOs are fundamentally at risk for the total cost of their members’ care, they are incentivized to proactively identify and offer additional service coordination and case management to members with special health care needs, including those whose needs stem from their socio-economic circumstances. Early intervention through effective and holistic referrals to both medical and social services improves the health and well-being of the individual while also driving down cost by avoiding expensive treatments in settings such as the emergency room.

2. The Centers for Centers for Disease Control and Prevention estimates that 1 of every 68 children and 1 in 42 boys are diagnosed with autism spectrum disorder. What should states be doing to protect this vulnerable population and ensure that children with autism can continue to access the treatment they need?

Response: Children with autism spectrum disorder (ASD) often have complex needs. One of the primary ways states can serve this population is to ensure that children with ASD, like all children with complex needs, have robust care coordination. Care coordination can play a vital role in ensuring children receive all medically necessary services available to them in the most efficient and effective manner possible.

The Honorable Richard Hudson

1. There are 234,000 kids enrolled in CHIP in North Carolina and I want them to know they will be taken care of. We can accomplish this by extending CHIP for at least five years, but we have to do so responsibly. It is imperative we craft a bill that will not continue to pile on to the massive debt and deficit we are already running, a scary burden I worry constantly will be handed down to members of the next generation, like my son. Both the National Governors' Association and MACPAC have recommended Congress extend CHIP funding for five years. Such an extension would be unprecedented in its duration, as the longest Congress has gone without providing additional funding or adjusting the formula is two years. I think many in Congress could support a longer extension if the funding is appropriately offset.
- (a) Do you have any policies to cut costs and help pay for extension that you or other Medicaid directors would recommend?
- (b) Do you think it's fair for the states to ask Congress to spend billions of dollars but not make any recommendations on offsets?

Response: As I testified, Texas has implemented a variety of cost-savings initiatives in both CHIP and Medicaid. We remain committed to ensuring both programs are administered in an efficient and effective manner, understanding our obligation to both state and federal taxpayers.

The Honorable Leonard Lance

1. A March 2017 report by MACPAC stated that "current grantees "are assessing the feasibility and usability of the measures at the state, health plan, and provider levels." A HHS Secretary report on in 2015 noted that higher numbers of states are reporting on quality measures. Within the context of the Pediatric Quality Measures Program that has often been funded alongside CHIP, what do states do with the pediatric quality data they report? Do you know what CMS does with the quality measures that are reported?

Response: Texas uses this data for a number of its quality initiatives, including:

- **The integration of quality metrics in MCO report cards which assist consumers in selecting the best health plan to meet their needs.**
- **The integration of key quality metrics in the state's Pay-for-Quality program, which places a percentage of the health plans' capitation at risk based on their performance on the identified metrics.**

CMS makes available state-by-state results for these measures. CMS may use the measures for other purposes. I would recommend contacting CMS officials directly for additional insight.

2. Health centers serve nearly 8 million children - about one-third of patients of all patients seen. However, CHIP only represented about 1% of health centers' revenue for FY 2016. Is that because these children are enrolled in Medicaid?

Response: Texas' utilization data shows FQHCs serve substantially more Medicaid clients than CHIP clients, which is reflective of the size of Texas Medicaid program relative to state's CHIP program. Texas Medicaid payments to FQHCs, for example, totaled more than \$8.5 million in fiscal year 2016, versus approximately \$425,000 in the CHIP program.