INVESTING IN AMERICA'S HEALTHCARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

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[1] The letter has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF14/20190604/109583/HHRG-116-IF14-20190604-SD022.pdf.

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[2] The letters have been retained in committee files and also are available at https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=109583.

INVESTING IN AMERICA'S HEALTHCARE

TUESDAY, JUNE 4, 2019

House of Representatives,
Subcommittee on Health,
Committee on Energy and Commerce,
Washington, DC.

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

Members present: Representatives Eshoo, Engel, Butterfield, Matsui, Castor, Sarbanes, Luján, Schrader, Kennedy, Cárdenas, Welch, Ruiz, Dinged, Kuster, Kelly, Barragán, Blunt Rochester, Rush, Pallone (ex officio), Burgess (subcommittee ranking member), Upton, Shimkus, Guthrie, Griffith, Bilirakis, Long, Bucshon, Brooks, Carter, Gianforte, and Walden (ex officio).

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

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

Ms. Eshoo. The Subcommittee on Health will now come to order. The Chair now recognizes herself for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

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

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

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

We are going to hear testimony about the bipartisan bills to extend and invest in the following programs, several that were authored by members of this subcommittee. This is a long list: Community Health Centers, National Health Service Corps, Teaching Health Centers for Graduate Medical Education, the Special Diabetes Program and the Special Diabetes Program for Indians, Family-to-Family Health Information Centers, the Patient-Centered Outcomes Research Institute, State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, the National Center for Benefits and Outreach Enrollment, the National Quality Forum, Certified Community Behavioral Health Clinics, Disproportionate Share Hospitals, and the Medicare Limited Income NET Program.

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

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

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

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

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

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

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

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

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

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

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

Finally, we are strengthening Medicare through stronger enrollment support and help for low-income beneficiaries. Today's hearing is critically important to make sure millions of our fellow Americans receive quality healthcare.

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

[The prepared statement of Ms. Eshoo follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO

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

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

We will hear testimony about the bipartisan bills to extend and invest in the following programs, several that were authored by members of this subcommittee:

- Community Health Centers;
- National Health Service Corps;
- Teaching Health Centers for Graduate Medical Education;
- The Special Diabetes Program and the Special Diabetes Program for Indians;
- Family-to-Family Health Information Centers;
- The Patient-Centered Outcomes Research Institute;
- State Health Insurance Programs;
- Area Agencies on Aging;
- Aging and Disability Resource Centers;
- The National Center for Benefits and Outreach Enrollment;
- The National Quality Forum;
- Certified Community Behavioral Health Clinics;
- Disproportionate Share Hospitals; and
- The Medicare Limited Income NET Program.

Many of these programs are stuck in a biennial cycle where they may expire because of Congress' inaction. Today, we will consider reauthorizing some of these programs for a longer timeframe, giving them the certainty and stability to conduct long-term planning to better serve patients and the American taxpayer.

I want to highlight a few of these important programs.

First, we're considering expanding several types of health centers that serve our communities in unique ways.

The Community Health Center Fund provides funding to nearly 12,000 health center locations across our country. These health centers provide primary healthcare to one in 13 Americans, regardless of their ability to pay.

A Community Health Center in my district, the Asian Americans for Community Involvement Health Center, provides services through a multilingual team of doctors, nurses, and patient navigators. This Health Center's team can speak up to 40 languages to make sure that vulnerable ethnic communities in my District are well served.

Building on the Community Health Center model is the Excellence in Mental Health and Addiction Treatment Expansion Act, authored by Representatives Matsui and Mullin. This important bill expands funding for Certified Community Behavioral Health Centers to 11 more States.

As we face a mental healthcare shortage, we must do more to expand access. In my State, half of all Californians say their community does not have enough mental health providers to serve local needs.

Another center serving the community are the Family-to-Family Health Information Centers, or F2F grant program. F2Fs assist families with children who have special health needs to make informed choices about healthcare. F2Fs are staffed by family members who have firsthand experience in navigating special needs healthcare services.

Community Health Centers, Certified Community Behavioral Health Centers, and the F2F Health Information Centers provide unique services for the specific populations that benefit greatly from these programs.

We're also considering other programs to improve access to vital primary care, including the Special Diabetes Program and funding for Disproportionate Share Hospitals which goes to hospitals that serve lower-income Americans.

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

Finally, we're strengthening Medicare through stronger enrollment support and help for low-income beneficiaries.

Today's hearing is critically important to make sure millions of Americans receive quality healthcare. I stand ready to work with my colleagues to make sure these programs are extended and expanded.

Ms. ESHOO. So the Chair now has the pleasure of recognizing Dr. Burgess, the ranking member of the Subcommittee on Health, for 5 minutes for his opening statement.

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

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

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

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

Community Health Centers, Teaching Health Centers, Special Diabetes Programs, Family-to-Family Health Information Centers are the bipartisan programs that make a real impact in providing access to quality healthcare for Americans.

The Community Health Center in my district, Health Services of North Texas, conducted more than 50,000 patient visits for more than 14,000 patients in 2017.

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

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

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

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

Again, I hope we can work in a bipartisan manner to get these reauthorizations across the finish line in a timely manner. In an effort to do so, I introduced H.R. 2700, which would use the $5 billion in offsets from the drug pricing bills that passed through this subcommittee with unanimous support and use that to pay for 1 year of public health extenders.

While 1 year is not a long enough extension, I thought it was important to show our commitment to reauthorizing these programs in a fiscally responsible way.

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

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

Additionally, there are a number of Medicaid deadlines looming, the most significant of which is for the mandatory cuts to the Disproportionate Share Hospitals.

The bill before us today, H.R. 3022, entirely eliminates the DSH cuts. So OK, I am supportive of delaying DSH for 2 years or repealing them for 2 years, as Representative Olson does in H.R. 3054.

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

A 2-year delay would provide Congress with ample time to revisit DSH and make any changes necessary to improve both the efficiency and the effectiveness.

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

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

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

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

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

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

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

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

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Today we are considering legislation to reauthorize vital public health programs, which expire in the coming months. Community Health Centers, Teaching Health Centers, the Special Diabetes Programs, and Family-to-Family Health Information Centers are bipartisan programs that make a real impact in providing access to quality healthcare for Americans. The Community Health Center in my district, Health Services of North Texas, conducted more than 50,000 patient visits for more than 14 thousand patients in 2017.

Community Health Centers are on the front lines of caring for some of the most vulnerable individuals in our communities, and there is bipartisan support for extending this and other public health programs. Reauthorizing these programs can take a substantial amount of time, and I certainly hope that we will be able to accomplish these reauthorizations prior to the end of the fiscal year. I do remain concerned, however, that these bills have funding increases but include no offsets. Additionally, the language in the Community Health Centers reauthorization bill does not include Hyde protections, which have long been bipartisan and were included in the Alexander-Murray Senate companion bill. By not including these protections, the Majority puts the effort to reauthorize these critical programs at risk, and I worry about the ability to move them all forward if that position does change.

Again, I do hope that we can work in a bipartisan manner to get these reauthorizations across the finish line in a timely manner. In an effort to do so, I introduced H.R. 2700, which would use the $5 billion in offsets from the drug pricing bills that passed through this committee with unanimous support to pay for 1 year of public health extenders. While 1 year is not a long extension, I thought it was important to show our commitment to reauthorizing these programs in a fiscally responsible way. In fact, every Republican Member of the Energy and Commerce Committee is a cosponsor of H.R. 2700.

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

Additionally, there are a number of Medicaid deadlines looming, the most significant of which is for mandatory cuts to Disproportionate Share Hospitals. The Majority bill before us today, H.R. 3022, entirely eliminates the DSH cuts. I am supportive of delaying DSH cuts for 2 years or repealing them for 2 years as Rep. Olson does in H.R. 3054. However, eliminating the cuts entirely would prove a costly task and preclude us from making any valuable changes—changes DSH payments desperately need if they are to have a meaningful relationship to the level of uncompensated care actually being provided at the State level.

A 2-year delay would provide Congress with ample time to revisit DSH and make any changes necessary to improve upon both efficiency and effectiveness. MACPAC recently recommended three policy changes to improve the structure of these DSH allotment reductions, and we should take the time to revisit this topic and engage with stakeholders to pave a smooth path forward.

Another Medicaid topic that is absent from today's conversation is reauthorizing Medicaid for Puerto Rico and our other territories. We must remember that the individuals reliant upon Medicaid in the territories are American citizens, and that they are some of the most vulnerable. Letting Medicaid funding for these individuals lapse would be disappointing and unfair to those living in our territories. And let me be clear, finding enough money to adequately fund the territories will be much more difficult if we are paying for a permanent elimination of the DSH Cuts, etc.

Reauthorizing the public health programs and delaying DSH cuts are important in maintaining access to quality healthcare for Americans. I hope that we will be able to work in a bipartisan way to ensure that we get legislation to the President's desk prior to the end of the fiscal year. I remain concerned that the total cost of these bills could exceed $50 billion and that no offsets have been identified to pay for these policies. Additionally, we have another $8–10 billion at a minimum, we will have to spend on Medicaid funding for the territories. I hope we can work together to resolve these issues before the end of September so that we can keep our promise to the Americans who rely upon these programs and resources.

Ms. ESHOO. The gentleman yields back.

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

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

[Applause.]

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

Now, I have the privilege of recognizing the chairman of the full committee, Mr. Pallone, for 5 minutes for his opening statement.

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

Mr. PALLONE. Thank you, Madam Chair.

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

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

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

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

And today, nearly 12,000 Community Health Centers provide essential care to millions of patients across the country. I am grateful to my colleagues, Representatives Clyburn and O'Halleran, for their leadership in providing robust funding for both Community Health Centers and the National Health Service Corps, which offers loan forgiveness to health professionals who commit to provide service in medically underserved areas.

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

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

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

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

Medicaid Disproportionate Share Hospital funds, or DSH funds, provide critical financial support to hospitals that care for some of the most vulnerable.

Without action by Congress, DSH funding will be cut by $4 billion in October of this year. These cuts will place an incredible strain on hospitals that are already struggling to provide care to children with complex medical needs, low-income Americans, and rural communities, and I commend Representative Engel for his efforts to permanently eliminate these harmful cuts.

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

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

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

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

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

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On our second panel, we'll examine proposals related to the Medicare and Medicaid programs. We'll discuss a proposal led by Representative Engel that would permanently eliminate the cuts to hospital funding that Congress has been forced to delay year after year. Medicaid Disproportionate Share Hospital funds, or DSH (DISH) funds, provide critical financial support to hospitals that care for some of our most vulnerable.

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I'm committed to working with all of my colleagues to advance all of these important programs before the September 30th deadline. It is also my hope that we can find a way to provide longer-term extensions so that those who operate or receive services from these programs have greater certainty.

Thank you to all of the witnesses for being here today.

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

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

First, the Community Health Investment Modernization and Excellence Act would reauthorize and provide moderate increases in funding for Community Health Centers, the National Health Service Corps, over a period of 5 years.

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

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

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

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

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

And I yield back.

Ms. ESHOO. The gentleman yields back.

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

[Applause.]

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

Mr. WALDEN. Madam Chair?

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

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

Ms. ESHOO. I apologize. You have 5 minutes.

Mr. WALDEN. Not 6?

Ms. ESHOO. Five wonderful minutes.

Mr. WALDEN. I have one——

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

Mr. WALDEN. OK. I will try——

Ms. ESHOO. For my blunder.

Mr. WALDEN [continuing]. To knock this out faster than that.

Ms. ESHOO. Yes.

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

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

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

These programs, which have long enjoyed, and I think you have heard this this morning, strong bipartisan support, include Community Health Centers, Teaching Health Centers, the National Health Service Corps, Special Diabetes Programs, and more.

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

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

In the last Congress, I helped lead the effort to provide record funding for our Community Health Centers and reauthorize and fund these other programs.

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

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

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

And while we are the authorizing committee—I understand that—we also know it is a bit of a false promise to set a high reauthorization level without also doing the heavy lift to figure out how to pay the bill, because we are going to get called upon to do that.

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

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

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

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

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

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

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

My legislation, H.R. 3074, the Continuing Access to Mental and Behavioral Health Care Act, would extend funding for the original eight States for an additional 2 years so we can complete the demonstration project and get the data that taxpayers really deserve.

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

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

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

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

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

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

I yield back.

[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 examine legislation that strengthens our healthcare safety net by extending critical public health programs.

These programs, which have long enjoyed strong bipartisan support, include Community Health Centers, Teaching Health Centers, the National Health Service Corps, and the Special Diabetes Programs. Each program plays a significant role in our Nation's safety net for millions of Americans, especially the medically underserved who face barriers to care. In my rural district in Oregon, we have 12 Community Health Centers that serve more than 240,000 Oregonians across 63 delivery sites, so we need to work together to strengthen this program and the others we are examining today. I led the effort in the last Congress to provide record funding for America's Community Health Centers—and we did it in a bipartisan effort.

We are also reviewing legislation that extends the Patient-Centered Outcomes Research Institute, the Excellence in Mental Health Demonstration Program, and legislation that repeals the part of Obamacare that requires cuts to Disproportionate Share Hospital (DSH) payments.

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

In addition, I'm concerned that most of the bills we are reviewing significantly increased the authorized funding levels, but don't identify pay-fors to keep the promise of higher funding levels. And while we are the authorizing committee, we all know it's a false promise to set a high reauthorization level without doing the heavy lift of figuring out how to pay the bill.

Of significant concern is H.R. 3022, the Democratic bill to eliminate the DSH cuts—giving hospitals relief from cuts established under Obamacare. Let me be clear, Republicans have never supported the DSH cuts and worked successfully to prevent them, but we should not surrender our ability to reform and modernize the program to ensure that funding is directed to those that need it.

In March of this year, MACPAC report's own report points out, and I quote: "The Commission has long held that DSH payments should be better targeted to hospitals that serve a high share of Medicaid-enrolled and low-income uninsured patients and have higher levels of uncompensated care, consistent with the original statutory intent of the law establishing DSH payments." We should make sure the law is working as intended.

I am pleased to see the bipartisan commitment to continue funding for the Excellence in Mental Health Demonstration. As one of the eight States to be awarded funding, Oregon has seen significant, positive results that have truly helped Oregonians. I recently met providers at a certified community behavioral health clinic in southern Oregon that is involved in this demonstration. The initial findings show they're achieving good results in the community.

So, count me as a fan. But demonstrations are created to determine if new programs actually work. We need to get the results of this demonstration before we dramatically expand it, as the legislation we're reviewing today would do by adding 11 States to the program.

My legislation, H.R. 3074, the Continuing Access to Mental and Behavioral Health Care Act, would extend funding for the original eight States for an additional 2 years so we can complete the demonstration project and get the data taxpayers deserve, rather than prejudge the outcome.

I'm disappointed that the committee did not include in this hearing H.R. 2700, the Lowering Prescription Drug Costs and Extending Community Health Centers and Other Public Health Priorities Act. Republicans are serious about our commitment to responsibly extend these critical public health programs with bipartisan offsets. I'm not sure why our legislation was excluded from the discussion today. We need to work together to avoid an unnecessary shutdown of these programs in September when their authorizations expire.

Ms. ESHOO. The gentleman yields back.

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

Dr. Aaron Kowalski, president and chief executive officer of JDRF—marvelous organization that has chapters all over the country, and they come on a regular basis to my Palo Alto district offices. I am sure they do to every Member's office here. Dr. Lisa Cooper, professor of medicine, Johns Hopkins University School of Medicine—welcome to you, and thank you.

Just a quick word about the lights. First it is green. When it turns yellow, you have 1 minute, and red you stop. So it is only as complicated as that, and I know that you will adhere to it.

So now I would like to recognize Mr. Germano for 5 minutes for your testimony. If you would like to summarize what you have written and submit it to us and do something other than what you submitted to us, you are all welcome to do that.

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

STATEMENTS OF C. DEAN GERMANO, CHIEF EXECUTIVE OFFICER, SHASTA COMMUNITY HEALTH CENTER; DIANA AUTIN, EXECUTIVE CODIRECTOR, SPAN PARENT ADVOCACY NETWORK; AARON J. KOWALSKI, PH.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, JDRF; AND LISA COOPER, M.D., BLOOMBERG DISTINGUISHED PROFESSOR OF MEDICINE, JOHNS HOPKINS MEDICINE

STATEMENT OF C. DEAN GERMANO

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

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

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

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

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

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

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

I am very grateful that Representatives Ruiz and McMorris Rodgers have introduced bipartisan legislation, H.R. 2815, to extend the THC program for 5 years.

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

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

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

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

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

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

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

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

However, recent funding lapses threaten the notion of continuous access. We are grateful that Representatives O'Halleran and Stefanik introduced H.R. 2328 to provide 5 years of stable funding for the CHC fund including $200 million in annual growth and $15 million in annual growth for the National Service Corps.

Likewise, H.R. 1943, introduced by Representative Clyburn, provides 5 years of funding with 10 percent annual growth, an addition of $4.6 billion for health center capital funding, which would further—and would further expand the Corps.

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

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

Thankfully, Congress has extended the Corps through September and we are very concerned that another expiration of funding would cause great damage to the program.

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

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

Thank you.

[The prepared statement of Mr. Germano follows:]

Statement of C. Dean Germano

Chief Executive Officer, Shasta Community Health Center, Redding, California

Before the Subcommittee on Health of the House Energy and Commerce Committee

June 4, 2019

Chairwoman Eshoo, Ranking Member Burgess, and Distinguished Members of the Subcommittee:

Thank you for inviting me to speak to you about the Teaching Health Center Graduate Medical Education Program, which we call "THCGME," the Community Health Centers (CHC) program, and the National Health Service Corps (NHSC) program. On behalf of Shasta Community Health Center, which is a member of the American Association of Teaching Health Centers, the National Association of Community Health Centers, and the Association of Clinicians for the Underserved, I strongly encourage your Subcommittee and the Congress as a whole to enact reauthorization legislation providing increased and stable funding for these three programs in advance of their expiration on September 30, 2019. The three programs are inextricably linked because the success of the THCGME and NHSC programs are at risk when our Community Health Center funding is jeopardized. The Section 330 grants to Community Health Centers represent the foundational structure for access in our communities. I liken it to a three-legged stool with the CHC grant as the seat and one leg, with the NHSC and THCGME programs each the other leg. It stands best when all of it holds together.

I have had the honor of being the CEO of Shasta Community Health Center since 1992. We are based in Redding, California, about 160 miles north of Sacramento, in a predominantly rural and mostly medically underserved region of far Northern California. In addition to our Redding facility, we have two other sizeable clinics in the rural cities of Shasta Lake and

Anderson. We have been a federally funded Community Health Center since 1996, which permitted us to add a wide range of services that include dental, mental health, and healthcare for the homeless. In addition, I have also served as the Board Chair of the California Primary Care Association and Board Chair of a statewide foundation, called the California Endowment. Most recently, I served on a statewide California Future Healthcare Workforce Commission that produced over 30 recommendations to our State and other funders on strategies to mitigate healthcare workforce shortages. The physician shortage is particularly acute and even more among the ranks of primary care physicians. This shortage is why Shasta became a Teaching Health Center and implemented a strategy to "grow our own" to serve our community. As I will explain, the THCGME program works in unison with the NHSC and Section 330 CHC programs to enhance our ability to serve our patients and train the next generation of providers.

I should also point out that we are very grateful that our local Congressman, Doug LaMalfa, has visited Shasta on several occasions and has strongly supported the THCGME program from its inception and our efforts to train the next generation of doctors.

Shasta Community Health Center

Some background on Shasta will help members of the Subcommittee best understand why reauthorization of Community Health Centers, THCGME, and National Health Service Corps programs is so critical.

We care for over 40,000 unduplicated patients, or about one quarter of the total population of our county. Ten percent are uninsured, 70 percent are covered by Medicaid, and 16 percent are covered by Medicare. Over 94 percent live below federal poverty lines. We employ over 440 people, including nearly 100 different providers. We also utilize a wide range of sub-specialists from our community and make extensive use of telemedicine. Over 25 Shasta providers have utilized the NHSC loan repayment option as a crucial incentive in overcoming the salary constraints for physicians working in a non-profit setting. Without the NHSC, it is almost impossible to recruit physicians who face average education debts of around $200,000, and even as high as $500,000.

In recent years, we have been inundated by increasing numbers of patients as the primary care shortage in our community has moved beyond those served by Medicaid to Medicare and even to individuals with private medical insurance. Sadly, despite the demand, we have not been able to increase access at the same pace to accommodate this need, primarily because of the primary care workforce shortage. Shasta's four sites are located within a Health Professional Shortage Area (HPSA) for medical, dental, and behavioral health and we offer comprehensive care to everyone, no matter their insurance status. Not surprisingly, as more people have retained health insurance coverage, they have presented more often and frequently show up with late onset of diseases that have been neglected prior to obtaining insurance. Unfortunately, counties in the Far North and the Central Valley of California have suffered some of the worst health outcomes associated with chronic disease in our State, and this has been made more difficult because of the shortages of primary care clinicians. In addition, many of our patients have significant social, emotional, financial and transportation barriers to receiving adequate care. Through the use of integrated mental health and behavioral health services we are able to mitigate those barriers. Most recently, we have also directed more of our clinical efforts to supporting Medication-Assisted Treatment to combat the scourge of opioid abuse.

At this time, my health center is already short 4-5 primary care physicians and while we use and depend on NPs and PAs, the severity of many of our patients' chronic diseases makes dependency on physicians a necessity. Overall, local planning shows that our community is short 20 primary care physicians. In the area of dental and mental health, our HPSA shortage scores in those categories are among the highest in the nation. In summary, "growing our own" through training programs like the THCGME program is not only a good idea, it is a survival imperative for my center in Redding and for centers throughout the country that utilize the THCGME program or want the program to expand to include them.

The Primary Care Physician Shortage and Teaching Health Centers Graduate Medical Education (THCGME)

Since HRSA selected Shasta for the THCGME program, we have had several classes of two primary care residents each. That makes us one of the smaller programs, but our results are comparable to other Teaching Health Centers. Specifically, of our eight THC graduates, five continue to work with primarily underserved populations in Redding and similar communities in California and Arkansas, as well as a tribal health care facility.

Shasta's experience proves that the THCGME program works and deserves to be extended this year. In 2018, Congress reauthorized the THCGME program through Fiscal Year 2019, getting us back to a more sustainable level of $150,000 per resident by providing $126.5 million in appropriations per year for FY18 and FY19. Without Congressional action, the program will lapse again on September 30, so I am very grateful that the Subcommittee is holding this hearing and that Congressman Ruiz and Congresswoman McMorris Rodgers have introduced bipartisan legislation (H.R. 2815) to provide a five-year extension.

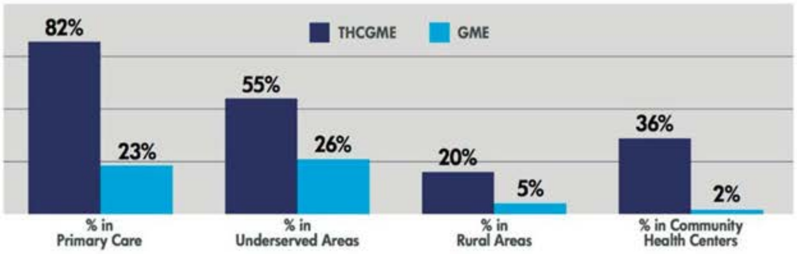
Legislation that responds to the primary care physician shortage is incredibly timely, as the entire nation faces a severe doctor shortage. In fact, by 2030 we will need more than 120,000 physicians to meet the growing demand for health care services across the country, with California alone needing 40,000 physicians. According to the Association of American Medical

Colleges, by 2030, the United States will require nearly 50,000 primary care physicians, and the shortage is being felt most deeply in HPSAs and medically underserved areas (MUAs). As many as 84 million people living in these areas experience disparities in health care access either because they are uninsured, or because they live in rural, urban, or suburban areas without enough primary care physicians. Additionally, we have reached a critical time when the number of medical school graduates is now greater than the number of residency slots. Without a residency, medical school graduates are unable to obtain a medical license.

While patient care increasingly occurs in ambulatory settings, such as community health centers, medical education occurs mainly in inpatient hospital facilities, funded primarily by CMS under a Medicare formula. This hospital-based training produces a health care workforce whose skills and experiences are poorly matched to the primary care needs of the population, and who rarely choose to practice in rural or underserved areas. In order to address the changing healthcare system and address the disparities in the health care workforce, the THCGME model uses community-based ambulatory health centers, such as nonprofit community health centers and community consortia, to train primary care residents who will practice 21st century care in urban and rural underserved communities during their training and after they complete their residencies. During their residency training, THC residents practice in the approved primary care specialties of Family Medicine, General Internal Medicine, Obstetrics and Gynecology, Pediatrics, Psychiatry and General Dentistry.

Evidence has shown that resident physicians who train in health center settings are nearly three times as likely to practice in underserved settings after graduation. They are also 3.4 times more likely to work in a health center, compared to those who did not train in health centers. The difficulties in recruiting community-based primary care physicians are also welldocumented; only investment in the community health care workforce pipeline will help meet the workforce demands.

Analysis of the THCGME programs continue to show promising results:



> TEACHING HEALTH CENTER SUCCESSES

Analysis of THCGME programs shows promising results that signal this innovative education model is working:

As I noted earlier, we were very grateful that as an initial step last year, Congress provided sufficient funding to bring the per resident allocation back up to a more sustainable level. H.R. 2815 would provide another element of sustainability by reauthorizing the THCGME program for five years, just like the two bipartisan Senate reauthorization bills introduced by Senators Alexander and Murray on the one hand and Senators Collins and Tester on the other. Five years will help teaching health centers fulfill their binding three-year training commitments to their recruits. We can budget more efficiently and ensure that we can keep our doors open for enthusiastic future doctors who are committed to practicing medicine in underserved communities. Primary care saves lives and saves money. The Ruiz-McMorris Rodgers bill will improve medical education and save lives in many of our communities.

H.R. 2815 will also help THCs restore some resident slots that were authorized by HRSA but not filled during the last couple years of uncertainty. Within the $126.5 million, there should be enough funding for a THC like ours to recruit and fill some residency slots that we need to meet all national accreditation requirements and to grow from our current class of two residents to four residents in each entering class. H.R. 2815 also includes funding for a very modest increase in the per resident allocation (PRA) to help offset inflation over the next five years. While Congress was very generous in restoring the $150,000 PRA in last year's law, our clinics and residency programs facing rising costs and we are hopeful that Congress can help us preserve our purchasing power during this five-year reauthorization period.

Lastly, H.R. 2815 includes additional funding for expansion of the THCGME program to meet pent-up demand in many communities for a residency program such as Shasta's. It has been five years since HRSA last approved a new Teaching Health Center and many potential sponsors of such centers have reached out to our association expressing interest in becoming a THC. In fact, I know of at least five CHC's in California who are getting accredited and are awaiting a funding opportunity like the THCGME program. HRSA, however, has correctly prioritized trying to sustain existing THC's for the past two years and we are hopeful that this reauthorization process will include additional funds that permit HRSA to solicit proposals and approve entirely new centers or expansion of programs offered at existing centers. Every dollar spent on expansion will generate tangible benefits for your communities and those of other Members. Lives will be saved, economic growth generated, and we will make a dent in the medical care shortage that plagues too many parts of our country to this day.

Community Health Centers Reauthorization Legislation

None of the work that I have already described today would be possible without the foundation provided to every health center through Section 330 federal grant funding. Especially in times of change and transition, sustaining and boosting health center funding provides continuity for the patients and communities we serve. Federal grant dollars allow health centers to expand their facilities, open new sites, and broaden their services to meet unmet need in areas with limited access to care. These dollars are invested in services that grant patients easier access to primary care, including transportation, care coordination, and translation and interpretation services. And, leveraging of federal resources occurs because the federal Section 330 grant remains the unofficial stamp of approval that our other sources of funding and support look for as a representation of a high quality health care provider.

Broad bipartisan support for health centers has brought us to where we are today: 1,400 Community Health Center organizations currently provide care to over 28 million patients in more than 11,000 rural, urban, and frontier communities.

Despite this success providing access to primary care services to millions of medically-underserved patients, the nation's CHS's still face a funding crisis on September 30, 2019 that threatens the very existence of the Health Center Program. As you know, federal grant funding for the Health Center program currently comes from two sources: roughly 30 percent in annual discretionary funding through the Appropriations process and a little more than 70 percent - $4.0 billion annually - in the Community Health Centers Fund (CHCF), which will expire at the end of this fiscal year without Congressional action.

Federal investments supporting the health center system of care must be sustained in a long term and stable manner to ensure health centers' ability to plan for the future, recruit staff, and expand services for patients, as well as to reduce the uncertainty caused by year-to-year renewals of this critical investment in access to care.

Over the last several years, Shasta Community Health Center and health centers in California and across the nation have experienced serious uncertainty due to the challenges we have faced due to recent funding disruptions. By design, health centers are hubs for easier access to care – our doors are open to everyone regardless of ability to pay, services are offered on a sliding scale discount to patients, our patients make up majority portions of our boards of directors, and we locate our sites in medically-underserved communities. However, the instability and uncertainty that occurred in the fall of 2017 through early 2018, when mandatory funding for these programs lapsed, threatened the notion of continuous access. Health centers around the nation scrambled to keep their doors open, serve patients, preserve and secure bank loans, and reassure staff and patients that we'd remain open and continue to provide the level of service patients have become accustomed to over the years.

Frankly, some health centers were luckier than others who were denied for bank loans, lost National Health Service Corps commitments, or closed sites and laid off staff. During this six-month period of uncertainty, there was serious concern among some that the federal government may abandon programs that have shown great promise and provided concrete results in helping expand access to primary care, train the next generation of providers, and recruit clinicians to practice in medically-underserved communities.

Some may wonder about the need for ongoing federal grant support in Medicaid expansion states like California. Like other health centers around the nation, despite our diligent efforts, Shasta Community Health Center still serves a significant number of patients with no insurance. In addition, many insured patients are still low-income and unable to access critical primary and preventative care services because their copays and deductibles are unaffordable. Clearly our work is not done. Despite the strong bipartisan support and history of investment in our capacity, many communities in need still lack a health center or any other form of primary care. Even in communities with a health center, demand often far exceeds supply and significant unmet need remains due to limited resources. The one constant throughout all of these factors, and at every CHC, is the essential role of the federal Section 330 grant that supports our ability to provide care to uninsured and underinsured patients.

I note for the Committee that there are bills pending in the House to provide stable and full funding for CHC programs and to prevent a repeat of the disruption and uncertainty that has occurred during recent reauthorization processes. For example, H.R. 2328, the Community Health Investment, Modernization, and Excellence (CHIME) Act of 2019, introduced by Representatives Tom O'Halleran - a Member of this Committee - and Elise Stefanik, would provide five years of stable funding for the Community Health Center Fund, including $200 million in annual growth. It also provides five years of funding for the NHSC, including $15 million in annual growth. Likewise, H.R. 1943, Community Health Center and Primary Care Workforce Expansion Act of 2019, introduced by Representative Jim Clyburn would provide five years of funding for the Community Health Center Fund, including 10 percent annual growth, as well as an additional $4.6 billion for health center capital funding. H.R. 1943 also includes a significant commitment to expand the NHSC to meet the need for that program across the country. On behalf of the country's health centers I want to thank these Members for introducing this important legislation, and I want to thank the Members of this Committee who have cosponsored this critical funding extension.

National Health Service Corps (NHSC) Reauthorization Legislation

Shasta has benefited greatly from the National Health Service Corps, and I would like to share some thoughts on why a robust reauthorization of the NHSC is essential. Since its creation nearly 50 years ago, NHSC has effectively placed more than 50,000 quality health care providers in the highest need areas of our country at approved sites providing primary medical, dental and/or mental and behavioral health services in underserved communities, with more than 10,000 placements in the last year alone.

In exchange for the participants' service, the program helps alleviate the burden of debt accumulated during the course of their education. The NHSC includes four distinct programs: the Scholarship Program, the Loan Repayment Program, the State Loan Repayment Program and the Students to Service Program. Each of these enable the Corps to recruit primary care clinicians at different stages of their education and careers to serve in shortage areas of the country. While most of the program's placements are within the Loan Repayment Program (81% in 2018), the other three programs are also crucial to getting high quality providers in the areas that need them most.

The NHSC is a vital program for those mission-driven students who want to choose primary care but are burdened by the overwhelming cost of their education. Over the years, medical school debt has increased some 20-fold. The median four-year cost to attend a public medical school is about $240,000 and a private medical school degree can be more than $340,000. As I noted earlier, the average medical school graduate starts with about $200,000 in debt and 14 percent start their residency training owing $300,000 or more. These debt levels are larger than most mortgages.

The NHSC Scholarship program enables primary care providers to come out debt free in return for four years of service in a shortage area like mine. In addition, the Loan Repayment Program provides $25,000 per year of service, starting with a two year term. Our clinicians have come to Shasta with student debt, entered the NHSC Loan Repayment Program and through their service been debt free in just a matter of years. It is an incredible program that encourages students to choose primary care and serve in the highest need areas of the country without the worry of student debt forcing them to choose otherwise.

Today, NHSC providers are focused on primary care providers in the following fields:

35%................Nurse practitioners, physician assistants, certified nurse-midwives
29%................Mental and behavioral health professionals
20%................Physicians
16%................Dentists and dental hygienists

There has been a number of bills introduced to expand this list to include other provider types (optometrists, physical therapists, pediatric psychologists, etc). While we certainly understand the need to fill vacancies in high need areas of the country, and appreciate the focus on the NHSC as an effective mechanism to do so, I'd like to say that this is a zero-sum game. If we add additional providers without increasing the funding, in essence we are reducing the number of current provider types able to use the NHSC.

Centers like Shasta were pleased to see that last year, Congress was able to extend funding for the NHSC through September 30, 2019 at the current level of $310 million. Shasta and other supporters of the NHSC are very thankful for additional discretionary appropriations specifically targeted to the loan repayment program for use placing substance use disorder professionals to help address the opioid crisis. So today, much like the CHC program, the NHSC receives a significant part of its funding through the trust fund (70%) and partial funding through the annual appropriations process (30%).

Supporters of the NHSC program like me are very concerned about the potential expiration of NHSC funding on September 30, which would cause even greater damage to the program as people lose faith in the stability of the program. This will result in a dramatic decrease in field strength, jeopardizing access to care for millions of people. Therefore, supporters of the NHSC encourage Congress to authorize mandatory funding without a gap this Fall and to provide funds for the longest period of time possible.

As a supporter of the NHSC, I urge Congress to fund it at a level that would enable it to fund all the number of applicants for loans and awards through this critical program. The current funding level for the program allows for only 40 percent of Loan Repayment applicants and a mere 10 percent of scholarship applicants to be granted awards. Clearly, more needs to be done since the actual need far exceeds the resources ability of the NHSC, with more than 72 million people living in primary care shortage areas, 54 million living in dental shortage areas, and more than 111 million living in mental health shortage areas. Both H.R. 2328 and H.R. 1943 would move us toward our shared goal of increasing access to care for those in need. With thousands of applicants already looking to serve, please enable the NHSC to support these providers and serve our communities.

Thank you for giving me the time to testify this morning on behalf of the THCGME program, the Section 330 Community Health Centers program, and the National Health Service Corps.

Ms. CASTOR [presiding]. Thank you.

Ms. Autin, you are recognized for 5 minutes.

STATEMENT OF DIANA AUTIN

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

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

I am here today to support H.R. 2822, the Family-to-Family Reauthorization Act, which will extend funding for F2Fs for an additional 5 years at the current funding level of $6 million a year.

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

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

Throughout the U.S. there are about 14 million children with special healthcare needs, 19 percent of all children under 18 and more than one in five families with children.

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

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

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

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

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

For example, in New Jersey, a father called our F2F about his 13-year-old son with Downs Syndrome, autism, major behavioral challenges. He was struggling to afford prescribed medications which were making his son's behavior worse and making him gain weight.

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

Within 6 months, his son was weaned off the medications and had lost 30 pounds, and his overall health and behavior had improved.

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

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

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

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

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

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

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

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

The bill before you today would extend the F2F program for an additional 5 years, longer than ever before. Although modest, the F2F grant provides a foundation upon which other funding and activities can build.

Status as a Federal grantee provides credibility that makes it easier to secure additional funds and partners. However, those other funding sources—government agencies, foundations and individual donors, and community partner organizations don't want to invest time or money in an entity that might not survive for more than a year.

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

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

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

Thank you.

[The prepared statement of Ms. Autin follows:]

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. . . keeping families at the center of children's health care

SPAN
Parent Advocacy Network

TESTIMONY
on
Investing in America's Health Care
before the
Health Subcommittee
House Committee on Energy & Commerce
June 4, 2019

Good morning Mr. Chairman, Mr. Ranking Member, and Members of the Subcommittee. My name is Diana Autin and I am the Executive Co-Director of the SPAN Parent Advocacy Network (SPAN), home of New Jersey's Family-to-Family Health Information Center (F2F), one of 59 such parent-led organizations across the country, territories and tribes. I am here today representing SPAN and Family Voices, the national, family-led organization that has provided guidance for the development of the F2Fs since 1999, and technical assistance since the first federal funding for F2Fs in 2007.

Each F2F receives an annual grant amount of $96,750 from the Maternal and Child Health Bureau to assist families of children and youth with special health care needs (CYSHCN) in their state, territory or tribal community. Family Voices, under a cooperative agreement with the federal Maternal and Child Health Bureau, receives funding of $600,000 per year to provide technical assistance and support to the F2Fs and to promote partnerships between health professionals and families of CYSHCN so that these children receive "family-centered," appropriate, and cost-effective care. SPAN has collaborated in this national technical assistance project as a sub-contractor of Family Voices for the past three years and I serve as one of three Co-Directors of this project.

Family Voices and SPAN strongly support the bill introduced by Representatives Sherrill and Upton -- the *Family-to-Family Reauthorization Act of 2019* (H.R. 2822) -- which will extend funding for Family-to-Family Health Information Centers for five more years, through 2024.

Family-to-Family Health Information Centers (F2Fs)

As explained in more detail below, F2Fs help families whose children have special health care needs to navigate the health care system, effectively advocate for their children, and work as partners with health care providers. They reach out to underserved communities and provide their services in a culturally and linguistically appropriate manner. F2Fs also assist providers, state and federal agencies, legislators, and other stakeholders to better understand and serve CYSHCN and their families. Ultimately, these efforts result in higher quality, more cost-effective care, and better health outcomes. All F2F services to families and professionals are provided without charge.

There has been one F2F in each state and the District of Columbia since 2009, when the program was fully phased in. Thanks to a 2018 amendment to the program, there are now additional F2Fs in American Samoa, Guam, Puerto Rico, the Northern Mariana Islands, and the U.S. Virgin Islands, plus three F2Fs dedicated to serving American Indian and Alaska Native families. These new F2Fs are serving particularly vulnerable and underserved communities.

The Maternal and Child Health Bureau (MCHB) has long recognized the importance of partnering with families to create effective health care services and systems and, since 1999, has funded Family Voices to provide technical assistance and training to families of children with special health care needs to become effective partners at all levels of health care. The focus of this national family network has evolved as the strength of family leadership has grown and federal funding for F2Fs in the states has been put in place. For the past nine years, Family Voices has provided technical assistance and training to the F2Fs through a project called the National Center for Family Professional Partnerships (NCFPP); as of June 1 of this year, this national project supporting the F2Fs is called "Leadership in Family Professional Partnerships."

As its name indicates, the F2F program is based on the idea that families who have experience navigating the health care system for their own children are the best guides for other such families. By statute, F2Fs are staffed by family members of children and youth with special health care needs. Beyond their training, they bring expertise and empathy learned through their personal experiences to their F2F work.

Federal taxpayers get great value from the F2F program, the total cost of which is only $6 million annually. Extremely dedicated, F2F staff work tirelessly, often traveling long distances and working long hours. Despite their modest budgets, F2Fs provided information, training and/or assistance to nearly one million families in 2018.

Background on children and youth with special health care needs

Children and youth with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.[1] They may have physical, developmental, or intellectual disabilities (e.g., cerebral palsy or autism), chronic health conditions (e.g., diabetes or epilepsy), serious illnesses (e.g., cancer), rare genetic diseases (e.g., mitochondrial disorders), severe injuries (e.g., traumatic brain injury), mental health conditions (e.g., serious depression or schizophrenia), or other conditions requiring frequent health care services.

Throughout the U.S., there are about 14 million CYSHCN, constituting 19 percent of all children under age 18. More than one in five families with children has at least one child with special health care needs.

Challenges faced by families of CYSHCN

The health conditions of CYSHCN can be chronic and complex, and finding the pediatric specialists to provide appropriate care can be a struggle. Moreover, necessary care is often extremely expensive; even people with insurance struggle to afford copayments and to pay for therapies and equipment that are not covered. The web of available services – covered through private insurance, Medicaid, CHIP, the school system, state Title V maternal and child health programs, or other agencies and organizations – is difficult to navigate and involves multiple eligibility criteria and coverage standards. As a result, children may miss valuable services because their families are unaware of them, their eligibility criteria, and financing options to pay for them, or are unable to access or afford them.

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[1] This is the definition used by the Health Resources and Services Administration. From: McPherson M, Arango P, Fox H, Lauver C, McManus M, Newacheck P, Perrin J, Shonkoff J, Strickland B. A new definition of children with special health care needs. *Pediatrics,* 102(1):137–140, 1998.

Health care systems do not always work well for CYSHCN, particularly children with complex needs, and for those whose families are not proficient in English or come from diverse cultural backgrounds. Rural families also have particular difficulties accessing care for their children. Many children with special health care needs are eligible for Medicaid because of their conditions or family income, but may face complications in establishing eligibility or procuring services. Some challenges faced by families of CYSHCN include:

- a scarcity of subspecialty providers, especially in rural areas, or those who take Medicaid, resulting in the need to travel long distances and/or wait long times for an appointment;
- problems with insurance plans, including Medicaid managed care plans,[2] such as inadequate provider networks; failure to cover or slow approval of out-of-network or out-of-state care; lack of continuity of care due to changing provider networks; and lack of plan experience in adequately serving this population;
- inadequate coverage of medications, medical equipment, medical supplies, hearing aids, medical foods, and other necessities;
- inadequate coverage of nursing services, therapeutic services (e.g., occupational, physical and speech therapies), and non-medical services (e.g., transportation, respite, home or vehicle modifications, family lodging for out-of-area care);
- insufficient access to home and community-based care, including a shortage of home nurses, sometimes forcing children into nursing homes rather than allowing them to be cared for at home, or preventing them from attending school (if they need a nurse to accompany them);
- failure to integrate mental health and medical services and lack of provider expertise in treating children with co-occurring diagnoses;
- lack of or ineffective care coordination among the child's providers;
- long waiting lists for and incomplete information about Medicaid waivers;
- for families not proficient in English, a lack of interpreters during medical appointments, and a lack of informational materials and communications from insurance companies and Medicaid agencies in the family's language;
- lack of understanding about different cultures' views of health care on the part of health care providers, insurance companies and Medicaid agencies; and
- inadequate preparation for transition to adult-care services.

F2Fs help families

F2Fs help families in a variety of ways to access care, advocate for their children, partner with providers, and find ways to afford the care their children need. F2Fs provide one-to-one assistance, which might entail helping the family appeal a denial by their private insurance company, Medicaid or CHIP for services, equipment or supplies; helping the family gain

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[2] From the National Academy for State Health Policy: "The first wave of Medicaid managed care in the 1990s saw many states carving out services for children and adults with special needs through fee-for-service arrangements. However, these trends have changed dramatically since that time. Recent CMS data and a 2010 Kaiser Family Foundation survey indicate that 32 states mandatorily enroll at least some children and youth with special health care needs (CYSHCN) in managed care, 20 states enroll CYSHCN in managed care on a voluntary basis, and about half of states mandate managed care for at least some children who receive Supplemental Security Income (SSI)." (Source: http://www.nashp.org/early-highlights-of-what-the-final-managed-care-rule-for-medicaid/)

Medicaid eligibility under a state home and community-based services waiver or other eligibility pathway; helping the family get early intervention services, find an appropriate pediatric subspecialist or facility, or meet other needs, such as speech or other therapy services, home-nursing services, transportation, home modifications, or translation services. Since F2F staff are parents who have "been there" themselves, they can also offer emotional support and encouragement.

F2Fs also help families learn skills and gain confidence to communicate more effectively with health care professionals and to advocate for their children within hospitals and other provider settings. They disseminate information via fact sheets, manuals, toolkits, newsletters/e-newsletters, websites, and social media, and hold workshops for families on numerous topics, including those related to MCHB's six core outcomes for a system of care for CYSHCN -- early and continuous screening to identify needs, access to a medical home to coordinate care, help finding community services, access to adequate health care financing, preparation for transitions to adulthood, and effective partnerships with professionals.

Ninety-two percent (92%) of families helped by F2Fs report that they are better able to partner with providers and navigate systems as a result of the assistance received from their F2F, and 90 percent report increased confidence in their ability to access the services their child and family need.

F2Fs also help families financially, and thereby help their children. They assist families to access adequate health care financing, such as Medicaid, CHIP, and private insurance. F2Fs understand the particular health care financing issues faced by families of CYSHCN as well as special health care financing resources that might be available to them, such as State Catastrophic Illness in Children Relief Funds. In addition, many F2Fs have special expertise in helping diverse and underserved families understand complex financing systems. A family that is impoverished, in debt, or actually driven to bankruptcy due to out-of-pocket medical expenses, can have their financial and emotional well-being revived when their child gets Medicaid coverage, perhaps through a special waiver for technology-dependent children or developmental disabilities that the family would not have known about had they not received services from their F2F. A family that cannot afford both physical and speech therapy for their child can see their child learn to walk *and* talk once they gain public or private health insurance coverage. Parents who are unsure whether they can afford to fill a prescription for a critical medication can breathe more freely when an F2F helps them get their insurance company to pay for the drug. Parents who had to stay home to care for their child may be able to go back to work if they can get coverage for home-nursing services.

One example of how F2Fs help CYSHCN and their families comes from a father in New Jersey: "Losing my insurance turned out to be a blessing in disguise! I have a 13-year old with Down syndrome and autism. He has major behavioral challenges and at the suggestion of his neurologist, he was taking three different medications that made his behaviors worse and made him gain 40-50 pounds. I was desperate when I contacted SPAN because I could no longer afford the medications and was overwhelmed with his other health challenges. SPAN recommended the Federally Qualified Health Center near my home and over time we were able to wean him off the medications. I worked with SPAN to develop a positive behavior support plan for school and they helped us get connected with Special Child Health Services and the Family Support Organization. I am so amazed that my son is now a totally different kid! He lost 30 pounds in six months and his overall health and behavior has significantly improved. He can run around the park without wheezing!"

As discussed below, some families face more than the usual challenges experienced by those whose children have special health care needs. F2Fs assist these families as well.

Military Families

Military families must relocate more often than most other families. When they move to another state, they must find new medical specialists, reapply for Medicaid waivers, and negotiate for school-based health services with a new school district. Moreover, they might find that the military insurance program, TRICARE, makes different coverage decisions in different regions, and they must coordinate coverage between TRICARE and any new employment-based coverage the military spouse might have. On top of that, one parent may be deployed, meaning the parent at home is a single parent, possibly caring for multiple children without family, friends or support networks in the new area.

Resiliency for members of the military members and their families must be a priority; it's difficult for military members to concentrate on the important work they do if their family is not able to access what they need. Some F2Fs in areas with many military families have developed expertise in serving them. SPAN is an example of such an F2F, and has worked hard to establish and maintain a deep partnership with Joint Base McGuire-Dix-Lakehurst. In fact, there are F2F workers embedded on the base, co-located with the Exceptional Family Military Program (EFMP) Medical, Family Support, and School Liaison Office, the on-base clinic, and all the on-base supports for military families of children with disabilities. To date, SPAN's one-stop program has served well over 1,000 military-connected families, and has been recognized as a Department of Defense best practice.

Military families come to SPAN's F2F with issues ranging from a child with a transplant needing hands-on advocacy to facilitate their return to a safe educational placement, to a child with Prader-Willi Syndrome and other significant health complications with a need for nursing supports, to a young student in 5th grade bullied to the point of suicidal ideation, who needed access to effective providers and support. For this child and family, SPAN went with the family to the school to make a harassment/intimidation/bullying report and worked with the base's Security Police to get a mental-health mobile response team onto the base without requiring the parents to leave their struggling child to sign them in.

Other F2F grantees that offer special help to military families include the Rhode Island Parent Information Network and Washington State's PAVE (Partnerships for Action, Voices for Empowerment).

Underserved and culturally diverse families

Almost 40 percent of the families served by F2Fs reported that they were non-white, and almost 16 percent were Hispanic/Latino/Latina. F2Fs reach families of diverse backgrounds in many ways—hosting support groups and leadership conferences for families in multiple languages, facilitating focus groups to learn about outreach and service delivery strategies and to create culturally competent materials, participating in community meetings serving diverse communities, and partnering with community-based "cultural liaisons." F2Fs also help develop the leadership skills of diverse families, which has been a major focus of the last three years of the NCFPP project. F2Fs partner with agencies that serve a high percentage of underserved families, such as Federally Qualified Health Centers (FQHCs). For example, in Georgia, the F2F houses regional coordinators in clinics serving underserved populations. After a family sees the doctor, the regional coordinator connects the family to local resources, matches them to another family for emotional support, and provides them with information. In New Jersey, SPAN partnered with three FQHCs in low-income, high-immigrant communities. Trained Family Resource Specialists provided training to the FQHCs and to immigrant, limited-English-proficient parents served by those FQHCs, leading to statistically significant improvements in outcomes. Several of the FQHCs continue to facilitate ongoing parent-support groups for families of CYSHCN in their practice. F2F staff and trained parent leaders work with the 20 FQHCs with which SPAN has written linkage agreements to provide ongoing support to families of CYSHCN.

Family Voices supports multiple opportunities for F2Fs to expand their cultural competence and outreach to diverse families through conference sessions, webinars, materials and sharing of best practices. Family Voices projects offer F2Fs chances to engage families from diverse cultures in leadership roles, such as the Family Wisdom project, federally funded through a Patient Centered Outcomes Research grant. This project supported diverse family leaders from 16 F2Fs in an 18-month "Community of Practice" activity in which participants met monthly to share strategies for how to facilitate participation in health research by members of diverse communities.

Native American and Alaska Native Families

Native American and Alaska Native CYSHCN and their families face particularly difficult circumstances. They experience high levels of poverty, and many live in extremely sparsely populated areas lacking basic services like water, electricity, and heat. It may take many hours to get to a health care facility, let alone a pediatric subspecialist, and transportation options may be very limited. In some areas, roads are impassable in bad weather. In addition, these families must navigate the Indian Health Service, as well as the private or public insurance they might have. Since reservations may span multiple states – the Navajo Nation spans three –they may have to obtain out-of-state or out-of-network services more frequently than other families, which can be difficult with Medicaid (or even private) coverage. (Other rural and border-state families have the same problem.)

As you know, in early 2018 Congress authorized the establishment of F2Fs for five U.S. territories and at least one tribal community, a goal toward which Family Voices had been working for a long time. It is extremely exciting that in October 2108, grants were awarded to establish F2Fs in five U.S. territories (discussed in the next section), and three F2F grants were awarded to serve Native Americans and Alaska Natives:

Navajo Nation

Indian Country Grassroots and Navajo Family Voices has been designated the F2F for the Navajo Nation. The Navajo Nation straddles the states of Arizona, New Mexico and Utah, each with its own state-based set of resources for families as well as resources provided by tribal government and community groups. Integrating these resources and understanding how they work together is fundamental to Nahat'á (planning for balance and harmony). The F2F will develop and provide peer-to-peer connections, support, resources, and training for parents, family members, providers, and communities to better support children and youth with special health care needs on the Navajo Nation. Their goal is to establish a holistic information and support system incorporating Diné cultural practices and principles in planning and decision-making for wellness and success. *Álchíní hózhóóji bá Nahat'á* means "planning for the children in a blessing manner."

Parents Reaching Out (NM) and Raising Special Kids (AZ)

Project CARES (Cultivating American Indian Resource Expansion in the Southwest) is a collaboration between two experienced state F2Fs, Raising Special Kids and Parents Reaching Out, to provide culturally appropriate resources, support, training, and technical assistance to families of CYSHCN within seven medically underserved tribal communities. Communities to be served include the Hopi, Mescalero Apache, Navajo Nation, Salt River Pima-Maricopa Indian Community of the Salt River Reservation, Tohono O'odham Nation, White Mountain Apache Tribe, and Zuni Pueblo.

Alaska F2F at Stoue Soup Group

Stone Soup Group, an experienced F2F, serves as Alaska's designated Alaskan Native F2F. The project is staffed primarily by parents and family members of CYSHCN who understand the systems and processes from a unique first-hand perspective. F2F staff will assist families to navigate through the often-overwhelming maze of programs and services, facilitate productive, healthy relationships between families and professionals to promote family-centered, culturally appropriate care, and assist families, health care providers, social workers, government entities, and other community organizations to partner to improve systems.

Families in U.S. Territories

Families in U.S. territories, particularly those who have CYSHCN, face special challenges for several reasons, including high levels of poverty, a scarcity of local health care providers, the need to travel long distances to obtain pediatric subspecialty care, capped Medicaid funding, substandard infrastructure, and high incidences of certain health conditions. In October 2018, F2F grants were awarded in Puerto Rico, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, and Guam. Family Voices has been able to make in-person technical assistance visits to each of these new F2Fs in the current year and all these new F2Fs sent representatives to the May 2019 Family Voices Leadership Conference in Washington DC.

Puerto Rico

The Puerto Rico F2F is a Project of the Puerto Rico University Center for Excellence in Developmental Disabilities (UCEDD), part of the Graduate School of Public Health, School of Medicine of the University of Puerto Rico. Staffed with parents of CYSHCN, this F2F focuses on providing support, information, resources, tools and training to empower families to advocate for services and improve systems. Professionals, and students from a variety of fields, will receive training and information to learn about the needs of families and how to engage families as partners.

The U.S. Virgin Islands

The F2F at the Developmental Disabilities Center in the U.S. Virgin Islands was funded in 2018 in response to the needs of the families in this territory. In this eight-month planning year the F2F staff has convened key partners across the territory, engaged parents of CYSHCN to assess their needs, and is informing and educating key elected officials about the needs of CYSHCN. The goal of the F2F is to support and empower families to seek appropriate services to address the needs of their CYSHCN while being attentive to the diverse cultures that exist on the islands.

American Samoa

American Samoa is a U.S. territory located in the south Pacific with over 55,000 residents. The American Samoa Department of Health received funding to plan for and develop an F2F. During this eight-month planning year, American Samoa has undertaken a comprehensive formative assessment, meeting with families, self-advocates, service providers, and agency and government leaders to evaluate the community's needs and assets. The results of that assessment will inform F2F activities aimed at building family leadership capacity, facilitating interagency collaboration, improving collection and sharing of data on CYSHCN, and promoting public awareness of disability issues.

Commonwealth of the Northern Mariana Islands (CNMI)

The Commonwealth of the Northern Mariana Islands (CNMI) is a U.S. territory in the northwestern Pacific with about 55,000 residents. The CNMI Department of Health received funding to plan for and develop an F2F. They have used this planning period to develop and implement an extensive assessment to determine the needs of families by meeting with all stakeholders, including families, providers and government officials. The assessment results will inform the next steps for developing the activities of the F2F, which include goals of building the capacity of families to advocate for their needs and for improvements in the system of care. Activities to improve interagency collaboration, collect and share data on CYSHCN and to promote public awareness of disability issues will be an essential aspect of the work.

Guam

Guam is a U.S. territory located in the western Pacific with 162,000 residents. Through Guam's Department of Health, this newly funded F2F will focus on the development of a centralized data system and on developing a health resource center that will benefit families of CYSHCN. The Center will provide information and resources to these families and direct them to the appropriate programs or agencies to receive the assistance they need.

Family Voices staff member Glenn Gabbard, who is of Samoan heritage, has been assisting health agencies and family organizations prepare for F2Fs in the three Pacific territories – American Samoa, CNMI, and Guam. His observations on recent trips to the territories are valuable:

> Each of the three Pacific territories that I am working with demonstrate the diversity of colonial history and current socio-economic status between and among the territories themselves. While visiting, I was deeply impressed with how important the presence of

> the Family to Family Centers will be. Having met with over 30 different families as well as the territorial legislators and public offices designed to serve them, it became very clear that the current health care delivery systems do not adequately represent the aspirations and challenges which these families have. There are significant cultural challenges to building the capacity of families to actively engage in the various systems which are intended to serve them; however, I was convinced by the passion and dedication of families for their children and their hopes for a healthy, fulfilling future for their children.

F2Fs improve health outcomes for children and youth

Parents who advocate effectively on behalf of their children's health care, and who have the partnership skills to communicate and work with health care providers in meaningful ways, report improved health outcomes for their children as a result of that parent involvement. A growing body of evidence demonstrates that parents are more likely to be able to advocate effectively when they are provided with support by peers.

For example, in the Rhode Island Pediatric Primary Care Enhancement Project, a federally funded pilot project, trained parents of CYSHCN were placed in primary care practices for 20 hours per week to provide support to individual families (those with and without children with special health care needs) in navigating across and advocating in multiple systems. These family leaders also worked with primary care providers on partnering more effectively with families and connecting families to available resources and supports. A study of the project's impact found that placing trained parents of CYSHCN in pediatric practices reduced the cost of care, reduced inappropriate utilization of services, including inpatient care, and increased parent and provider knowledge and satisfaction.

F2Fs improve health systems and cost-effectiveness of care

Often, state Medicaid agencies, managed care organizations, and health care facilities do not meaningfully engage or consider the input of families and family organizations in the development, implementation and evaluation of their organizational policies, procedures, programs, and practices. As a result, they are missing opportunities to address some of the problems and inefficiencies in their systems, and thus to improve patient care, family satisfaction, and health outcomes.

Families have critical insights about how institutions and systems can best serve their children, and do so more efficiently. F2Fs promote family engagement with health care providers and government agencies with the aim of improving institutional and government policies affecting CYSHCN and their families. The NCFPP (now LFPP) and F2Fs train parents and professionals to become more effective partners in the treatment of CYSHCN, and train parents and youth of diverse backgrounds to meaningfully engage with policymakers at the individual, community, state and federal levels. They provide feedback to health care providers; participate on the advisory boards of health clinics, hospitals, and health maintenance organizations; work with state agencies on policies to ensure that they effectively meet the needs of diverse families; and participate in national-level partnership activities to improve policies and systems. Outcomes research provides evidence of the value of such participation at all levels of health care.

The importance of federal funding and the Family-to-Family Reauthorization Act of 2019

Each F2F receives a federal grant of $96,750, regardless of the state's population or geographic size. This small amount of funding can support only one or two employees, but it also provides something else of great value. As a federal grantee, an F2F has a certain degree of credibility that can help it secure other funding from foundations, state and local agencies, or private donors.

That credibility comes from the designation as the federally-recognized F2F, from the fact that organizations must apply for this funding and score high enough to be awarded an F2F grant, and from the results of the qualitative and quantitative evaluation that F2Fs must undergo. For example, at least 30 F2Fs also receive funding from their state Title V Maternal and Child Health Program via the block grant and/or other state funding, to supplement the individual assistance the F2Fs can offer or to support the F2F's role in other initiatives to improve quality and outcomes at the program and policy levels. For example, SPAN is funded by our Title V and other state agencies in the domains of maternal/infant health (Community Doula pilot); adolescent health (Parents As Champions for School Health); and child health (Parent Lead on Help Me Grow, Early Childhood Comprehensive Systems grant, and Home Visiting).

F2Fs can also use the credibility and data from their F2F status to secure funding from county and local agencies and foundations. For example, SPAN is funded by the NJ Bar Foundation to provide individual assistance to families and training to families, youth and professionals about the health and education rights of CYSHCN in the child welfare and juvenile justice systems and the resources available to support them. SPAN training is part of the professional preparation for every new social worker at our state's child welfare agency. And the recognition of SPAN as the state's F2F has also led to numerous fee-for-service contracts with local, county and state agencies to train their staff.

The information above provides clear evidence of the importance of continued funding for the nation's 59 F2Fs. But the proposed legislation does more than that. It extends the funding for five years rather than fewer. The length of the grant period is critically important. Although modest, the F2F grant provides a foundation upon which other funding can build. However, those other funding sources – state Title V programs, local government agencies, foundations, and individual donors – want to fund and partner with organizations that have stable base funding.

It is also difficult to recruit and retain staff when you have to tell them every other year that their job may disappear. All families need a sense of stability in their employment but this is even more critical for families of CYSHCN; they must maintain health insurance and they already face many challenges in their lives.

Finally, trusting and effective partnerships with community-based groups – such as FQHCs, hospitals, and other nonprofit organizations – require time and effort to develop and nurture. This can happen only if the partner agencies have confidence that their relationships and shared work with the F2F will continue for a meaningful period; otherwise, it's not worth their investment of time and energy.

It's important to note that some F2Fs are part of a larger organization, like SPAN, through which they may be able to receive in-kind support. Other F2Fs essentially stand alone, relying primarily on their federal F2F grant to keep their doors open. For both of these types of F2Fs, being able to rely on the continued existence of F2F funding is critical.

Since its inception over a decade ago, when it was created by Senator Charles Grassley and the late Senator Ted Kennedy, the F2F program has enjoyed strong bipartisan support. We are very grateful to Representatives Sherrill and Upton for continuing this bipartisan effort to ensure that families can secure timely, high-quality, family-centered care for their children and youth with special health care needs.

On behalf of Family Voices and SPAN, I would like to thank the Chairman, Ranking Member, and Subcommittee Members for the opportunity to testify about the value of Family-to-Family Health Information Centers. I would be happy to answer any questions you might have.

ATTACHMENTS

Below:
- F2F funding history
- F2F fact sheet
- The Value of F2Fs

Separate document:
- FY2018 F2F Data Brief [hyperlink]

Family Voices contact:
Janis Guerney
Director of Public Policy
jguerney@familyvoices.org
202.669.5233

FUNDING HISTORY FOR FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS

1999-2006: Family-to-Family Health Information Centers were developed in some states with the support of Family Voices and funding from the Robert Wood Johnson Foundation, the Maternal Child Health Bureau (MCHB), and the Centers for Medicare and Medicaid Services (CMS).

FYs 2007-present: The Family Opportunity Act (part of the Deficit Reduction Act of 2005), *as amended subsequently* (see table below), has authorized and funded F2Fs. After a phase-in period, one grant has been awarded in each state and DC since 2009. Through FY 2017 total program spending was $5 million per year. Beginning in 2018, an F2F was established in five of the U.S.territories - American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S.Virgin Islands) and three have been established to serve Indian tribes. Funding is automatic (not appropriated) once authorization is extended. Total program funding for FYs 2018-19 is $6 million per year.

Law Soc. Sec. Act §501(c) [42 U.S.C. 701(c)] as amended by:	**Federal Fiscal Year funded (10/1-9/30)**	**Grant cycle funded (June 1-May 31)**	**Amount (per Federal FY)**
Family Opportunity Act (FOA)/Deficit Reduction Act of 2005 (2/8/06) *(Grassley/Barton/Bush)*	FFYs 2007, 2008, 2009	Through May 2010	FFY 2007 - $3 million FFY 2008 - $4 million FFY 2009 - $5 million
Affordable Care Act (ACA) (3/23/10) *(Baucus/Waxman/Obama)*	FFYs 2010, 2011, 2012	Through May 2013	FFY 2010 - $5 million FFY 2011 - $5 million FFY 2012 - $5 million
American Taxpayer Relief Act of 2012 (ATRA) (1/1/13) *(Baucus/Upton/Obama)*	FFY 2013	Through May 2014	$5 million
Bipartisan Budget Act of 2013 (BBA) (12/26/13) *(Baucus/Upton/Obama)*	"Portion of FY 2014 before April 1, 2014" (first half FFY 2014)	Through November 2014	$2.5 million
Protecting Access to Medicare Act of 2014 (4/1/14) *(Wyden/Upton/Obama)*	"Portion of FY 2014 on or after April 1, 2014" (2nd half FFY 2014)	Through May 2015	$2.5 million
	+		+
	"Portion of FY 2015 before April 1, 2015" (first half FFY 2015)	Through November 2015	$2.5 million
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (4/16/15) *(Hatch/Upton/Obama)*	FFYs 2015, 2016, 2017	Through May 2018	FFY 2015 - $5 M (total) FFY 2016 - $5 M FFY 2017 - $5 M
The "Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act" within the Bipartisan Budget Act of 2018 (Sec. 50101) (2/9/18) *(Hatch/Walden/Trump)*	FFYs 2018 and 2019	Through May 2020	FFY 2018 - $6 million FFY 2019 - $6 million + amendment to develop at least one F2F for Indian tribes and an F2F in each of five U.S.territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S.Virgin Islands)

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Family-To-Family Health Information Centers (F2Fs)

- Throughout the US, there are nearly 14 million children and youth with special health care needs (CYSHCN), constituting 19 percent of all children under age 18. More than one in five households with children has at least one child with special health care needs. Nearly a third of these families who have insurance report that it is inadequate to meet their children's needs.
- It is very difficult for families to figure out how to finance their children's care, given the great expense and complexity of potential funding sources – including private insurance, Medicaid, CHIP, state Maternal and Child Health programs, and the Individuals with Disabilities Education Act (IDEA) – each with different eligibility and coverage criteria.
- The Maternal and Child Health Bureau (MCHB) administers a grant program to fund one Family-to-Family Health Information Center (F2F) in each state, the District of Columbia, and five U.S.territories, plus three F2Fs to serve tribal communities.
- Family-to-Family Health Information Centers (F2Fs) –
  - help families of CYSHCN learn how to navigate the complex health care system, advocate for their children, and make informed choices about health care in order to promote good treatment decisions, cost-effectiveness and improved health outcomes.
  - work with families, youth, and health care providers to help youth with special health care needs transition to adult services and independence.
  - provide training and assistance to health care providers and public agencies to promote family-centered, culturally competent, and linguistically appropriate care and medical homes for CYSHCN.
  - work to engage families and youth in efforts to improve the health care system.
- F2Fs are staffed by families of CYSHCN who have extensive personal experience and professional training in accessing and financing health care for CYSHCN.
- Each F2F receives less than $97,000 per year to serve its entire state/territory/tribal community. (The grant amount has not increased substantially since the inception of the program in FY 2007.)
- Despite their shoestring budgets, F2Fs provided information, training and/or assistance to nearly one million families and over 374,000 health professionals in 2018.
- The F2F grant program was established with bipartisan support by the Family Opportunity Act, part of the Deficit Reduction Act of 2005.
- After a three-year phase-in period ending in 2009, the program was extended through FY 2017, with level funding of $5 million per year, through amendments in various other laws.
- In 2018, the "Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act" within the Bipartisan Budget Act of 2018 (Sec. 50101) extended F2F funding through FY 2019, at $6 million per year, and allowed grants to be awarded for U.S.territories and Indian tribes. For the work of F2Fs to continue beyond this fiscal year, additional legislation will be needed.

(updated 05/02/19)

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The Value of Family-to-Family Health Information Centers

Imagine a family that is suddenly confronted with a very premature baby likely to have multiple health problems or disabilities, or discovers that their child needs a kidney transplant, or has autism, diabetes, epilepsy or a serious mental illness. They are likely to be at a loss for information about how to get the best treatment for their child – how to find the right specialists, therapists, or caretakers – and how to pay for that costly care (autism therapies, private-duty nursing, and specialized medications, for example, can cost tens or even hundreds of thousands of dollars per year.)

When a family receives help from a Family-to-Family Health Information Center, they can get this vital information, emotional support, and help in navigating the complex maze of health care financing. Your state's Family-to-Family Health Information Center can provide examples of how they have helped families in one or more of these ways.

The assistance that F2Fs provide:

(1) improves health outcomes for kids;

(2) reduces government health care spending (i.e., to Medicaid, public clinics, public hospitals) or costs to the health system in general (e.g., to families, insurance companies) by ensuring that children get timely, appropriate care, and cost-effective care;

(3) reduces government education spending (i.e., where early intervention helps to avoid or reduce the need for special education);

(4) enables families to get care for their kids without having to face bankruptcy or spend all their college or retirement savings;

(5) enables parents to continue to work (e.g., because they can get nursing care for their child); and/or

(6) keeps children at home with their families, and out of costly and psychologically harmful institutional care.

For national and state-specific information about F2Fs, see
http://familyvoices.org/ncfpp/f2fs/ or
contact Janis Guerney (jguerney@familyvoices.org or 202-669-5233)

***Family Voices** is an organization of and for families whose children have special health care needs.*
www.familyvoices.org

(updated 05/02/19,

Ms. CASTOR. Thank you very much.

Dr. Kowalski, you are recognized for 5 minutes.

STATEMENT OF AARON J. KOWALSKI, PH.D.

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

In 1977, my brother—my younger brother, Steven, was diagnosed with type 1 diabetes, or T1D, at the age of 3. In 1984, I too was diagnosed with T1D when I was 13 years old.

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

I've worked at JDRF, the world's largest charitable funder of type 1 diabetes research for 15 years, and just 8 weeks ago I became its president and CEO.

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

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

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

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

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

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

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

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

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

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

These communities have a diabetes prevalence rate approximately 2 times the national average and the death rate 1.8 times higher than the general U.S. population due to diabetes.

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

As you can see, SDP and SDPI programs are making a real difference in the lives of people with type 1 and type 2 diabetes. That's why JDRF strongly supports House Bills 2668 and 2680, introduced by Representatives DeGette, Reed, O'Halleran, and Mullin that will raise the amount of funding to $200 million a year for SDP and SDPI and fund them for 5 years.

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

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

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

[The prepared statement of Dr. Kowalski follows:]

JDRF IMPROVING LIVES. CURING TYPE 1 DIABETES.

Testimony by

Aaron J. Kowalski, Ph.D.

President & CEO, JDRF

Before the

U.S. House of Representatives

Committee on Energy & Commerce, Subcommittee on Health

Hearing on "Investing in America's Health"

June 4, 2019

For media inquiries contact:
C.J. Volpe, JDRF
cvolpe@jdrf.org
212-401-2136

Chairman Pallone, Ranking Member Walden, Chairwoman Eshoo, Ranking Member Burgess, and Members of the Subcommittee, thank you for giving me the opportunity to testify before you today.

In 1977, my younger brother Stephen was diagnosed with type 1 diabetes (T1D). It was a bolt out of the blue. I was diagnosed with type 1 diabetes in 1984, when I was 13 years old. Because of that, I went on to get my doctorate in microbiology and molecular genetics, and then I focused my career on the fight to cure this terrible disease and to help people with diabetes stay healthy until that day.

I have worked at JDRF – the world's largest charitable funder of type 1 diabetes research – for 15 years, and just 8 weeks ago, I became its President & CEO.

I have traveled the country talking with many thousands of people affected by diabetes. And I am here today with a simple message from our community: the Special Diabetes Program is making a tremendous difference in our lives and in our hopes for the future. We need you to continue to give it robust support.

We are grateful for the leadership of this committee on both sides of the aisle over the years and the strong bipartisan support in Congress for the Special Diabetes Program or SDP. By supporting the SDP, you have been the catalyst that has fundamentally changed diabetes management, diabetes care, and have brought us ever closer to cures.

What you are funding are not simply science experiments. What you are funding is research that has led – and is leading – to significant advances. I can't even begin to describe this transformation in how we manage diabetes in just the past 10 years. After pricking my fingers to draw blood an estimated 51,000 times over the last 35 years, continuous glucose monitoring (CGM) technology – the initial development of which was supported by the SDP – has allowed me to go without a single poke for over five months now. Vision loss used to be a given in T1D; today multiple therapies are available to help preserve sight. These advances would have been unthinkable to me in 1984, 1994, or even 2004.

Continued funding of the SDP, also known as the Special Statutory Funding Program for Type 1 Diabetes Research, will keep this research and this transformation going. It will relieve the daily burden for people with T1D, reduce serious complications of the disease, and bring us steps closer to a world without this disease.

In addition, lives are being transformed by the Special Diabetes Program for Indians or SDPI program which funds prevention and treatment programs for those in American Indian and Alaska Native communities that are disproportionately impacted by type 2 diabetes. The clinical results have been impressive, with the significant reductions in the incidence of kidney disease and other complications.

Today, I will discuss the progress that is a result of both programs, and then look forward to answering any questions you may have.

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Type 1 diabetes or T1D is an autoimmune disease in which a person's pancreas stops producing insulin, a hormone that enables a person to utilize energy from food. T1D lasts a lifetime and people with T1D must take insulin to live. Type 2 diabetes, also known as T2D, is a metabolic disease. With T2D, the body still produces insulin but cannot use it effectively. While T1D and T2D are different, the resulting complications are the same. Overall, diabetes imposes a tremendous burden on individuals who have it as well as society at large.

Approximately 30 million Americans have T1D or T2D, and that number is expected to rise in years to come. According to a study in *Diabetes Care*, diabetes cost the US economy $327 billion in 2017 alone. Since there are so many complications that come with diabetes, about a third of the Medicare budget is spent on people with diabetes.

To address the burden of diabetes, the Special Diabetes Program was created as part of a bipartisan budget deal, and has been supported by both chambers of Congress and both parties ever since. And thanks to the funding successive Congresses have provided, we have seen major progress in T1D research that has directly led to improvements in the health and quality of life of people with diabetes. Allow me to share some of the highlights.

Kidney disease is a potentially life-threatening complication of T1D, and end-stage renal disease creates a tremendous economic burden, costing Medicare $34 billion in 2015. If new therapies could lower end-stage renal disease rates by 50 percent, Medicare would save more than $51.6 billion in 10 years. A promising SDP-funded trial is testing whether allopurinol, a generic medication used to treat gout, may halt or slow the progression of early kidney disease in people with T1D. In this case, SDP is filling a critical gap as commercial pharmaceutical companies have no incentive to invest in testing new uses for this generic drug.

Diabetic retinopathy, which can lead to blindness, is one of the most devastating complications of diabetes. As a result of SDP research, the FDA has approved multiple drugs that preserve and even improve vision in people who have diabetic eye disease. These advances make the difference between being able to see well enough to drive or hold a job – or not. The SDP also filled a critical research gap by funding a comparison of three drugs for the treatment of diabetic eye disease. The results, released in 2015, help patients, clinicians, insurers and policymakers make better informed decisions about targeted treatment. This comparison likely would not have happened in the private sector. With continued funding researchers could conduct trials using a generic drug to see if it also prevents or halts the progression of retinopathy.

We know that one of the best ways to prevent these complications from diabetes is to make it easier to better manage diabetes. Over the years, the SDP has funded some of the most consequential leaps forward in diabetes management, giving people with T1D access to multiple new tools to enable better glucose control. These multiple options, which are essential as what may work for one person may not be the best for another, include the first FDA-approved CGM not needing finger-stick calibration, the first FDA-approved fully implantable CGM, and the first FDA-approved iCGM system that can be used as part of a system with other compatible medical devices and electronic interfaces. And perhaps the largest leap forward – the first FDA-approved artificial pancreas (AP) system – also came on the market several years earlier than expected thanks to innovative research supported by the SDP. This not only will transform lives: according to one study, Medicare could save $1 billion over 25 years with the use of AP systems in adults.

And this is just the start.

The SDP is supporting research that will lead to other next-generation systems being available in the future. This includes advanced clinical trials to test AP technology with greater automation, larger groups, wider age ranges, longer time periods and with understudied populations.

To make progress towards curing T1D, we need to understand why the immune system goes awry, and how we can eliminate these immune attacks. This has implications across numerous diseases, from multiple sclerosis and rheumatoid arthritis to cancer. We also need to understand how to protect and regenerate insulin-producing beta cells that have been damaged.

The SDP is funding innovative, multi-disciplinary scientific consortia and path-breaking research utilizing big data analytics and other new research methods.

For instance, The Environmental Determinants of Diabetes in the Young – or TEDDY program – has screened more than 425,000 children and enrolled 8,600 children determined to be at-risk of developing T1D to understand what environmental factor or factors trigger T1D onset. The study is more than halfway to completion and information on diet, infections, and other exposures is being analyzed from children who are progressing or now have full T1D onset. By identifying triggers, strategies could be developed to prevent onset altogether. The data collected from this study could also benefit other autoimmune diseases, such as celiac disease.

Another example is TrialNet – the International Consortium for Clinical Trials to Delay or Prevent T1D Progression – in which SDP-funded researchers have screened more than 200,000 relatives of people with T1D and continue to screen more than 15,000 people annually to identify the early stages of T1D before any symptoms appear. This, in turn, is allowing us to test novel approaches to prevent or slow the onset of T1D in those most at-risk to develop it.

Finally, the Human Islet Research Network is working to help us better understand how beta cells, the cells in the body that produce insulin, are lost in T1D and find strategies to protect or replace them in people, which is an important step toward curing the disease.

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While SDP research funding moves us closer to cures and improves the quality of care for those with T1D, the SDPI program that is funded by the Indian Health Service has played a critical role in tackling T2D among American Indians and Alaska Natives, a population that is disproportionately suffering from the disease.

In fact, between 1994 and 2002, the prevalence of T2D grew from 11.5 percent to 15.3 percent of the adult American Indian and Alaska Native population, and these communities have a diabetes prevalence rate approximately two times the national average. Moreover, American Indians and Alaska Natives are 1.8 times more likely to die from diabetes than the general US population.

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

In fact, there have been no further increases in the prevalence of type 2 diabetes in these populations since 2011. The average A1c level, the standard means of measuring glucose control, decreased from 9.0 percent in 1996 to 8.1 percent in 2014, resulting in reduced risk of eye, kidney, and other complications. From 1996 to 2013, there was a 54 percent decrease in the incidence of diabetes related end-stage renal disease in American Indian and Alaska Native adults, which saved thousands of people from a very debilitating complication and HHS estimates generated approximately $500 million of Medicare savings over a 10-year period.

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As you can see, the SDP and SDPI programs are making a real difference in the lives of people with type 1 and type 2 diabetes.

That is why JDRF strongly supports House bills 2668 and 2680 introduced by Representatives DeGette, Reed, O'Halleran, and Mullin that will raise the amount of funding to $200 million a year for SDP and SDPI, and fund them for five years.

All of us at JDRF are grateful that 378 Representatives, including nearly all of the Members on this subcommittee and the full Committee, signed a letter to leadership led by Representatives DeGette and Reed that recognizes the important contributions of the programs and calls for the programs' renewal. We look forward to working with this broad group to get these bills passed, and to continue to advance T1D research.

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

Ms. ESHOO [presiding]. Dr. Cooper, you are recognized for 5 minutes for your testimony.

Put your microphone on.

STATEMENT OF LISA COOPER, M.D.

Dr. COOPER. Good morning, Chairwoman Eshoo.

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

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

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

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

Over the past 9 years, my colleagues and I at the Johns Hopkins Center for Health Equity, along with our health system and community partners, have completed three NIH-funded clinical trials improving hypertension control in African-American communities.

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

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

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

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

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

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

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

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

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

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

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

To date, PCORI has funded more than 600 studies that address high-priority conditions, new and emerging approaches to care, as well as ways to improve doctor-patient communication and, importantly, PCORI funds the dissemination of research findings as well as implementation of actionable results.

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

Over 5 years this could benefit 9.4 million Americans and save $4.8 billion nationwide. Another example is a study in Washington State clinics that implemented an initiative focused on more cautious prescribing of opioid drugs, which led to reductions in high dose opioid prescribing while preserving patient pain control.

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

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

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

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

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

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

[The prepared statement of Dr. Cooper follows:]

Testimony for the Record
Submitted to the
House Committee on Energy & Commerce
Subcommittee on Health
For the hearing
"Investing in America's Health Care"

Tuesday, June 4, 2019

Lisa Cooper, MD, MPH
Bloomberg Distinguished Professor, Johns Hopkins Medicine

Chairwoman Eshoo, Ranking Member Burgess, and distinguished Members of the Subcommittee thank you for inviting me to participate in today's hearing. It is a great honor to appear before you to share my experience as a PCORI-funded researcher and to discuss the work PCORI has done over the past nine years, the impact their investments in research has made, and the importance of Congress's reauthorization of their funding through the PCOR Trust Fund. I am a professor jointly appointed at the Johns Hopkins Schools of Medicine, Nursing, and Public Health, where I have served as faculty for 25 years. The views I express in this testimony are my own, and do not necessarily reflect the views of The Johns Hopkins University.

As a board-certified general internist, I have had the experience of treating patients who struggle with a range of illnesses and health care needs. My patients live with chronic conditions such as heart disease, diabetes, kidney disease, asthma, and depression. Each patient's health is impacted by individual predispositions and behaviors, factors within the healthcare system, and a unique constellation of factors far removed from my office, including family and social networks, exposure to stress and discrimination, and the availability and quality of housing, healthy foods, and safe, clean environments for work and recreation in their communities.

As a health services researcher, I have devoted my career to improving quality and addressing disparities in care delivered within the U.S. health care system — specifically the ways race and socioeconomic factors shape these disparities, and the ways our health systems might help eliminate them. Currently, I direct the Johns Hopkins Center for Health Equity, where my colleagues and I work to identify practical, effective solutions to achieve health equity for every person and family, across healthcare settings and communities, in partnership with governments, non-governmental organizations, and academia. We have developed programs targeting health professionals' skills, patients' health behaviors, and health systems' ability to address patient's medical needs and social determinants of health. Over the past 9 years, we have completed three NIH-funded trials improving hypertension control within African-American communities. And now, with the support of PCORI, I am leading a new trial called "RICH LIFE," launched in fall 2016 with 30 primary care clinics in Maryland and Pennsylvania. RICH LIFE will investigate whether system improvements and team-based care models can help reduce disparities in cardiovascular risk factors including hypertension, diabetes, and depression. This study can help health clinic directors and primary care doctors choose how to care for people who have high blood pressure and could be extremely impactful in communities that have high rates of this condition and limited access to health care.

Throughout my experience as a practicing clinician and as a researcher, one theme is clear. Too often, patients and their caregivers simply do not have enough information, or that information is inaccessible or not relevant to their unique circumstances, to make informed decisions about their care. And too often, we as clinicians are left choosing among various options and forced to make decisions about our patients without knowing which specific choice would best fit each patient's unique needs and preferences. For all the advances we have made with new, innovative clinical research, we sometimes still lack the information we need to help our patients make the best choice based on their own individual preferences and values. That is why the Patient-Centered Outcomes Research Institute – or PCORI - is so important.

PCORI's unique governance structure emphasizes patient and stakeholder engagement.

PCORI was created as a private, nonprofit research organization led by a Board of Directors, supported by advisory committees, and designed to represent the entire health care community dedicated to supporting patient-centered outcomes research. It is the leading funder of comparative effective research (CER), which is research that compares how well different treatments and care approaches work so patients and doctors have the information they need to make decisions that are right for them. PCORI's research is unique and complementary to research funded or conducted by the NIH (which focuses on discovery), AHRQ (which focuses on health services research), and FDA (which focuses on reviewing drugs, devices and other products for safety and efficacy).

Specifically, PCORI funds patient-centered outcomes research (PCOR), which is CER that focuses not only on traditional clinical outcomes but also on the needs, preferences, and outcomes most important to patients and those who care for them. This research is helping patients choose the treatments best for them given their preferences and improve their health outcomes on a wide range of issues, including many of the most pressing health concerns our country faces today, such as heart disease, cancer, diabetes, and opioid dependence.

And unique to PCORI, they are the only research funder that ensures that everyone who has a stake in improving health care has a seat at the table. Patients and other decision-makers work right alongside researchers, to shape and guide this research, ensuring it will focus on the outcomes that matter most to patients and their clinicians. As a researcher who has received funding from both the NIH and from PCORI, I have seen firsthand the values and differences of both institutions and what they bring to the table. Clearly, with their focus on discovery and development, the NIH's work is critical. Given that discoveries lead to ever more options for care, there is a great need for the real-world, patient-centered research that PCORI funds so that we can figure out how to make optimal use of all those new discoveries and developments. Indeed, PCORI's fundamental mission is to fund the research that will help patients and their caregivers navigate through their various options and help them make the choice that is right for them. The unique perspective that PCORI has brought to the research funding scene is the expectation that any kind of research done on people has to be done with them, incorporating their views, experiences, and preferences, all the way from determining what problem to focus on to how it should be done, who the research should engage, and what should with the results once we have them.

Continued federal commitment to disseminating and implementing research findings will yield a significant return on investment.

To date, PCORI has funded more than 600 studies that address a variety of high-priority conditions and topics, such as cancer, cardiovascular disease, mental health, and opioid abuse. Their research has looked specific populations, such as veterans, older adults, minority populations, and patients with multiple chronic conditions and advanced illnesses. Their research also explores new and emerging approaches to care, such as the best ways to leverage telehealth, community health workers, transitional care and other system level interventions. PCORI-funded research also considers strategies and methods to help patients and doctors communicate with each other through approaches such as shared decision-making. And importantly, PCORI funds not just the dissemination of research findings, but also the implementation of actionable results.

For example, PCORI funded a study that found that a simple decision aid can help people who go to the ER with chest pain better understand their risk of having a heart attack and decrease unnecessary hospitalizations for testing. Hospitals can use a decision aid like the one in this study with ER patients who have chest pain but no heart attack diagnosis. The decision aid could help ER patients and doctors work together to make the best decision for each patient. Over five years, this could benefit 9.4 million Americans and save $4.8 billion nationwide. PCORI is now working to implement this aid in five other hospitals in Alabama, California, and Minnesota.

Another example is a study that compared rates of opioid use in Washington State clinics implementing an initiative focused on more-cautious prescribing of opioid drugs with clinics that did not use such strategies. This health system-based initiative led to reductions in high-dose opioid prescribing while preserving patient pain control.

One more study showed that a behavioral health home—a patient-centered way of coordinating care resources, including using a wellness coach to coordinate mental and physical healthcare services—can help people with serious mental illnesses manage their conditions, potentially enabling them to live longer, healthier lives. The success of this behavioral health home in improving important outcomes was so compelling that the Pennsylvania Medicaid program is expanding the model to more than 40 additional providers across the state. And PCORI is supporting efforts to expand this model to focus on adult opioid treatment programs and youth residential treatment centers that treat emotional, behavioral, and substance use issues.

These are just a few examples of PCORI's research having real-world impacts on patient care. Many of these studies showed that providing more information helped patients make better decisions based on their values and preferences. And based on these examples, using a more patient-centered approach not only improves health outcomes and patient quality of life, but it also reduces the utilization of health care services.

Research is a long-term endeavor. Sustained and robust investment in PCORI is vital.

This is why I am here. To share these success stories and to demonstrate the critical work that PCORI has been doing and to urge Congress to support a reauthorization and continuation of PCORI's funding that will enable this critical work to continue. These are merely a small handful of examples, but they tell a clear story. Simply put, results from PCORI-funded research are actionable, impactful, and have the potential to improve health outcomes for patients across the country. That is why it has strong support from more than 170 health care organizations ranging from patient organizations, such as the American Heart Association and the National Multiple Sclerosis Society, to provider groups, such as the American College of Physicians and the American College of Surgeons, to major medical and health systems, such as Johns Hopkins University and Stanford University School of Medicine, to payers, such as the Association of Community Health Plans and the Better Medicare Alliance.

But as much as PCORI has already contributed to changing the culture of research by engaging patients and stakeholders as partners instead of subjects, and beyond the impactful evidence that has already come out of PCORI-funded studies, there is still much more to be done. Patients and other health care decision-makers continue to face decisions every day about their care – whether it is considering what new drug would best manage their condition or how best to implement a behavioral health home model to most effectively managing patients with serious mental illness or what system improvements and team-based care models can help reduce disparities in cardiovascular risk factors. That is why it is critical to continue to provide a long-term and consistent investment in patient-centered outcomes research.

Ensuring PCORI has that long-term and consistent funding is not only vital to their mission of funding high-impact and patient-centered research, it provides the stability researchers need to conduct the research that answers questions patients and their caregivers have about their care, while also providing training and support for the next generation of researchers.

Recommendation: Preserve PCORI's authorization and funding for at least another 10 years.

In closing, our health care system requires solutions that are both evidence-based and patient-centered to improve care while also addressing health care spending. PCORI is uniquely set up to meet this challenge, as it is the only organization dedicated to funding comparative clinical effectiveness research (CER) studies to evaluate which treatment approaches work best, for which patients, taking into account the needs, preferences, and outcomes most important to patients and those who care for them. Delivering care that is most clinically effective and incorporates outcomes that matter to patients is both cost-effective and essential to our well-being as a nation. In view of our shared goal of improving the health and outcomes of all patients, I urge Congress to renew its investment in patient-centered outcomes research and enact a 10-year reauthorization of its charge and funding before it expires on September 30, 2019. Attached please find a letter detailing important views from the community that was sent on May 13 to Chairman Pallone and Ranking Member Walden, along with their counterparts at the Committee on Ways and Means, from the Friends of PCORI Reauthorization. Thank you for your time and for this opportunity to share my experiences as a PCORI-funded researcher and to provide my perspectives on the importance of their current work and potential for the future. I look forward to our discussion.

Ms. ESHOO. Thank you, Dr. Cooper.

We have now concluded the opening statements of our witnesses. Our thanks to each one of you. We will now move to Members' questions. Each will have 5 minutes to question the witnesses, and I will start by recognize myself for 5 minutes.

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

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

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

So the data is pretty clear. It is——

Ms. ESHOO. But what makes it so?

Mr. GERMANO. Well, I think a big part of it is——

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

Mr. GERMANO. Well, I think part of it is that they see the mission. They're connected to the mission. Many of them come from those communities or communities like it.

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

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

These are—these are large increases in healthcare coverage. So if someone really doesn't know that much about Community Health Centers and what they do, how would you respond to them and say this is why we are needed?

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

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

Our goal is primary prevention. We need a solid system. Any system in the world that has success in terms of caring for their populations and keeping a lid on costs really have strong primary care systems and that's what the Community Health Centers represent is a very strong primary care preventive health system.

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

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

Mr. GERMANO. Fourteen thousand.

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

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

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

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

Ms. ESHOO. But the larger population, though.

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

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

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

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

Dr. COOPER. So what we do——

Ms. ESHOO. Do people line up at a clinic——

Dr. COOPER. Right.

Ms. ESHOO [continuing]. To get the piece of paper that explains it?

Dr. COOPER. Right.

Ms. ESHOO. Tell us how it works.

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

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

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

Dr. COOPER. Right. But, you know, in another health system——

Ms. ESHOO. Always know the answer to your own question, right?

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

Ms. ESHOO. Well, my time is expired, and I thank the witnesses. The Chair now recognizes Dr. Burgess for his 5 minutes to question.

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

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

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

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

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

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

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

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

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

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

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

Do we have anything that would give us sort of a return on investment guide for the Patient-Centered Outcomes and Research Initiative?

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

So the example I gave you——

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

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

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

Dr. COOPER. Yes.

Mr. BURGESS. And I get that. And, you know, your specialty through the American Board of Internal Medicine several years ago came up with the Choosing Wisely program. Is that something you have looked at through PCORI, sort of look at those studies that we know we all do as physicians but the return on investment is not that great?

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

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

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

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

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

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

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

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

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

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

Ms. ESHOO. The gentleman yields back.

The Chair now recognizes the chairman of the full committee, Mr. Pallone, for 5 minutes for questions.

Mr. PALLONE. Thank you, Madam Chair.

I first wanted to ask the question of Mr. Germano. When the Community Health Center Fund was created in 2010 under the ACA, it was originally authorized to boost funding to Community Health Centers for 5 years and we have reauthorized it twice in the 4 years since for periods of 2 years each time.

Since we first passed the Community Health Center Fund, we've seen growth based on a record of success. Health centers have grown from serving 19.5 million patients and providing almost 77 million patient visits in 2010 to serving 27.2 million patients and 110 million patient visits in 2017.

For today's hearing, Chairwoman Eshoo has noticed two bills that both reauthorize Community Health Centers and the National Health Service Corps for 5 years as well as the 5-year extension of the Teaching Health Center Graduate Medical Education Program.

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

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

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

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

Think about building a new site, for example. I say it takes 4 to 5 years from thought to finish if you have all the means. When you—when you're working on short term appropriations it has a paralysing effect on your ability to plan ahead and make those kinds of investments. It really does.

2018, when we went through the 2-year—the fiscal cliff piece—I know of health centers that created layoffs. They did freezes of staff. They withdrew contracts for clinicians that they needed because they couldn't—they didn't know they could—they didn't have the confidence they could commit to meeting those obligations.

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

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

Mr. PALLONE. Thank you. I appreciate that. And I would add too—I have to go to the next question—-but, you know, a lot of these are very small, too, and I think when you talk about small

Community Health Centers, which many are including in my district—it is even worse, I think.

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

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

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

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

We also had the opportunity to do that because along with the two people from National Family Voices including Norah Wells, the executive director of Family Voices, I am one of the codirectors of the national center that provides technical assistance to the F2Fs, and one of the ways in which we do that is by providing peer-to-peer support.

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

Mr. PALLONE. All right. Thanks so much. Thank you.

Thank you, Madam Chair.

Ms. ESHOO. The gentleman yield back.

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

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

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

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

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

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

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

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

And both type 1 and type 2 diabetes complications are caused by high blood sugar, and high blood sugar has a nefarious effect of driving changes in your body that affect your eyes, your kidneys, your heart, and your limbs.

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

I use a continuous glucose monitor. I have not poked my finger in over 5 months. It is absolutely incredible, and we are seeing those advances be applied in type 1 and type 2 people to lower A1C measures, which is the measure of blood glucose levels.

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

Dr. KOWALSKI. Dexcom.

Mr. UPTON [continuing]. Monitor that so that they've got a new system now without having to poke and test that, literally, every day?

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

Mr. UPTON. Thank you.

Ms. Autin, H.R. 2822—it is a bill that I have cosponsored along with Ms. Sherrill, reauthorizes the F2F program for 5 more years. You talked a little about it—remarks about why this is so important and I know more than just New Jersey—my colleague is not—can you elaborate why it is—why this is an important issue for us to move forward?

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

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

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

Mr. UPTON. And that is important.

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

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

And, you know, I have had to have this experience multiple years where I have had to tell staff, I can't promise you that there is going to be a job here in the next six—you know, after 6 months from now, and then those families have to make that very difficult decision to possibly leave a job that they love and that they are really great at and go someplace else where they have more stability, and that means we have more turnover.

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

So the—you know, having the 5 years of funding is going to be one of the most important improvements in the F2F reauthorization that we have ever had.

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

Ms. ESHOO. The gentleman yields back.

The Chair now recognizes Ms. Matsui of California, who is the sponsor of H.R. 1767, for 5 minutes of questioning.

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

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

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

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

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

And I would like to get a better sense of how CHCs address serious mental and addiction disorders, specifically, the level of access that patients with schizophrenia and opioid use disorders have to intensive community-based services in Shasta and the surrounding counties.

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

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

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

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

That's important, and some screening can be done more effectively. We also employ psychiatrists on our staff—because our county and our systems in California are mostly county-based for the seriously mentally ill, have really struggled in trying to keep that—those services going.

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

Ms. MATSUI. Right.

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

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

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

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

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

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

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

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

I now would like to recognize the gentleman from Virginia, Mr. Griffith, for 5 minutes for his questions.

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

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

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

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

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

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

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

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

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

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

Dr. KOWALSKI. Yes, that is a great question. Thank you.

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

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

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

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

And what we have seen in that procedure is you can cure people with diabetes. I was with one of the founders of that procedure and he has people 17 years post-transplant off insulin.

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

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

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

Mr. BURGESS. Yes, please.

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

Yield back. Yield back to my friend.

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

Mr. Germano, you heard my earlier discussion about the liability issues and in Community Health Centers you are under, if I recall correctly, a national——

Mr. GERMANO. Federal Tort Claims Act?

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

Is that true in the teaching health centers as well?

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

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

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

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

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

Mr. GRIFFITH. And I yield back.

Ms. ESHOO. The gentleman yields back.

It is a pleasure to recognize the gentleman from New York, Mr. Engel, for 5 minutes.

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

Let me say that there are six Community Health Center networks in my district. I want to mention them, as they do a good job: Bronx Community Health Network, Hudson River Health

Care, Morris Heights Health Center, Mount Vernon Neighborhood Health Center, New York City Health and Hospital Corporation, Open Door Family Medical Center, Incorporated.

Together, they deliver high-quality care to nearly half a million of my constituents. Now, I have heard from some of these clinics that 2-year reauthorizations can hinder their ability to implement innovative care programs and retain experienced staff, and to that end I am pleased to cosponsor the CHIME Act, a bipartisan measure which would provide 5-year reauthorization to increase funding.

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

Mr. GERMANO. Thank you for that question.

As was mentioned before, the biggest effect is the paralysing effect of not knowing what your future has in store. We are making long-term commitments to really change the face of delivery in our communities, whether that be the hiring of clinicians, whether that be creating of points of access.

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

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

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

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

Let me ask you, Mr. Kowalski, what are some innovative diabetes technologies that have been developed with SDP funds and how are they improving diabetes care?

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

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

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

Mr. ENGEL. Thank you very much.

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

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

So, Mr. Germano, can you please describe how a 5-year reauthorization will help Teaching Health Centers prepare the next generation of primary care physicians?

Mr. GERMANO. Thank you for that question. The 5-year authorization goes to that issue of stability. When we take a class in, we are committing to 3 years.

So when we have 1 or 2 years' worth of funding, it is a real leap to guarantee to these young people that we are going to continue to support them.

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

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

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

Mr. ENGEL. Thank you.

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

Thank you.

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

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

Mr. LONG. Thank you. Appreciate being recognized.

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

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

Mr. GERMANO. Thank you for that question.

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

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

We are looking for people with experiences that would demonstrate that they will be successful in our environment. We then surround them with support and faculty and all the other resources we have to make sure they are successful in working in our communities.

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

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

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

To me, that is the long term. That is what 5 years of commitment does. It gives us that kind of support.

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

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

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

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

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

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

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

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

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

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

Mr. GERMANO. It is true.

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

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

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

I think it can and it should.

Mr. LONG. OK. The National Health Service Corps will play a vital role in bringing more primary care physicians to rural and underserved areas.

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

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

Mr. GERMANO. Specifically, the scholarship program and the State loan repayment program? I want to be clear—is that what you're referring to?

Mr. LONG. The—all but the loan—yes, the repayment—the State loan repayment program, student to service program, and the scholarship program.

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

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

Ms. ESHOO. The gentleman yields back.

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

Ms. CASTOR. Well, thank you very much, Madam Chair, and thank you for organizing this hearing because it is very important that the committee examine health initiatives that are effectively helping families back home.

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

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

Probably the most impactful in my Tampa area district will be Community Health Centers, and since the adoption of the Affordable Care Act with the Community Health Center funding that provides grants, I have seen significant expansion.

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

Now, Community Health Centers, they rely on a number of funding streams—Medicare and Medicaid reimbursements, some private pay. But the grants that come from the Community Health Centers fund are critical to expansion.

Mr. Germano, tell us how health centers across the country are using the grants that come from specifically the Community Health Center Fund.

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

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

Ms. CASTOR. And isn't that important in States that did not expand Medicaid, which, unfortunately, includes the State of Florida.

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

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

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

So the Federal grant is fundamental as a foundational building block for what we do.

Ms. CASTOR. And a couple of years ago, we were entirely frustrated because the Community Health Centers Fund was in need of reauthorization. I think you answered Chairman Pallone's question about the importance of continuity and on the longer term extension.

I know in my community the 6-month delay in funding for Community Health Centers, the National Health Service Corps, the Teaching Health Centers, among others, was particularly damaging.

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

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

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

So the continuity and being able to plan ahead to do that, I mentioned earlier, takes three to 5 years to plan a new site, you know, from thought to finish, and you have to have some certainty of your funding is going to be there.

The Teaching Health Centers, as I mentioned, every class is a 3-year commitment. You have 1 or 2 years' worth of funding and a 3-year commitment, it doesn't serve anybody very well.

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

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

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

Thank you, and yield back.

Ms. ESHOO. The gentlewoman yields back.

A pleasure to recognize the gentleman from Kentucky, Mr. Guthrie, for 5 minutes of questions.

Mr. GUTHRIE. Thank you, Madam Chair.

My first question is for Mr. Germano. I am a big supporter in Community Health Centers. I think they do a fantastic job.

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

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

So I just kind of—what innovation do you see Community Health Centers doing to be part of the great revolution or innovation revolution in healthcare and how they are innovating to better serve their communities?

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

We have to make sure that the health centers have the resources to take advantage of those technologies and those therapies. I know that we look at best practices all the time in our practice—what can we do, how can we influence, for example, our State Medicaid authority to make sure that these technologies are somehow added to our scope—are paid for under our scope of services.

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

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

Mr. GUTHRIE. OK. Thanks. I just have a couple questions.

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

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

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

Mr. GUTHRIE. The artificial pancreas is something that is now available——

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

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

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

Dr. KOWALSKI. Absolutely.

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

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

Dr. COOPER. Certainly I can do some of that. So I can tell you that in the work that I am currently doing the practices that we work with are—many of them are Community Health Centers and they are eager to test different evidence-based approaches in their own settings and to try different ways of actually implementing the things that we know from NIH discoveries should be used in practice but aren't because often those studies aren't done in the real world practices with the people who actually have to deliver those services and treatments.

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

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

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

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

And then we look to see to what extent that uptake actually leads to the outcomes that we look at.

Mr. GUTHRIE. OK. Well, thank you, and my time has expired and I will yield back.

Ms. ESHOO. The gentleman yields back.

Now I would like to recognize the gentleman from New Mexico, Mr. Luján, for 5 minutes of his questioning.

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

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

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

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

I believe it is our responsibility to ensure that these vital programs have the funding necessary to continue but also to expand.

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. KOWALSKI. There is no doubt that here in the United States we have a problem on kind of both ends of the spectrum, meaning that even people with the best tools still struggle.

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

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

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

And with that, Madam Chair, I yield back.

Ms. ESHOO. The gentleman yields back.

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

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

Ms. ESHOO. Thank you.

I now would like to recognize the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

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

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

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

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

I mean, Dr. Burgess introduced H.R. 2700 to reauthorize the Community Health Centers and National Health Service Corps, the Teaching Health Centers GME, Special Diabetes Program, Family-to-Family Health Information, centers in sexual risk, avoidance, education, and personal responsibility education for 1 year, and his bill would have used the savings gained from the recently passed—at least committee-passed bipartisan drug pricing bills to fund that extension, even though it is short, it had a pay-for.

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

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

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

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

Can you talk more about how the Federal funding helps support these and other important services that Shasta Community Health Centers provide?

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

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

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

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

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

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

And things like telemedicine and other things that I think Community Health Centers in rural areas can provide is really critically important, and I am hopeful that we can come to an agreement on how to make sure that we get all of these programs that

I mentioned reauthorized hopefully for more than just a year or 2 years, but longer, because as I think you outlined, this certainty involved in that is really a critical piece to this puzzle.

With that, Madam Chairwoman, I yield back.

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

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

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

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

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

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

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

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

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

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

You, obviously, have the young people there, and if you can deliver services right there on site and do it in a consistent way and a comprehensive way, it can make a dramatic difference, not just for those individuals—for those students, for their families, for the community, for the health of the school, et cetera. You can spot issues that may be arising.

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

Can you speak to—and I know that I think about 50 percent of the school-based health centers in the country have some linkage to community-based health centers and maybe you could talk a little bit to that relationship because through that lens you would know of or have a perspective on how important it is to deliver those services at the school level because I really—I have introduced some legislation that would strengthen the support of school-based health centers but I have always viewed the Community

Health Centers and their health as fundamental, kind of foundational to building off of that the school-based health response. So if you could speak to that, it'd be terrific.

Mr. GERMANO. Thank you for that question.

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

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

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

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

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

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

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

And then to your point, making sure that the linkages are there so that you can, you know, make the right kind of referrals, you can step back, get a more holistic view of what that individual and their family needs, et cetera, and then provide other services as a result.

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

And with that, I yield back my time.

Ms. ESHOO. The gentleman yields back.

Pleasure to recognize the gentleman from Illinois, Mr. Shimkus, for 5 minutes of his questions.

Mr. SHIMKUS. Thank you, Madam Chairman.

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

Mr. GUTHRIE. OK. Thank you for yielding.

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

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

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

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

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

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

Mr. GUTHRIE. OK. Thank you.

And, Mr. Germano, Community Health Centers program's annual funding has more than tripled between fiscal year 2002 and 2018 due to increases in community health center funds.

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

Mr. GERMANO. I think—thank you for that question.

The biggest increase is in new sites and new services. We have seen a tremendous expansion of the Community Health Center model across the United States.

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

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

Mr. GUTHRIE. OK. Thank you.

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

Mr. BUTTERFIELD [presiding]. The gentleman yields back.

The gentleman from Oregon, Mr. Schrader, is recognized for 5 minutes.

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

Dr. Cooper, thanks for being here. As one of the original sponsors of the bipartisan bill that put PCORI into effect, the Comparative

Effectiveness Research bill in 2009. So very interested in the work that you're doing and trying to bring it to fruition and implementation.

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

Things have changed a little bit in the intervening 10 or 15 years and particularly in the drug space. Things are becoming very expensive. Some lifesaving medications—there has been the discussion on this panel about value-based reimbursement for some of these, you know, medications and what have you and the cost of treatment, the copays, et cetera, are getting a little more attention for that upper middle class in the Affordable Care Act.

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

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

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

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

But I think we would all agree that it is important work that needs to be done and coordinated with the work that's happening at PCORI, either coordinated or done there.

Mr. SCHRADER. All right. Thank you. Thank you.

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

Mr. GERMANO. It does drive my clinicians up the wall because we have all these multiple standards and what are we held to and what are they held to.

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

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

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

Mr. BUTTERFIELD. The gentleman yields back.

The gentlelady from Indiana, Mrs. Brooks, is recognized for 5 minutes.

Mrs. BROOKS. Thank you, Mr. Chairman.

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

Can you further discuss the kind of treatments that Community Health Centers are using combatting the opioid epidemic?

Mr. GERMANO. Thank you for that question.

Our primary mechanism is to use buprenorphine Suboxone—medically assisted therapies. We have created clinic systems around that. We have about 200 patients now in therapies right now. Behavioral health is a big component of that; not just the drug, but the behavioral health and the follow-up.

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

Mrs. BROOKS. And do you know is that a trend that you are seeing with other Community Health Centers?

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

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

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

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

Mrs. BROOKS. That is excellent. Do you know if that is something that other Community Health Centers are doing as well?

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

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

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

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

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

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

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

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

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

Mrs. BROOKS. Thank you.

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

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

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

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

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

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

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

I yield back.

Mr. BUTTERFIELD. I thank the gentlelady.

The gentleman from California, Dr. Ruiz, is recognized for 5 minutes.

Mr. RUIZ. Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. RUIZ. I've got 1 minute, so I got too many questions.

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

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

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

Mr. RUIZ. Right. The other problem is that for these programs most of them have residencies that require 3 years, right. That's one of the minimum years for a family medicine residency program. But we have been reauthorizing them for 2 years. Why is that a problem?

Mr. GERMANO. Well, every class you take is a 3-year commitment. When you have 2 years' worth of funding, it creates a lot of insecurity.

Mr. RUIZ. Exactly. So this is going to add funding for 5 years and, hopefully, will start to change that problem.

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

So how does this help that?

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

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

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

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

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

Mr. GERMANO. I agree.

Mr. RUIZ. I yield my time.

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

The gentleman from Florida, Mr. Bilirakis, is recognized for 5 minutes.

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

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

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

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

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

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

Mr. BILIRAKIS. Sure.

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

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

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

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

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

Mr. BILIRAKIS. OK. Next question. Can you describe how Community Health Centers—I am a huge proponent of Community Health Centers, as cochair of the caucus—how are they—and then also the community clinics—how are they sustained?

Mr. GERMANO. We have multiple funding sources. The 330 is the building block which we all work from. We have—Medicaid is another big piece of it. Medicare is another large piece of it.

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

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

Mr. BILIRAKIS. What is your position on veterans having access to Community Health Centers and actually the Community Health Center would be reimbursed by the VA? And, you know, there aren't a lot of—in some rural areas, you know, you don't have a lot of access. We don't have VA clinics in some areas, VA hospitals.

What is your position on that and can the Community Health Center actually provide for those veterans? Is there room for that?

Mr. GERMANO. I think—it think that is already happening in many places where the—there the Veterans Administration has reached out to the Community Health Centers, and I think they are limited by capacity issues—going back to workforce again.

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

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

Mr. GERMANO. Absolutely.

Mr. BILIRAKIS. Instead of the VA saying, you know, you can go into the community, the veteran should have the choice to go to the Community Health Center because, again, the care is very good.

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

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

I yield back, Mr. Chairman.

Mr. BUTTERFIELD. The gentleman yields back.

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

Mr. GIANFORTE. Thank you, Mr. Chairman. I appreciate you having this important hearing. It is imperative that we find common ground on these very bipartisan programs so that there are no lapses in funding.

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

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

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

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

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

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

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

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

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

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

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

Dr. KOWALSKI. Both forms of diabetes are under funded by Congress. So we believe that both SDP and SDPI are really a tip of the iceberg—that there is an unmet need here that is significant.

Mr. GIANFORTE. OK. Thank you.

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

What role do Community Health Centers play in serving—ensuring that patients have access to mental health?

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

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

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

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

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

Can you talk about what the Community Health Centers are doing, given how closely related mental health and substance abuse are?

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

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

With that, I yield back.

Mr. BUTTERFIELD. The gentleman yields back.

The gentleman from Illinois, Mr. Rush, is recognized for 5 minutes.

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

I want to take a moment to discuss Community Health Centers. You know, Community Health Centers assure that healthcare is affordable and accessible for patients in my district and around the country. There are eight federally funded health centers in my district that serves almost 341,000 patients each and every year, and in my State 2 out of 10 patients are unserved, and 6 out of 10 are Medicaid beneficiaries. Without Community Health Centers, we would be far worse off than we are right now.

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

Mr. GERMANO. We have—yes, we do. We do quite a bit, actually.

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

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

So my question, if given the authority do you believe that there is a role that Community Health Centers can play in running freestanding pharmacies and would it be helpful if there were public-private partnerships between private pharmacies and Community Health Centers?

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

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

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

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

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

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

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

Mr. BUTTERFIELD. I thank the gentleman.

The Chair now recognizes himself for 5 minutes—5 absolute minutes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. GERMANO. Absolutely. Sure.

Mr. BUTTERFIELD. Thank you. I yield back.

The gentlelady from Illinois, Ms. Schakowsky, is recognized for 5 minutes.

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

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

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

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

It is clear that we have to reauthorize the National Health Service Corps and the Teaching Health Center Graduate Medical Education Program for at least 5 years, if not longer, and increase funding levels to strengthen our workforce and increase access to care.

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

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

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

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

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

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

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

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

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

Ms. SCHAKOWSKY. Thank you.

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

Dr. COOPER. So——

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

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

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

And I also think that funding for agencies like PCORI that does address the needs of underserved populations and addresses disparities and care and health outcomes is an encouragement to people from diverse backgrounds who want to pursue careers that are focussed on research. But if they feel that the research that they're interested in or that will benefit their communities is not being supported, that's also a discouragement.

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

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

Ms. ESHOO. The gentlewoman yields back.

I now would like to recognize the gentleman from Oregon, Mr. Walden, for 5 minutes of his questions.

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

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

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

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

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

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

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

Mr. GERMANO. Yes.

Mr. WALDEN. You mentioned it takes 18 months or whatever to fill——

Mr. GERMANO. Recruit a physician, yes.

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

Mr. GERMANO. Yes.

Mr. WALDEN [continuing]. And the rest Oregon, and some of this doesn't make sense anymore in today's telehealth world to have these——

Mr. GERMANO. Artificial barriers.

Mr. WALDEN. Thank you.

Mr. GERMANO. Yes.

Mr. WALDEN. Do you run into that?

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

Mr. WALDEN. Right.

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

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

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

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

Mr. GERMANO. Exactly.

Mr. WALDEN [continuing]. And you literally can't access them. So and then can you help me and the committee—explain the differences between the Teaching Health Center GME program and other GME programs.

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

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

Mr. WALDEN. Got it.

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

Mr. WALDEN. Yes, it is really important and I think we've got to figure out how to make sure we are staffing up—that you are able to staff up. I run into that as well, just the recruitment and the retention. What I have also found is if they come through one of these programs and practice in that area there is a higher likelihood they stay. Is that what you run into as well?

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

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

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

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

I know that Mrs. McMorris Rodgers is waiting. But we need to take the Members and then you will waive on. So I will now recognize Mr.—the gentleman from California, Mr. Cárdenas, for 5 minutes of his questions.

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

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

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

Health centers are also far more likely to serve patients that speak only—other than English, for example, when compared to other primary care settings. These are the primary care providers that these communities have come to rely on and where many families have received life-saving care we need to make sure that these centers actually are able to continue to serve.

Again, I just want to point out that far too often when people think of people getting care where there is little to no fee to the actual end user that it is somebody who is not working for a living.

I want to make it very clear that I know that in my district I have many, many working poor individuals who fit the results that the Kaiser Family Foundation research has exposed.

Mr. Germano—in my district we would call you Germano—I am sorry if I am saying it wrong—so can you talk about some of the outreach activities that Community Health Centers are able to do to reach these communities?

Mr. GERMANO. Our health centers in our region and across our State and our Nation really is about outreach. We have a number of our staff who that is their job is to reach populations, people who won't normally connect with us whatever the situation.

So we work with churches. We work with social services agencies. We work with our police departments, law enforcement. They come in contact with folks or families or situations—social services agencies.

So our goal is to make sure that we are connected to all these other resources and that we welcome everybody into our medical home.

Mr. CÁRDENAS. OK. Where would these communities go if they no longer had access to services provided by Community Health Centers?

Mr. GERMANO. You know, I shudder to think. The default is the emergency room, right, and——

Mr. CÁRDENAS. Or no care at all?

Mr. GERMANO. Pardon me?

Mr. CÁRDENAS. Or no care at all.

Mr. GERMANO. Or they—right. They defer until it becomes a critical issue, and that would be horrible for everybody.

Mr. CÁRDENAS. I just had an unfortunate reality conveyed to me by a young woman who was explaining to me the horrors of her family's experience in this country when it came to healthcare.

She had two parents that were working poor. They had to rely on facilities like this to get their care. Her little brother was born with congenital conditions that they never could figure out exactly what it was, and he passed away.

And later on, her father became very, very ill—the father of this little boy—and he, apparently passed away as well. So two tragedies in one family.

And the actual tragedy to her little brother was actually a factor in why her father passed away way, way too young, because his exact words to her that she conveyed to me when she said, "Dad, you're really sick. You need to go to the doctor," and this is pre-Affordable Care Act, because I asked the question—I said, but the Affordable Care Act.

She said my father passed away a month before the Affordable Care Act kicked in. He said, "I am sick and tired of seeing all these bills. I can't afford it."

So your—the facilities that we are talking about today are the facilities that will actually help individuals get access to healthcare and, secondly, not be afraid—not be afraid of the financial burdens at least—at least to see a doctor. At least to find out am I going to die or am I going to be OK.

Mr. GERMANO. You know, even today we see some of our uninsured patients come in with late onset diseases and you ask them, we've been here—we've been—why—they have reasons, and we don't fully understand it.

But it is up to us to get the message out that this—you can come here and you will see a doctor or a nurse practitioner or PA. We will help you to get medications. Anything we can do within our four walls we will try to do for you. It gets tougher once you get outside of our four walls. But we can do a lot within our four walls.

Mr. CÁRDENAS. And what area of California do you serve?

Mr. GERMANO. Up in Redding, California.

Mr. CÁRDENAS. Do you know a Dr. Lupercio? Have you ever met him? He works in a hospital. I was curious if you have come across each other.

Mr. GERMANO. I don't think so.

Mr. CÁRDENAS. Pulmonary specialist, born in Mexico, got educated here. Serving the community. Amazing human being.

Mr. GERMANO. I will have to meet him.

Mr. CÁRDENAS. Thank you, Madam Chair. I am sorry. I went over my time. Thank you so much.

Ms. ESHOO. I am a nice chair. I let people go over and finish their thoughts.

But we are winding down. Now, I would like to recognize the gentlewoman from New Hampshire, Ms. Annie Kuster of the famous Kuster family in her home state.

Ms. KUSTER. Thank you, Chairman Eshoo, and thank you for this hearing and for all you for your patience today.

Many of the programs that we are talking about today are critical in my home state of New Hampshire where we are in the midst of a major opioid epidemic. 2017 we had 424 drug overdose deaths involving opioids and many of the programs that we are discussing are critical to combatting this epidemic.

I want to give a particular shout out to our Community Health Centers serving some of the most vulnerable populations in our rural state. They have been instrumental in providing comprehensive care to those who need it, particularly, after Medicaid expansion under the Affordable Care Act.

And programs like PCORI have funded incredible research at Dartmouth Medical School in my district, studying treatment for pregnant women with opioid use disorder.

So I also appreciate that this collection of bills address the workforce issues that we have been seeing. We are trying to encourage young people getting into career in technical education in our high schools, to get an LNA coming out of high school and then go to our community colleges and then go to our 4-year colleges and working their way up in the healthcare credentials.

I want to start, Mr. Germano—you spoke of the difficulties in recruiting and retaining primary care physicians to underserved areas, and I am hoping that you could speak particularly with the Community Health Center model and the workforce that stands up the Community Health Centers are especially equipped to handle many of the public health challenges we face, and if you could elaborate on how these programs will make a difference for these workforce issues.

We have an unemployment rate of 2.4 percent, which is the envy of many of my colleagues. But it creates tremendous challenges in rural communities.

Mr. GERMANO. Definitely. The health centers more and more across this country have become, in my judgement, the de factor public health department now. They are the ones touching the lives of great swaths of our community.

No disrespect to public health. They have gone into more the monitoring and surveillance and those kinds of very necessary things. So the primary care networks—the Community Health Centers have been the face of immunizations and sort of other surveillance and interventions.

So yes, we play a critical role as a safety net. That is our job. That is what we should—one of our jobs—that should be one of the things we do. Workforce with the lower—I mean, it is a great thing we are seeing our unemployment rates drop but it creates some real challenges in terms of recruitment and retention.

Can we stay competitive, and not just about the doctors and the nurse practitioners but all our front line staff and what have you. So we are constantly chasing our tail, making sure that we are remaining competitive to keep our employees and sustain them.

So, again, ongoing sustainable funding is really critical in us to predict what we can afford.

Ms. KUSTER. Great. Thank you, and thank you for appearing on behalf of the Community Health Centers, a great asset to our community.

Dr. Cooper, I am going to turn to you about the PCORI funding—that we have researchers at Dartmouth College examining the outcomes of prenatal care for women receiving medication-assisted treatment and the research is integral to understanding how to—prenatal, postpartum, how to support moms to have healthy babies. Could you discuss how a gap in appropriations will impact projects like these and the need for predictable and consistent funding?

And just while you are at it, in your opinion are there any other entity sources—NIH or the Agency for Health Care Research and Quality—that would be able to fill the gap or is this research that wouldn't continue?

Dr. COOPER. I think a gap in funding from PCORI would significantly threaten a project such as the one you described for a number of reasons.

One of them is that oftentimes when we do have results from such a project and they are positive results the promise that they hold is that we could then spread them to other settings or disseminate them more widely.

But without ongoing support from an institute like PCORI the ability to package the materials that have been developed and to use the learnings from that research to spread to other settings or to disseminate it would be limited significantly.

Additionally, you would have researchers who are conducting patient-centered outcomes research who may leave the field because of that uncertainty and either go back into clinical practice or do administrative work or something else.

They might also pursue research that is not patient-centered outcomes research and I don't think NIH and AHRQ would fill that gap completely. I think that there are some institutes at NIH that support similar work.

For the most part, they don't support the level of stakeholder engagement that PCORI does. It takes a long time to build partnerships with patient advocacy groups, family members, health insurers, health system leaders to conduct the research that ends up being very practical and sustainable over time, and we don't get that kind of funding.

Ms. KUSTER. My time is up. I apologize. I would like to yield back. But thank you. Thank you.

Ms. ESHOO. The gentlewoman yields back.

I now would like to recognize the gentlewoman from Illinois, Ms. Kelly, for 5 minutes of questioning.

Ms. KELLY. Thank you, Madam Chair and Ranking Member, and thank you for your testimonies this morning.

I have heard from patients and providers that PCORI's approach to incorporating patients into research process makes the results more meaningful to people who will actually use it.

Dr. Cooper, you mentioned PCORI's unique governance structure with the emphasis on patient input and engagement. For the last couple of years I have been very involved with legislation dealing with maternal mortality, and while no one knows exactly what happens and why there are the healthcare disparities—I mean, some things we can guess—do you see PCORI being helpful or instrumental in dealing with that healthcare disparity? Because there is a great one in this country.

Dr. COOPER. Most certainly I do see a strong potential for PCORI to contribute to research in the area of disparities in maternal mortality, one reason being that often women who come from underserved communities and African-American women in particular and American-Indian women who have higher rates of either maternal mortality or infant mortality are not represented in a lot of studies. So their perspective isn't given.

And so at PCORI they would have the opportunity to contribute to the research questions that would be answered and to contribute to the way that research should be conducted and the way the results should be shared with other patients and family members who would need the information in their decision making around their care.

Ms. KELLY. I know in these we had OB/GYNs in and I know in the State of Washington, Native American women died 8 times the rate of white women, and in my State of Illinois black women die 6 to 1 times rate, which is bigger than the national average.

And then you have been here a long time, so is there anything we haven't asked you that you want us to know about PCORI?

Dr. COOPER. I think the only thing I would say is that I was so excited when PCORI was funded because it is the kind of work that I thought was needed for a long time—that we have a lot of wonderful discoveries and therapies and drugs but they just weren't getting out to the people who need them, and people weren't able to make sense of a lot of the information that was coming at them.

And what PCORI allows us to do is actually to compare a lot of these different developments and discoveries and actually learn more about how each one of them works and applies to different people because they don't all work the same for everyone and it is really important to get everyone's perspective and to tailor those treatments and the appropriate concerns that people have and to the appropriate needs and resources within the context where they get healthcare.

Ms. KELLY. Thank you very much, and I will yield back.

Ms. ESHOO. The gentlewoman yields back.

Now I will recognize the gentlewoman from California, Ms. Barragán, for 5 minutes of questioning.

Ms. BARRAGÁN. Thank you. I wanted to first thank the panel for being here. There is so much to cover in so little time. But before I do that, I wanted just to quickly talk about something that's going to happen on the second panel. I want to just spend a moment to discuss the Medicare limited income newly eligible transition program.

This demonstration program which began in 2010 provides temporary Part D prescription drug coverage for low-income Medicare beneficiaries not already in the Medicare drug plan.

This program has been incredibly successful in the past 10 years, saving $300 million and making sure beneficiaries get access to medication.

I was proud to introduce the Improving Low-Income Access to Prescription Drugs with my colleagues, Congressmen Olson, Marchant, and Lewis, that would make the LI NET program permanent.

Far too many individuals across America already struggle to afford their prescription drugs. By making the LI NET program permanent, we can continue to provide transitional prescription drug coverage for those with low incomes.

I look forward to advancing our work to help all Americans get the medications they need.

Now, talking a little bit about Community Health Centers, this past week in my district I held a round table with Community Health Centers and other healthcare providers in my district, and in my district we work very closely with the Harbor Community Clinic in San Pedro.

And I know there is already been a lot of discussion about what Community Health Centers do and I also know some of this has been covered earlier.

But I think it is really critically important. Mr. Germano, if you could just tell us what the impact would be on communities of color if the fund is not reauthorized.

Mr. GERMANO. Health centers are very centered in communities of color around the country. They really are. They have a huge presence, and not enough, in my judgment.

And if funding becomes destabilized then I think you start losing those investments that have already been made and it prevents further investments in those communities because you can't plan ahead. It is that certainty again.

Ms. BARRAGÁN. So we've recently seen an outbreak of the measles——

Mr. GERMANO. Yes.

Ms. BARRAGÁN [continuing]. And Community Health Centers provides, as you mentioned, immunizations. Would that be at risk if this was not funded?

Mr. GERMANO. It goes back to that public health safety net role again. We had that situation in my own community where we became ground zero for detection as we had a couple cases in our community, and public health rallied around us to be that face of prevention in our community.

Yes, it would be—it would be a loss across this country and a danger.

Ms. BARRAGÁN. Thank you. My district is California's 44th. It is south L.A., it is Compton, it is Watts, it is the Port of L.A. It is a majority minority district. It is about almost 90 percent Latino/African American, and we have the highest diabetes rate than any other congressional district in the State of California.

It is also very personal. My mother has diabetes. Family members have type 1. And so Mr. Kowalski, what would be the impact on communities of color if this program were no longer funded—the Special Diabetes Program?

Dr. KOWALSKI. So the Special Diabetes Program has delivered on a number of advances that will help anybody with diabetes. But, of course, in underserved communities you have a much higher incidence and prevalence rates.

We have tremendous momentum on many fronts via treatment, preventative therapies, and ultimately cures for diabetes, and it would be a tremendous shame to see us lose that momentum and what we would be doing is costing individuals time in their lives, literally, and ultimately our system millions and millions of dollars.

So I urge the Members, as you know, that this program is paying dividends and it will help all communities who are impacted by diabetes.

Ms. BARRAGÁN. All right. Thank you.

Dr. Cooper, I want to thank you for your work on the issue of racial health disparities. It was in 1999 when I was working at the NAACP that this issue became one near and dear to me.

Can you tell me how the Patient-Centered Outcomes Research Extension Act of 2019 plays a role in helping address racial health disparities?

Dr. COOPER. Yes, I would be happy to do that. One of PCORI's main focus areas is addressing disparities. So they also focus on several special populations which include racial and ethnic minorities, persons with low socioeconomic status as well as people who have many disabilities.

So I think because they have a special portfolio focused on addressing disparities a lot of that work actually does address issues that are critical to those communities and those populations.

For example, you might have a new drug or therapy for diabetes. But what we might not understand is how acceptable is that treatment to people who will have low income or people who live in an ethnic minority community. Are there stigmas around certain kinds of therapies? What about the costs associated with getting those things or any other barriers to managing their condition that might get in the way of them benefiting from those therapies, and

PCORI has the ability to address a lot of those with their research portfolio.

Ms. ESHOO. Does the gentlewoman yield? The gentlewoman yields.

I now would like to recognize the gentlewoman from Delaware, Ms. Blunt Rochester, for 5 minutes of questions.

Ms. BLUNT ROCHESTER. Thank you, Madam Chair, for the recognition and for turning the committee's attention to the critical public health programs that must be reauthorized this fall.

Just yesterday I introduced legislation to reauthorize another program set to expire in September—the Personal Responsibility Education Program, or PREP—and I look forward to working with my colleagues on the committee to ensure that this and other public health programs are reauthorized before the September deadline.

Delaware has three federally qualified Community Health Centers, serve approximately 50,000 patients across the State each year. So in Delaware that's one in 19 Delawareans.

And I support both H.R. 1943—the Community Health Center and Primary Care Workforce Expansion Act—and H.R. 2328—the Community Health Investment Modernization and Excellence—CHIME Act, because Community Health Centers need long-term sustained funding. I think that is a message that we have heard loud and clear here today.

Delaware has seen the impacts of this firsthand because Westside Family Health Center became the first Community Health Center in the country to lose a location because of unstable Federal funding, a closure that impacted about 2,800 patients who were disproportionately low income.

So I want to just kind of turn to the issue of planning—short-term planning but, specifically, on the impact of recruiting and retaining particularly primary care physicians.

And I know, Mr. Germano, you talked about this. In Delaware, it has a huge impact. It is estimated that we have just 815 primary care physicians in Delaware, down 5.4 percent since 2013.

And so I just wanted to ask you, you talked a little bit about the impact but and you said—you talked about the fact that wherever a person is trained they might tend to stay.

So if you could just reiterate that, and also just briefly talk about suggestions that you would have to incentivize people to continue to stay and work in those underserved communities.

Mr. GERMANO. Thank you for those questions. The data shows overall, I had mentioned, that 70 percent of residents stay within 100 miles of where they have trained, and the Teaching Health Centers go even further. We had more success because we have looked or providers who meet our mission, who are interested in our mission, and are many times tied to our communities in other ways, so have roots or will develop roots there.

So I think absolutely critical. That is the pipeline bringing them into our system and then getting them through and then helping them stay.

So I think those are—those are the big ones. Those are the issues.

Ms. BLUNT ROCHESTER. No, that's helpful. That's helpful.

I am going to shift very quickly to Dr. Cooper. You talked about PCORI and, you know, one of the reasons why what you shared is so vital is because of the issue of health disparities and I was hoping that you could spend a little bit of time on that, the impact of addressing health disparities.

In Delaware, we have the Nemours child health system and health corps that are key stakeholders in receiving these funds and doing exciting work. But particularly as it relates to trust in clinical trials and how you get people to actually participate for their own—the connection to the healthcare system.

Dr. COOPER. Thank you. Yes, so I will just mention briefly, I actually had a project that was funded that engaged with the Westside Health Center in Delaware many years ago.

It was not funded by PCORI. It was funded by AHRQ, and we were able to successfully engage health centers and African-American patients in a project that compared two different approaches to treating depression.

The difference between that project and my PCORI-funded work is that I did not have the benefit of the full year of planning to engage all the appropriate stakeholders and to get their input into the program.

And so when that project ended, even though we showed successful results, it wasn't actually sustained. But now, with the kind of funding that PCORI offers, there is actually a full year devoted to planning and to stakeholder engagement so that everyone sort of on board with the plan gives input to it and a lot of discussion takes place about how this program will be sustained if it is shown to be successful.

Ms. BLUNT ROCHESTER. Excellent. Thank you for sharing that.

Just one last point. Delaware had the sixth highest rate of overdose deaths in 2017, and so we know that the opioid crisis is having a huge impact, and one of our health centers, La Red, actually has focused on this.

So I will submit some questions for the record surrounding the opioid addiction crisis as well. So thank you and I yield back.

Ms. ESHOO. The gentlewoman yields back.

Now it is a pleasure to recognize the gentleman from Georgia, Mr. Carter, and followed by the patient gentlewoman from Washington State, Ms. McMorris Rodgers.

So first, the gentleman from Georgia.

Mr. CARTER. Thank you, Madam Chair. I thank all of you for being here. I know it is been a long day and you're almost there, so hang in there, OK?

Certainly important things we are talking about. There is no question about that. Mr. Germano, I wanted to ask you, do you happen to know how many health profession shortage areas there are in this country? Any idea?

Mr. GERMANO. I don't, but there are a lot.

Mr. CARTER. There is a lot. Most of them in rural areas, I would assume, as opposed to urban. But I suspect we'd be surprised to find them in urban areas as well.

Mr. GERMANO. I think there are quite a few in urban areas as well.

Mr. CARTER. Right. Right. Earlier, we—earlier one of my colleagues asked you about dental health and that is certainly important.

First of all, again, I am from Georgia, and remember there are two Georgias. There is Atlanta, and there is everywhere else, and it is true. And I represent south Georgia. We got a lot of rural areas in south Georgia, a lot of healthcare needs.

Accessibility to healthcare is a big concern of ours and a big challenge and particularly oral healthcare as well, and I was just wondering if you could reiterate what you said earlier about oral healthcare and how important it is, particularly in our most needy areas like that.

Mr. GERMANO. Well, know that oral health disease is not just a cosmetic thing. It has the underlayment of causes other problems. Women who are pregnant with oral health disease could have bad outcomes with their babies, for example.

We know that we can prevent a lot of this. It is not just having a dental office. We have embedded dental hygienists in our pediatric practices now where they are going in after the—after the visit, in many cases, and they are doing a little education and they are painting the teeth of children so to try to prevent, you know, cavities and other problems and educating as well.

Oral health disease—number-one pediatric disease in America is oral health disease.

Mr. CARTER. Right.

Mr. GERMANO. And it is preventable. That's the thing. A lot of oral health disease is preventable.

Mr. CARTER. You know, we talk a lot about making sure we have—with good reason making sure we have doctors in underserved areas. But there are other healthcare professionals that we need to concentrate on also such as dentists.

Mr. GERMANO. Yes.

Mr. CARTER. Any others that you can think of that really propose a glaring void there—healthcare professionals that we just——

Mr. GERMANO. Well, I would love to see the role of the pharmacists be more——

Mr. CARTER. Thank you very much. Oh, did I mention that I am currently the only pharmacist serving in Congress?

Ms. ESHOO. That was a good answer.

Mr. CARTER. It was a good answer.

[Laughter.]

Mr. GERMANO. I do think there is a role for—the problem is in the FQHC world, pharmacists are not recognized as billable providers; hence, it makes it difficult to put it together.

But it makes total sense. My clinicians clamour for that—you know, that kind of direct clinical pharmacy involvement, not just on the retail side but on the clinical side. It would make a world of difference.

Mr. CARTER. Right. Thank you for that.

Let me switch now to a problem that, unfortunately, we are a leader of in the State of Georgia and that is maternal mortality. And, you know, it is—it is embarrassing for me to say that and whereas I do question sometimes how we arrive at some of these figures because I want to make sure we are comparing apples to apples when we talk about maternal mortality. But we cannot deny the fact that it is a problem and particularly in the State of Georgia.

And I am just wondering, you know, one of the challenges that we face, as I mentioned before, is just a lack of providers, and what—you mentioned earlier, and you are spot on because, when I served in the Georgia State Legislature, one of the things that we discovered was that most of the physicians—as Dr. Burgess pointed out as well—most of the physicians stay where they practice—where they do their residency—and we learned that in Georgia.

That is why we increased the number of residencies in our State in order to try to attract physicians and try to get them to stay.

But any ideas on what we can do aside from that to increase the number of providers, particularly in the—in the rural areas and particularly in the way of OB/GYNs where we need this for—to address the situation of maternal mortality?

Mr. GERMANO. Well, most OB/GYN training programs are in big cities, so that you are running against it right away in terms of attracting OB/GYNs to rural communities. So that is tough.

But what we can do is to work with, like, our nurse practitioners.

Mr. CARTER. There you go.

Mr. GERMANO. Early prenatal care, getting women in the first trimester, really critical. Getting them tucked into prenatal care and then we can help monitor and support them through their pregnancy. I think that can make a world of difference.

Mr. CARTER. And, you know, scope of practice is pretty much a State issue. But at the same time, if we—if we empower some of these other healthcare professionals to give them the opportunity to serve, I think they can help us to achieve what we are trying to achieve here.

Mr. GERMANO. I agree.

Mr. CARTER. Very good. Again, thank all of you. This is extremely important and we certainly support what we are trying to do here. The question is how we are going to pay for all this. But nevertheless, this is very important.

And thank you, Madam Chair, and I yield back.

Ms. ESHOO. The gentleman yields back.

And now the ever-patient gentlewoman from the State of Washington, Mrs. McMorris Rodgers, also the sponsor of H.R. 2818, which we thank you for. It is an important bill. You are recognized for 5 minutes.

Mrs. RODGERS. Thank you, Madam Chair, and just thank you everyone who has been a part of this, the witnesses, and your testimony today.

I am pleased that you are bringing this legislation forward today. Earlier, Representative Ruiz was talking about the Teaching Health Centers and how important they are.

I am proud in Spokane to represent one of the Teaching Health Centers that is making a big difference in our region. We are excited that Washington State University has built a medical school. The University of Washington and Gonzaga are partnering on a rural training track.

I represent an area that has a lot of rural communities and these—this effort in Spokane is definitely part of the solution.

When you—when I look at the partnership between the Teaching Health Center, the universities, the local hospitals, and then our local VA, we need more doctors. We need more doctors throughout eastern Washington.

And I am also reminded that where the doctor does their residency they are more likely to practice. I met a guy, a doctor, not too long ago who had come from California to Spokane 30 years ago to do his residence and he is still there.

And it underscores how important it is, these residency programs. So I am a strong supporter of the Teaching Health Center Graduate Medical Education Program, that legislation that is before the committee today.

You know, it is estimated that nationwide we will have more than 23,000 shortage—we will be short 23,000 doctors by 2025, and it is really unacceptable. And you see it further in the rural communities where the physician-to-patient ratio is especially stark.

Only 10 percent of physicians practice in these areas, even though a quarter of the population lives there. Compared to doctors who trained in the traditional Medicare program, those trained at Teaching Health Centers are 60 percent more likely to practice primary care and 30 percent more likely to work in a rural or underserved community.

I was proud to help lead this legislation in the last Congress where we doubled the funding, and I am excited and encouraged that we are continued that effort in this Congress.

Representative Ruiz, Torres Small, Representative Roe and I have joined in introducing H.R. 2815. What it does is continue the support for this program by extending it for another 5 years and increasing the funding and providing more certainty, which we need across the country.

This legislation and this program is important—meeting the needs of rural and underserved communities for a new generation of primary care medical professionals.

The Teaching Health Center has programs that are meeting important needs in psychiatry, OB/GYN, primary care, internal medicine—you know, the very fields that we need more of our doctors to be pursuing.

So I have a few questions to Mr. Germano. I wanted to—in your testimony you talked about the Shasta Community Health Center electing to become a Teaching Health Center as a means of addressing the ongoing physician shortage.

And I just wanted you to elaborate on that decision and just comment on how positively that may have impacted your effort to meet the needs in your community.

Mr. GERMANO. It is a big decision for a health center to be a sponsoring entity. You have to meet all the accrediting requirements. There are resources that go into it.

In the beginning it is tough because your best clinicians become your teachers, which means you take them out of the direct services and now you're teaching.

So the investment is more medium to long-term when you make that decision. But my job and my board's job is to look ahead and look at what's coming at us, and the shortage was very real then. It is even more so now.

So the Teaching Health Center Program is a huge investment in our future—in our current and into our future, and we are seeing the paybacks now.

Mrs. RODGERS. Would you just address how your facility compares to other Teaching Health Centers across the country, and then also—I am afraid I am going to run out of time—the importance of the 5-year reauthorization?

Mr. GERMANO. Well, each health center has their own sort of reality that they are—the resources they have available to them. So we are all a little different in that respect. Some are urban. Some are rural. Some are frontier.

So, you know, we are very rural and, hence, I think we have a few more challenges we are starting to get our hands around. We are not having the same exact retention rates as some of the city programs but we are getting there. So I am really excited about that.

And, I am sorry—the second question was?

Mrs. RODGERS. Well, the importance of a 5-year reauthorization.

Mr. GERMANO. We have to—we commit 3 years to every class. They have to know when we are recruiting. I can't have a medical student say to me, are you going to be around in 2 years if this program is going away? That is not a great recruitment tool into our program. We need to know—we have to have certainty.

Mrs. RODGERS. All right. A 2-year reauthorization for a 3-year program just——

Mr. GERMANO. Doesn't make sense. Thank you.

Mrs. RODGERS. Doesn't make—OK. I appreciate the chairwoman for allowing me to waive on today. Thank you.

Ms. ESHOO. Thank you for your patience and thank you for your important work on the—on the legislation. I think that we have really very strong bipartisan support on this and which is really pleasing.

Now I am going to recognize the gentleman from Arizona, Mr. O'Halleran, who is one of the sponsors—key sponsors—of H.R. 2328, 2822, and 2680, 5 minutes of questioning.

And then I think after Mr. O'Halleran we'll be—we'll ask the staff to ready the table for the next panel. But I want to recognize the gentleman now and thank him for his patience, too.

Mr. O'HALLERAN. Thank you, Madam Chair.

A little perspective—my district is larger than the State of Arizona—I mean, Illinois—60 percent of Arizona. It goes from a few small urban areas to frontier—a Navajo reservation, a Hopi reservation, 12 Native American Tribes.

Economic conditions on the Tribal lands anywhere from—most of them 50 to 85 percent unemployment rate, getting worse. You can imagine the problems associated with that and the quality of life that people coming in to those areas have to address their lives to and the change.

You know, Mr. Germano, the National Health Service Corps provides vital scholarship and loan repayment programs that reduce workforce shortages in medically underserved areas and it has a successful retention program.

For instance, a 2012 study found that an amazing—more than half of the participants in the National Health Service Corps stayed in a health shortage area 10 years after their participation in the program ended.

My anecdotal information in my district, that is not true. Not that it is not true nationwide, but the realities of this district are different, and thank God for Community Health Centers.

What effects could we expect to see in rural and medically underserved areas if we—in the longer authorized and increased funding for this program?

Mr. GERMANO. Well, I think if it is tough now, I can only imagine how tough it would be without that loan repayment. The cost of medical education has gone out of sight and these young people are making decisions about where they're going to practice and what they're going to practice.

And if they don't see the opportunity of loan repayment as an option, it is going to be very difficult for us as Community Health Centers or any real provider in rural communities to be able to recruit them to our communities.

Mr. O'HALLERAN. Thank you.

Mr. Kowalski, thank you for your testimony here today. And as you are well aware, the Special Diabetes Program for Indians is tremendously important.

According to the Centers for Disease Control and Prevention, the American Indian and Alaska Native communities suffer from disproportionately high rates of diabetes.

This high prevalence, coupled with food deserts and limited access to healthcare facilities, can lead to more negative outcomes for these communities.

In addition, the high level of unemployment, Tribes with the inability to find jobs even if there was the ability to find the economic conditions under which those were to survive, will you please highlight how this program effectively supplements the Indian Health Care Services work in preventing diabetes and related complications among Native American populations?

Dr. KOWALSKI. Thank you, Representative, for that question and thank you for your leadership in introducing H.R. 2680, which would increase funding and extend funding for this incredibly important program.

As you point out, in your State we have Tribes that have diabetes incidence rates of over 50 percent, some Tribes upwards of 80 percent, and they are very underserved.

It is this program that has made significant differences. We talk about the importance of culturally tailored interventions and we have seen that in this program.

And I said earlier the proof is in the pudding. We have data-driven metrics in terms of the impact, in terms of glucose control levels being better, reducing the risk of complications.

For those complications, significant decreases, for example, in kidney disease and eye disease, which will save money. This is a critical program for underserved community—the Tribal communities in your State and across the country that deserves renewal and re-upping and I, again, thank you for your leadership.

Mr. O'HALLERAN. Well, thank you. And another question for you is this program has remained flat since fiscal year 2004. It is amazing. At the same time, the population served by Indian Health Care Services increased.

Will you please explain what the effects would be if Congress simply reauthorized the program but did not increase its annual appropriations?

Dr. KOWALSKI. So since 2004, if you did just the simple math of inflation, we are talking about $150 million versus what would now be $230 million for a problem that has only grown.

So we are, again, under resourced for a problem that is hurting these communities and costing our economy. We need to do better and we are seeing results from the program, I think. The up side is huge here.

Mr. O'HALLERAN. Thank you, Madam Chair. Sorry for taking so much time, and I yield.

Ms. ESHOO. The gentleman yields back.

And that concludes our first panel. I want to thank each one of the witnesses. You have done a superb job. I know that this has been a long hearing. You haven't had a break.

But we are taking up 12 bills and these are all important to the American people. So you have given marvellous testimony.

You have underscored the need for stability and confidence in the program so that we—in our reauthorizations that they have a longer pathway before reexamination by the Congress, and I think that that's a very prudent way to go.

But I just—I couldn't help but think during the hearing what would we ever do without what each one of you testified about. All the people in our country that are being cared for as a result of your work and your leadership.

So every blessing on each one of you in your work. We thank you for being here, and we will ask the staff to prepare the table for the next panel of witnesses.

Thank you, everyone.

[Pause.]

Ms. ESHOO. We now will hear from the second panel of witnesses and we want to thank you for—I think you were all waiting patiently. I think you have been here for the better part of the day and we thank you for that and what you are about to do.

Mr. Thomas Barker, partner and cochair of Healthcare Practice at Foley Hoag; Ms. Mary-Catherine Bohan, vice president of outpatient services at Rutgers University Behavioral Health Care; Mr. Fred Riccardi, who is president of the Medicare Rights Center, and I want to call on our—the vice chair of our committee to introduce his constituent, Dr. Michael Waldrum.

Mr. BUTTERFIELD. Thank you very much, Madam Chair, and I realize the hour is late. It looks like we are going to have votes in just a few minutes.

But I would like to recognize and to join the subcommittee in receiving the chief executive officer of—and distinguished professor of internal medicine and pulmonary and critical care at the Brody School of Medicine at East Carolina University.

Very briefly, my district consists of 14 counties and one of those counties is called Pitt County, and this university is a major economic engine in Pitt County.

And so I want to welcome Dr. Michael Waldrum to the subcommittee and look forward to his testimony. Thank you.

Ms. ESHOO. Thank you.

So we will—at this time the Chair recognizes Dr. Green for 5 minutes for your opening statement.

Mr. Barker. I am sorry.

STATEMENTS OF THOMAS R. BARKER, PARTNER, COCHAIR, HEALTHCARE PRACTICE, FOLEY HOAG; MARY-CATHERINE BOHAN, VICE PRESIDENT, OUTPATIENT SERVICES, RUTGERS UNIVERSITY BEHAVIORAL HEALTH CARE; MICHAEL WALDRUM, M.D., CHIEF EXECUTIVE OFFICER, VIDANT HEALTH; AND FREDERIC RICCARDI, PRESIDENT, MEDICARE RIGHTS CENTER

STATEMENT OF THOMAS R. BARKER

Mr. BARKER. Thank you, Madam Chair—Chairwoman Eshoo, Dr. Burgess. Thank you very much for the opportunity to appear before the subcommittee today.

Thirty-eight years ago this week, I started my first job on Capitol Hill as an intern in this building, and when I walked through the Rayburn Horseshoe from the Capitol South Metro I never in a million years would have imagined that I would have had the honor of appearing before this subcommittee. So thank you very much for this opportunity.

I want to clarify at the outset, Madam Chair—you mentioned my affiliation with my law firm. I want to clarify at the outset that although I was recently appointed the MACPAC, I am not appearing today on behalf of the Commission.

Rather, I am speaking to you as a healthcare lawyer with many years' experience representing both the Government as the chief legal officer of CMS and HHS. I also represent healthcare providers and payers in private practice and as a former professor of healthcare law and policy at George Washington University and Suffolk University School of Law.

My remarks today focus on the bill that was introduced by Mr. Engel that deals with the pending cuts in Medicaid DSH payments that were enacted as part of the Affordable Care Act and that had been deferred several times since then under current law.

As the members of the subcommittee know, the first round of DSH cuts will occur in fiscal year 2020. So my testimony, which I am not going to, obviously, repeat but my testimony focuses on those pending cuts and it gives a little bit of history of the DSH payment system, which I hope will be helpful to the subcommittee as it begins its deliberations on an extenders package.

I think it is important to understand that the DSH cuts of the ACA did not happen in isolation but, rather, as a part of a nearly 40-year history of Congress recognizing the special needs of Disproportionate Share Hospitals.

In my testimony I went through the history of DSH, which actually started in 1981, probably in this room, when the House was beginning deliberations over the Omnibus Budget Reconciliation Act of '81, which was the first time that Congress told the States to focus on the needs of DSH hospitals, and that statute was amended again in 1987, 1991, 1993, the BBA in 1997 and then again in 2010 when the ACA was enacted into law.

And my testimony concludes by referring the subcommittee to recommendations that MACPAC made to structure the DSH cuts differently by phasing them in over a longer period of time to allocate the cuts first to States that have unspent DSH allocations and then really—and most importantly, in my view, to restructure the DSH allotments or the DSH caps to better align the State-specific DSH caps to the percentage of low-income nonelderly individuals in a State.

After all, that was the real original intent of DSH when it was enacted in 1981, which was an agreement by the Reagan administration, by the Governors, and by the Congress over how Medicaid rates should be set by States.

So let me conclude by thank you for the opportunity to testify before the subcommittee this afternoon. I would be pleased to answer any questions that you have and I am happy to make myself available to the members of your staff if you have any questions about DSH.

Thank you.

[The prepared statement of Mr. Barker follows:]

COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH

"INVESTING IN AMERICA'S HEALTH CARE"

JUNE 4, 2019

TESTIMONY OF THOMAS R. BARKER, J.D.

Madame Chairwoman Eshoo, Dr. Burgess, and members of the Subcommittee:

I. INTRODUCTION

Thank you for the opportunity to appear before the Subcommittee today. Thirty-eight years ago this week, I started my first job on Capitol Hill, as an intern, in this building. I could have never imagined, as I was walking into the Rayburn Building from the Capitol South Metro that morning, that I would one day have the honor of appearing before this Committee, so thank you for this opportunity.

I would like to clarify at the outset that although I was recently appointed to MACPAC, I am not appearing today on behalf of the Commission. Rather, I am speaking to you today as a health care lawyer with many years' experience representing both the government (as the chief legal officer of CMS and HHS) and health care providers and payers in private practice, and as a former professor of health care law and policy at George Washington University and Suffolk University School of Law.

I understand that the Subcommittee is in the process of considering the various Medicaid extenders that must be addressed by Congress before the end of this fiscal year. I would like to focus on one extender in particular: the disproportionate share hospital cuts that were enacted as a part of the Patient Protection and Affordable Care Act, or the ACA, in 2010. I thought it might be helpful to provide a bit of perspective on the original policy behind DSH payments overall, changes that Congress made to DSH policy to curtail perceived financing abuses in the late 1980s and early 1990s, and the DSH cuts that were enacted in the ACA. I think it is important to understand that the ACA policy was not enacted in isolation; it was part of a decades-long history in addressing the situation of hospitals that treat low-income, uninsured, and Medicaid patients.

That history may be helpful to the Subcommittee as it moves forward with an extenders package. This year, the Subcommittee is called on to address the fact that, absent Congressional action this year, Medicaid DSH payments will be cut by $4 billion this year and $8 billion per year starting in 2021 through 2025. I understand that there is general consensus among members of the Committee that the full $4 billion cut should not take effect in 2020. I hope that my testimony is helpful to the Committee as it considers an appropriate policy with regard to DSH payments.

A. HISTORY OF MEDICAID DSH POLICY

The original DSH policy in the Medicaid program was actually written in this room during the mark-up of the Omnibus Budget Reconciliation Act of 1981. At the time, Congress was trying to provide more flexibility to States in setting Medicaid payment rates to hospitals. Prior to OBRA'81, States were generally required to pay hospitals on a reasonable cost basis. Congress, the Reagan Administration and the Governors felt that States should have more flexibility to design payment policies in Medicaid and so repealed the reasonable cost requirement. At the same time, Congress was also concerned that giving States carte blanche authority to set Medicaid payment rates could result in under-paying some hospitals, so Congress included language instructing that States take into account the needs of what became known as disproportionate share hospitals.

As passed by the House, OBRA instructed States to "take into account the special costs of hospitals whose patients are disproportionately Medicaid eligible or without third party coverage."[1] The Senate modified this language slightly and instructed States to "take into ... account the atypical costs incurred by hospitals which serve a disproportionate number of low income patients."[2] In other words, whereas the House focus was hospitals that treated a disproportionate number of Medicaid and uninsured patients, the Senate focus was more generally on hospitals that treated a disproportionate number of low income patients.

Ultimately, the Senate language prevailed in conference. However, the Conference Agreement went on to note that "public hospitals and teaching hospitals which serve a large Medicaid and low-income population are particularly dependent on Medicaid reimbursement, and are concerned that a State take into account the special situation that exists in these situations in developing their rates."[3] The statutory language implementing this statement of Congressional intent now requires that a State plan for medical assistance "take into account ... the situation of hospitals which serve a disproportionate number of low-income patients with special needs."[4]

B. CURTAILING THE USE OF PROVIDER TAXES AND DONATIONS TO OBTAIN THE STATE SHARE OF MEDICAL ASSISTANCE

Although Congress first imposed a DSH obligation on States in 1981, it wasn't until the Omnibus Budget Reconciliation Act of 1987 that the Congress imposed specific statutory

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[1] House of Representatives, Committee on the Budget, Conference Agreement to Accompany the Omnibus Budget Reconciliation Act of 1981, H. Rept. 97-208 (July 29, 1981) at 962.

[2] *Id.*

[3] *Id.*

[4] Social Security Act § 1902(a)(13)(A)(iv).

requirements that specified, with some precision, how States were required to implement the "take into account" requirement.[5] Congress specified a minimum threshold for the types of hospitals that States were required to designate as DSH.[6] Additionally, DSH payments do not count against a State's upper payment limit, thereby giving States more flexibility in developing a payment policy for DSH hospitals.[7]

This flexibility, however, created the opportunity for States to use provider taxes and donations that contained a hold-harmless feature to derive the State share of medical assistance expenditures. DSH expenditures exploded between fiscal year 1990, when the federal share of DSH funds was $1 billion, and 1992, when the federal share of DSH funds increased to $17.4 billion.[8] Because Congress felt that some of these financing techniques were abusive, it enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991.[9] Under this statute, a State is only permitted to derive its share of medical assistance via the use of provider taxes that are broad-based, uniform, and that do not contain a hold-harmless feature.[10] The statute also imposed the first statewide limitation on DSH payments that was based on DSH payments made to a state in 1992.[11]

Shortly after Congress enacted the Provider Tax statute, it imposed an additional limitation on DSH payments. As part of the Omnibus Budget Reconciliation Act of 1993, Congress imposed a hospital-specific cap on DSH payments. Under the statute, DSH payments generally cannot exceed the costs that a hospital incurs in providing care to Medicaid patients and uninsured patients.[12] Several years later, as part of the Balanced Budget Act of 1997, Congress further curtailed DSH by imposing a specific, State-by-State cap on DSH payments in

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[5] Social Security Act § 1923.

[6] *Id.* at subsection (b)(1). In general, a State must designate at least two categories of hospitals as DSH: first, any hospital with a low-income utilization rate (a fraction that reflects, in part, the amount of uncompensated care provided by the hospital) of at least 25%. Subsection (b)(1)(A). Second, any hospital with a Medicaid inpatient utilization rate greater than one standard deviation from the mean Medicaid utilization rate of hospitals in the State must be designated as DSH. Subsection (b)(1)(B).

[7] 42 C.F.R. § 447.272(c)(2).

[8] Congressional Research Service, "Medicaid Disproportionate Share Hospital Payments" (June 17, 2016) at 2.

[9] Pub. L. No. 102-234, 102nd Cong., 1st Sess., 105 Stat. 1793 (Dec. 12, 1991). The main provisions of the statute are codified at section 1903(w) of the Social Security Act.

[10] Social Security Act § 1903(w)(3)(B),(C).

[11] Pub. L. No. 102-234, *supra* n. 9, 105 Stat. at 1799 – 1802.

[12] Omnibus Budget Reconciliation Act of 1993 § 13621(b)(1), Pub. L. No. 103-66, 107 Stat. 312, 630 – 31 (Aug. 10, 1993). This requirement is codified at section 1923(g) of the Social Security Act. CMS implementation of this requirement is currently subject to litigation in multiple United States Courts of Appeal.

statute.[13] Because these caps are trended forward by inflation, the total amount of federal funds allotted for DSH in 2019 is $12.6 billion.[14]

C. ENACTMENT OF THE ACA

By the time that President Obama signed the ACA into law in 2010, there was a clear, nearly thirty-year history of DSH payments to hospitals. Although Congress had initially intended to give States broad flexibility to design a DSH payment mechanism, that flexibility began to be curtailed in 1987. That history, combined with the belief that the ACA was expected to result in a reduction of the uninsured due to the then-mandatory Medicaid expansion[15] and the availability of tax credit subsidies for qualified health plans sold on an Exchange, led Congress to believe that a reduction in the DSH allotments was warranted.[16]

As initially enacted, the ACA called for a reduction in total DSH allotments of $500 million in 2014; $600 million in 2015 and 2016; $1.8 billion in 2017; $5 billion in 2018; $5.6 billion in 2019; and $4 billion in 2020.[17] Since the enactment of the ACA, Congress has amended the DSH reduction statute multiple times; under current law, as noted above, the aggregate reductions to the DSH allotments will begin in 2020 with a reduction of $4 billion, increasing to $8 billion in 2024 and 2025. The DSH allotments would then return to their regular statutorily-assigned level in 2026.

D. OPTIONS TO ADDRESS PENDING REDUCTIONS

Congress, of course, has many options available to it to address the pending reduction of $4 billion. It could further delay the reductions; it could simply repeal the reductions; or it could phase them in and develop a new policy. Of course, these decisions must be made in the context of the federal budget deficit and the overall impact of federal and state DSH policy on safety net hospitals.

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[13] Balanced Budget Act of 1997 § 4721, Pub. L. No. 105-33, 111 Stat. 251, 511 – 12 (Aug. 5, 1997). The DSH caps are codified at section 1923(f) of the Social Security Act.

[14] Medicaid and CHIP Payment Access Commission, "Improving the Structure of Disproportionate Share Hospital Allotment Reductions" at 4 (March, 2019) (hereafter, MACPAC DSH Recommendations).

[15] In 2012, the Supreme Court, in a 7 – 2 decision, held that the mandatory ACA Medicaid expansion was unconstitutional. *NFIB v. Sebelius*, 567 U.S. 519, 575 – 88 (2012).

[16] In addition to the reductions in the Medicaid DSH allotments, Congress also revised the Medicare DSH formula by holding back 75% of otherwise-payable Medicare DSH funds and re-distributing those funds based on a hospital's uncompensated care level. *See* Social Security Act § 1886(r)(2)(C).

[17] Health Care Education and Reconciliation Act, Pub. L. No. 111-152 § 1203(a)(2), 124 Stat. 1029, 1053 – 55 (March 31, 2010). The reductions were codified (and now appear, in their current form) in section 1923(f)(7) of the Social Security Act.

One option that Congress may wish to consider is adopting the recommendations that MACPAC proposed in March of this year. The MACPAC recommendations could be implemented on a budget neutral basis and phased in more gradually than scheduled under current law. The MACPAC recommendations contain three parts:

First, rather than applying a $4 billion reduction in 2020, the MACPAC recommendation would be a $2 billion reduction in 2020, $4 billion in 2021 (rather than $8 billion), $6 billion in 2022 (rather than $8 billion), and $8 billion per year in 2023 – 2029. Under current law, the DSH reductions end in 2025; under the MACPAC recommendations, they would extend for four additional years in order to achieve budget neutrality over the 10-year budget window.[18]

The second MACPAC recommendation would be to apply reductions to States with unspent DSH allotments before applying reductions to other States. Not all 50 States are using their full DSH allotments; under this recommendation, States with unspent DSH allotments would have their allotments reduced before reducing allotments to other States.

Finally, the third recommendation would be to direct CMS to revise the State-specific DSH caps to better align the relationship between the DSH allotments in a State and the number of low-income non-elderly individuals in that State (after adjusting for hospital costs, using the Medicare area wage index, in different geographic areas). The merit in this recommendation reflects the simple fact that the current DSH allotments relate back to the level of historic DSH spending in a particular State in the early 1990s. But that historic DSH spending may bear little or no relationship to the low-income non-elderly population in that State today. Revising the formula accordingly would better correspond to the original intent of the DSH program as enacted by Congress in 1981.

II. CONCLUSION

Madame Chairwoman, Dr. Burgess and members of the Subcommittee, thank you again for the opportunity to testify before you this morning. I would be pleased to make myself available to any of you or your staffs if you have any questions or would like further information.

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[18] According to the Congressional Budget Office, the MACPAC proposal would actually achieve budgetary savings ranging from $1 - $5 billion over the period. MACPAC DSH Recommendations, *supra* n. 14, at 8.

Ms. ESHOO. We thank you for that, Mr. Barker, and I love the history. We never know what paths in life—where they are going to lead us and take us.

Mr. BARKER. Well, Mr. Waxman was here then. Mr. Dingell was here then. I certainly remember working for them. Thank you.

Ms. ESHOO. Yes. It is a wonderful story. We stand on great shoulders.

Now I would like to recognize Ms. Bohan. You are recognized for your 5 minutes of testimony, and thank you.

STATEMENT OF MARY-CATHERINE BOHAN

Ms. BOHAN. Thank you for the opportunity to testify in support of the Excellence in Mental Health and Addiction Treatment Expansion Act, and to share with you how becoming a certified community behavioral health clinic—CCBHC—has impacted my organization and community.

I am honored to be there today on behalf of the National Council for Behavioral Health, a national association that represents 3,100 member organizations who, collectively, serve more than 10 million adults and children living with mental illness and addiction.

I am further honored to represent Rutgers University Behavioral Health Care, one of the seven CCBHCs participating in the 2-year demonstration project in New Jersey.

Established in 1972, UBHC is one of the largest academic behavioral healthcare delivery systems in the Nation and is the largest behavioral health provider in the State of New Jersey, serving over 18,000 individuals per year.

I have been vice president of outpatient services at UBHC since 2016. I am a clinical social worker by training and I have been a direct provider and administrator of mental health, addiction treatment, and community-based services for over 35 years in three different States.

I know only too well how siloed mental health and addiction services can be. Historically, neither system assessed the physical well-being of their clients, often missing vital information that should be part of their care.

At Rutgers, CCBHCs have been the vehicle that has allowed us to finally offer integrated services and provide holistic care to those we serve.

I would like to take a moment to share what behavioral health services at Rutgers UBHC look like now as compared to before the CCBHC implementation.

The three outpatient clinics that were transitioned to CCBHC served about 3,300 individuals. In the first year of the program, we increased the number of people served to 5,000. In year 2, we have treated 6,000 individuals and families.

We currently maintain 300 clients on medication-assisted treatment, or MAT, versus the 30 individuals that we treated the year prior to CCBHC.

Before the demonstration, the average wait time for first appointment was 21 days with a no-show rate of 50 percent. Individuals with behavioral health issues need immediate access to care and we were losing the opportunity to help people at the time that they identified their need.

Now we proudly offer same-day/next-day access. Our no-show rate is down to about 24 percent and continues to drop. When individuals were disengaged in treatment, outreach was limited to phone calls or letters. We now engage clients face to face in the community, person to person.

In one instance, a clinician was concerned about an adolescent who had missed an appointment and could not be reached by phone. The case manager did a wellness visit at her home and intervened with the client, who was in the middle of a self-harm episode.

The case manager contacted EMS, the family, and facilitated getting this client to the appropriate level of care. This type of intervention simply would not have been available to us prior to the CCBHC.

Two years into this program, Rutgers UBHC is just hitting its stride. We are positioned to go further and do more for our community. But with the continued funding at risk, we have been unable to hire additional staff or pursue initiatives that would drive further innovation.

If the CCBHC demonstration project is not extended past June 30th, the impact on Rutgers UBHC is enormous. Case management and peer support services will be discontinued, which means our ability to engage individuals in the community will end.

Without case management and peer support, our same-day/next-day access model, which relies on a team approach to function, will be greatly impacted and I fear that wait times will again grow to be weeks long.

Health screens and subsequent linkage to primary care will be greatly reduced. The ambulatory withdrawal management program that treats individuals with opiate use disorder will likely close.

To be frank, if the program expires all of the success I shared with you today is at risk. We cannot go back to business as usual. Not Rutgers, not the other UBHCs, and most importantly, not our clients, because those are the ones who will lose out the most if this program ends.

So today I am asking for the committee's support in passing the Excellence in Mental Health and Addiction Treatment Expansion Act so that the eight States who are currently operating CCBHC can continue this work and additional States can be afforded the opportunity to transform their behavioral health delivery systems.

On behalf of the individuals and families we serve, I would like to thank this committee for your focused attention on this issue and I would especially like to thank Congresswoman Doris Matsui and Congressman Markwayne Mullin for their leadership in sponsoring the Excellence Act expansion bill.

Thank you, and I look forward to your questions.

[The prepared statement of Ms. Bohan follows:]

Statement by Mary-Catherine Bohan, MSW
Vice President of Outpatient Services at Rutgers Health: University Behavioral Health Care

on

Investing in America's Health: Extending and Expanding Certified Community Behavioral Health Clinics

before

Committee on Energy & Commerce,
Subcommittee on Health
U.S. House of Representatives
June 4, 2019

Summary

In 2014, the bipartisan Excellence in Mental Health and Addiction Treatment Act began to address the desperate need for treatment for addictions and mental illnesses by establishing criteria for Certified Community Behavioral Health Clinics (CCBHCs), which provide a comprehensive range of addiction and mental health services to the communities they serve, especially vulnerable individuals. In return, CCBHCs receive a sustainable payment that is reflective of their actual cost of providing services.

Since 2017, clinics in eight states have been piloting this approach and are leading a bold shift to transform community services into a comprehensive and responsive array of clinics that provide accessible patient-centered care. CCBHCs have treated hundreds of thousands of individuals, increasing patient caseloads while decreasing patient wait times. They have hired new staff, started or expanded treatment and recovery programs. They have expanded access to medication-assisted treatment.

The Excellence in Mental Health and Addiction Treatment Act demonstration is set to expire in these eight states on June 30, 2019. The Excellence in Mental Health and Addiction Treatment Expansion Act (S. 824/ H.R. 1767) would extend the demonstration by affording the eight original states two more years and expanding the program to include the other 11 states that originally applied but were not selected for participation. The

National Council for Behavioral Health and Rutgers University Behavioral Health Care strongly support this legislation and urge the support of Congress to pass it into law.

Statement

Chairwoman Eshoo, Ranking Member Burgess, and Members of the Health Subcommittee, thank you for the opportunity to testify in support of the Excellence in Mental Health and Addiction Treatment Expansion Act and on behalf of Certified Community Behavioral Health Clinics. In 2014, Congress established criteria for Certified Community Behavioral Health Clinics (CCBHCs), which provide a comprehensive range of addiction and mental health services to the communities they serve, especially vulnerable individuals. In return, CCBHCs receive a bundled Medicaid payment rate that allows them to expand services to previously untreated populations. Since 2017, clinics in eight states (MN, MO, NJ, NV, NY, OK, OR, PA) have been piloting this approach and are leading a bold shift to transform community services into a comprehensive and responsive array of clinics that provide accessible patient-centered care. In the first year alone, CCBHCs served nearly 400,000 people with mental illnesses and addiction disorders with nearly 20 percent of those individuals having received care for the first time. However, with CCBHC demonstration funding set to expire on June 30, 2019, access to these lifesaving treatments — and the lessons learned for the nation at-large — could be lost without immediate Congressional action.

I appreciate the opportunity to speak for the 3,100 National Council for Behavioral Health member organizations that provide front-line addiction and mental health treatment across the country and for the more than 120 Certified Community Behavioral Health Clinics across the country. We deeply appreciate Congress's interest in extending CCBHCs and allowing the community-based providers who have made incredible strides the last two years the opportunity to continue expanding access to comprehensive addiction and mental health services.

About the National Council for Behavioral Health

The National Council for Behavioral Health is the unifying voice of America's health care organizations that deliver mental health and addictions treatment and services. Together with their 3,100 member organizations serving over 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery.

About Rutgers University Behavioral Health Care

I serve as Vice President of Outpatient Services for Rutgers University Behavioral Health Care. UBHC was established in 1972 and is one of the largest academic behavioral health care delivery systems in the nation, and is the largest provider of behavioral health services in the state of NJ. UBHC serves over 18,000 individuals per year and provides a comprehensive continuum of services including inpatient, outpatient, acute partial hospitalization, and community outreach, servicing children, adults, families and veterans.

LEGISLATION IS NEEDED TO EXTEND AND EXPAND THE CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC MEDICAID DEMONSTRATION PROGRAM

The Problem

Throughout my career, I have been concerned with how siloed the behavioral health system is and with the circuitous routes one needs to take to get comprehensive care. It is incredibly difficult for individuals and families to navigate and they often have to navigate multiple systems in order to get their addiction, mental health and physical health care needs met. Recent data from the Substance Abuse and Mental Health Services Administration (SAMHSA) indicate that only 43.1 percent of all people living with serious mental illnesses like schizophrenia, bipolar disorders and major clinical depression receive behavioral health care. The remainder are served in homeless shelters, hospital emergency rooms and penal institutions, which serve as the largest inpatient psychiatric facilities in the U.S. Only one in 10 Americans with an addiction disorder receives treatment in any given year.[1]

Thirty five years ago, a client had to be psychiatrically stable in order to address their alcoholism or drug addiction and they had to be clean and sober for 6 months before a provider would even consider treating their mental health needs. And neither the mental health or addiction systems assessed individuals' physical health. We treated above the neck only. We have come so far in that we now treat these disorders concurrently. However, the behavioral health field has known for well over a decade that individuals with mental illness die 25 years sooner than the general public, but we struggled to adequately address their physical health concerns.

For Rutgers UBHC, CCBHCs have been the vehicle that has allowed us to finally move toward integration of services and provide holistic care to those we serve. CCBHCs are available to any individual in need of care, regardless of their ability to pay, including people with serious mental illness, opioid use disorders, serious emotional disturbance, long-term chronic addiction, substance use disorders (SUD) and complex health profiles. Quite simply, CCBHCs are a better way of providing care.

The History

The Excellence in Mental Health and Addiction Treatment Act demonstration established a federal definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs). As a CCBHC, Rutgers UBHC is designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals. In return, UBHC receives an enhanced Medicaid reimbursement rate based on our anticipated costs of expanding services to meet the needs of these complex populations we serve in New Jersey.

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[1] Park-Lee, E., Lipari, R. N., Hedden, S. L., Kroutil, L. A., & Porter, J. D. (2017, September). Receipt of Services for Substance Use and Mental Health Issues among Adults: Results from the 2016 National Survey on Drug Use and Health. NSDUH Data Review. Retrieved from https://www.samhsa.gov/data/

The service selection is deliberate, expanding the range of care available. Rutgers UBHC provides a comprehensive collection of services needed to create access, stabilize people in crisis, and provide the necessary treatment for those with the most serious, complex mental illnesses and substance use disorders. The required service line for CCBHCs includes but is not limited to the following:

- ***24/7/365 crisis services*** including a 24-hour psychiatric care facility to help people stabilize in the most clinically appropriate, least restrictive, least traumatizing, and most cost-effective settings.
- ***Immediate screening and risk assessment*** for mental health, addictions, and basic primary care needs to ameliorate the chronic co-morbidities that drive poor health outcomes and high costs for those with behavioral health disorders.
- ***Easy access to care*** with criteria to assure a reduced wait time so those who need services can receive them when they need them, regardless of ability to pay or location of residence. UBHC is proud to offer our clients same day/next day access for services.
- ***Tailored care for active duty military and veterans*** to ensure they receive the unique health support essential to their treatment.
- ***Expanded care coordination*** with other health care providers, social service providers, and law enforcement, with a focus on whole health and comprehensive access to a full range of medical, behavioral and supportive services.
- ***Commitment to peers and family***, recognizing that their involvement is essential for recovery and should be fully integrated into care.

Positive Impact of CCBHC on Workforce, Client Access

At Rutgers UBHC, outpatient services before CCBHC provided traditional services, including individual counseling, group therapy and medication management. Substance use disorder treatment was limited to three small, state funded grants. Rutgers UBHC transitioned three clinics in Middlesex County, NJ into CCBHC programs on July 1, 2017. These clinics collectively served 3,300 unique individuals in the year prior to CCBHC implementation. Of this number, 100 individuals with substance use disorder were treated and only 30 individuals received medication-assisted treatment (MAT). In the first year of CCBHC, UBHC increased the number of people served by 65 percent to over 5,000 individuals and tripled the number of persons served with Substance Use Disorder and those treated with MAT. Across the nation, CCBHCs cared for nearly 400,000 people with mental illnesses and addiction disorders in the program's first year alone. Patient caseloads have increased by nearly 25 percent based on expanded staff capabilities and new programs, with most of the increase from individuals seeking services for the first time.

Access to care used to be limited primarily to referrals from within the UBHC system. The average wait time for first appointment was 21 days and half of these individuals would not show up. But now, we proudly offer same day/next day access for our clients. Our no-show rate is down to 24 percent, and continues to improve. Across forty-seven CCBHCs surveyed by the National Council for Behavioral Health in 2018, 78 percent of CCBHCs can offer an appointment within a week after an initial call or referral compared to the national average of up to 48 days.

Where before, clinicians and physicians reported that up to fully half of their time with individuals was spent dealing with social determinants of health like housing, food insecurity, and insurance benefits, UBHC now employs 15 case managers and 3 peer support specialists who have freed practitioners up to practice at the top of their licensure. Nationwide, over 2,100 new staff were hired including psychiatrists specializing in addiction, and children and adolescents.

When individuals become disengaged in treatment, outreach was limited to phone calls or letters. Because of the CCBHC demonstration, Rutgers UBHC is able to offer staff who work in the community and to check on and connect with clients face-to-face and person-to-person. In one instance, a clinician was concerned about an adolescent who had missed an appointment and could not be reached by phone. The case manager did a wellness check at her home and intervened with the client who was in the middle of a self-harm episode. The case manager contacted EMS, the family, and facilitated getting this client to the appropriate level of care. This type of intervention would not have been available to us in this way prior to CCBHC.

Outlook for Rutgers UBHC if CCBHC Demonstration Expires

As we get near our second full year in this new model, Rutgers UBHC is just now hitting its stride. We are poised to go further and do more for our community, but with the continued funding at risk, we have been unwilling to hire additional staff or pursue business agreements with other entities.

If the CCBHC Medicaid demonstration is not extended, the impact on Rutgers UBHC will be enormous. Case management and peer support services will have to be discontinued. Access to interventions targeted to address the Opioid Epidemic in our community, such as MAT and Ambulatory Withdrawal Management (AWM,) is at risk of being restricted or eliminated. Physical health screens and subsequent linkage to primary care will be greatly reduced. Our same day/next day access model, which relies heavily on a team approach to function, will return to the traditional model without case management and peer support. Wait times for appointments will again grow to be weeks long.

Should this program expire, all of the success shared with the Committee today is at risk. We cannot go back to business as usual. Not Rutgers, not the other CCBHCs and most importantly, not our clients. They are the ones that will lose out the most if the CCBHC program ends.

National Support for the Continuation of CCBHCs

The National Council appreciates the efforts this Committee, including Representatives Matsui and Mullin, for introducing legislation to extend and expand Certified Community Behavioral Health Clinics. The Excellence in

Mental Health and Addiction Treatment Expansion Act (S. 824/ H.R. 1767) would afford the current eight-states participating in the Medicaid demonstration an additional two years, while expanding the program to include the other 11 states that initially applied but were not chosen for participation in the demonstration.

The National Council is proud to support this legislation is concert with over 50 national advocacy organizations representing providers, consumers, family members, law enforcement officers, first responders and other interested stakeholders.

Conclusion

Thank you again for considering my testimony in support of the Excellence in Mental Health and Addiction Treatment Expansion Act (S. 824/ H.R. 1767) that would extend the current eight demonstration states while expanding the program to include the other 11 states ready to transform their behavioral health service model.

Ms. ESHOO. Thank you for your outstanding work. It is very hopeful, what you described to us. Thank you for your testimony. Powerful testimony.

Now I'd like to recognize Dr. Waldrum. You have 5 minutes for your testimony, sir. Thank you.

STATEMENT OF MICHAEL WALDRUM, M.D.

Dr. WALDRUM. Thank you, and good afternoon.

And thank you, Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of this subcommittee for inviting Vidant Health to testify at today's hearing.

I am Michael Waldrum, chief executive officer of Vidant Health, a health system guided by its mission: to improve the health and well-being of the people of eastern North Carolina, a geographic region the size of Maryland that 1.5 million people call home, including the subcommittee's vice chair, Congressman Butterfield.

I am honored to speak to you today about the vital importance of Medicaid Disproportionate Share Hospital, known as DSH, funding is for my health system and the people and communities we serve.

Vidant Health is a nine-hospital system and includes one of four academic medical centers in North Carolina, the Vidant Medical Center, which is a tertiary referral center and the only level one trauma center on the Eastern Seaboard between Norfolk, Virginia, and eastern—and Charleston, South Carolina.

We employ more than 14,000 North Carolinians and contribute $3.5 billion to North Carolina's gross State product.

Vidant Health and the hundreds of essential hospitals like it across the country reach well beyond our walls to meet people where they live and help communities cope with social, economic, and environmental factors that affect their health.

We have ample experience with this. The majority of the counties we serve are among the most economically distressed areas in our State.

In the Vidant Medical Center primary service area, Pitt County, 60 percent of the public school students are enrolled in free or reduced lunch programs and the poverty rate is 24 percent.

Our providers work hard every day to combat obesity, chronic conditions, the infant and maternal mortality crisis, the opioid epidemic, and to support our communities where they live who are disproportionately burdened by these illnesses.

So we fund programs that empower community partners to overcome social economic factors that contribute to poor health, from chronic conditions support to food banks for school health programs and many other initiatives we are making a difference.

In fact, last year Vidant Health partnered with more than 159 different programs across eastern North Carolina, contributing almost $2 million in grant contributions to other social service organizations which serve more than half a million of our neighbors.

Today's hearing is about investment in healthcare and these programs represent our investment in the health and productivity of our community.

We can do these things because Medicaid DSH helps us ease the financial pressure that comes with our commitment to meeting the healthcare needs of all of our people, including those faced with severe financial hardships.

That commitment to mission translates to more than $200 million in uncompensated care costs annually for Vidant Health. Medicaid DSH helps close that gap.

Our situation is not unique. The 300 hospitals in our national association, America's Essential Hospitals, alone provide nearly a quarter of all charity care nationally and more than nine times the amount of uncompensated care on average than other U.S. hospitals.

Vidant Health and the Nation's other essential hospitals depend on Medicaid DSH to offset the financial losses we sustain caring for our Nation's most vulnerable people who are often are the most complex and costliest patients.

This leaves essential hospitals with no financial cushion to absorb a cut the magnitude of this year's DSH reduction, $4 billion, or a total of a third of the DSH funding.

A cut this size would deeply change our ability to meet the needs of the individuals and families who depend on Vidant Health. These cuts will be felt even more so by the patients in States that have not expanded Medicaid, such as North Carolina.

DSH cuts would devastate the Nation's safety net and jeopardize healthcare access and jobs in eastern North Carolina and the communities in the country with a particularly acute impact of rural America and including the rural environment that we serve.

Congress has wisely chosen to delay these cuts four times previously, each time with strong bipartisan votes. We greatly encourage—we are greatly encouraged to see the same bipartisanship on this issue this year.

We thank Congressman Engel and Olson for organizing a letter to the House leaders calling for a further delay and we thank the 300 bipartisan House colleagues including the members of this subcommittee who signed that letter.

Thank you for allowing me to share Vidant's story.

[The prepared statement of Dr. Waldrum follows:]

Testimony of Michael Waldrum, MD, MSC, MBA
Chief Executive Officer
Vidant Health

Hearing on "Investing in America's Health Care"

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

June 4, 2019

Good morning and thank you Chairwoman Eshoo, Ranking Member Burgess, and distinguished Members of the Subcommittee for inviting Vidant Health to testify at today's hearing. I am Michael Waldrum, chief executive officer of Vidant Health, a health system guided by its mission to improve the health and well-being of Eastern North Carolina, a geographic region the size of Maryland that 1.5 million people call home—including the district of the subcommittee's vice chair, Congressman Butterfield.

I am honored to speak to you today about the vital importance of Medicaid disproportionate share hospital (DSH) support for my health system and the people and communities we serve.

Vidant Medical Center, in Greenville, is one of four academic medical centers in North Carolina. It is a tertiary referral center and the only level I trauma center on the Eastern seaboard between Norfolk, Virginia and Charleston, South Carolina. Overall, our system is the site annually of more than 64,000 inpatient admissions, 347,000 outpatient visits, 265,000 emergency visits, and 5,600 births.

Vidant Health also is a major employer and source of economic activity in our state. We employ more than 14,000 North Carolinians and contribute $2.85 billion to the gross regional product of Eastern North Carolina and $3.5 billion statewide.

But those numbers reflect care largely inside our walls, and they tell only part of the story about our service to the community and our vision to be a national model for rural health care.

Vidant Health and the hundreds of essential hospitals like it across the country reach well beyond their walls to meet people where they are and help communities cope with social, economic, and environmental factors that influence health.

We have ample experience with this. According to the 2016 County Tier Designations, a majority of the counties we serve are among the most economically distressed areas of our state. In Vidant Medical Center's primary service area, Pitt County, 60 percent of public school students are enrolled in free or reduced lunch programs, and the poverty rate is 24 percent, compared to about 18 percent statewide. Feeding America calculates that nearly a quarter of Pitt County's residents experience food insecurity. With this reality, our care providers work hard to combat climbing rates of obesity, chronic conditions, the infant and maternal mortality crisis, and the opioid epidemic.

So, we fund programs throughout our system that empower hospitals and community partners to overcome socioeconomic factors that contribute to poor health. From chronic condition support to food banks to school health programs and many other initiatives, we're making a difference. In fact, last year, Vidant Health partnered with more than 159 different programs across Eastern North Carolina, contributing almost $2 million in grant contributions to other social service organizations and serving more than half a million of our neighbors.

Today's hearing is about investment in health care, and these programs represent our investment in the health and productivity of our community. We can do these things because Medicaid DSH helps ease the financial pressure that comes with our commitment to meeting the health care needs of all people, including those who face severe financial hardships.

That commitment to mission translates to more than $200 million in uncompensated care costs annually for Vidant Health. This includes charity care, bad debt, and shortfalls from government programs. Medicaid DSH helps close that gap.

Our situation is not unique. The 300 hospitals in our national association, America's Essential Hospitals, alone provide nearly a quarter of all charity care nationally and more than nine times the amount of uncompensated care per hospital than other U.S. hospitals.

Vidant Health and the nation's other essential hospitals depend on Medicaid DSH to offset the financial losses we sustain caring for our nation's most vulnerable people, who often are the most complex and costliest patients due to their socioeconomic challenges. This leaves essential hospitals with no financial cushion to absorb a cut the magnitude of this year's DSH reduction: $4 billion, or a third of total DSH funding.

A cut this size—and the following year's unthinkable $8 billion reduction—would deeply damage our ability to meet the needs of the individuals and families who depend on Vidant Health. These cuts will be felt even more so by the patients in states that have not expanded Medicaid, such as North Carolina. DSH cuts would devastate the nation's safety net and jeopardize health care access and jobs in eastern North Carolina and communities across the country, with a particularly acute impact on rural America. It is important to recognize that 102 rural hospitals have already closed between January 1, 2010 and March 19, 2019.

Congress has wisely chosen to delay these cuts four times previously—each time, with strong bipartisan votes that underscored the concern of how broadly these cuts could impact care. We're greatly encouraged to see the same bipartisanship on this issue this year. We thank Congressmen Engel and Olson for organizing a letter to House leaders calling for a further delay, and we thank their 300 bipartisan House colleagues, including the members of this subcommittee, who signed that letter.

Thank you for letting me share the story of Vidant Health, the people and communities we serve, and the vital need for strong federal funding support to help us meet our mission.

Ms. ESHOO. Thank you, Dr. Waldrum, very much.

Mr. Riccardi, you are recognized for 5 minutes for your testimony.

STATEMENT OF FREDERIC RICCARDI

Mr. RICCARDI. Good afternoon, and thank you.

Chairwoman Eshoo, Dr. Burgess, and members of the subcommittee, I am Fred Riccardi, president of the Medicare Rights Center.

Medicare Rights is a national nonprofit organization that works to ensure access to affordable healthcare for older adults and individuals with disabilities through counselling and advocacy, educational programs, and public policy initiatives.

Thank you for the opportunity to speak with you today about several bipartisan Medicare-related programs that we urge you to address in extenders legislation this year.

Specifically, there are three points I would like to share. I request that for permanent authorization for the low-income program outreach assistance, the Part D safety net program known as LI NET, and continue funding for the National Quality Forum.

Doing so will ensure that these initiatives continue to help improve the health and financial stability for people with Medicare.

Every day on our national consumer help line we hear from people who are struggling to cover healthcare and prescription drug costs. For many, particularly those with low or fixed incomes, the program's premiums and cost-sharing amounts are just out of reach.

Already half of Medicare beneficiaries—nearly 30 million people—live on approximately $26,000 or less a year and a quarter of them live on approximately $15,000 or less a year, and healthcare costs are taking up larger and more disproportionate share of beneficiaries' very limited budgets.

Thankfully, assistance is available. The Medicare Part D extra help benefit helps beneficiaries access the prescription drug program by paying their premiums and lowering the cost of their copayments.

Additionally, the Medicare savings program pays for Medicare Part B premiums. But people don't always know how to access these programs or how to apply for them and, as a result, they may not be getting the help or the care that they need, which can lead to worse health outcomes and higher costs.

The extra help in the Medicare savings program benefits increase affordability and access to care can truly be lifesaving, helping beneficiaries manage chronic conditions and better meet the needs of daily living.

At Medicare Rights, we have seen people access extra health benefit in the Medicare savings program and acquire transplants and heart surgery and treatment for Parkinson's disease.

One such program encompasses outreach and enrollment efforts aimed at enrolling more people into the extra help and Medicare savings program benefit, authorized by the Medicare Improvements for Patients and Providers Act—known as MIPPA—of 2008.

This funding allows community-based organizations to connect beneficiaries with limited incomes to these programs, and since

2009 the program has helped nearly 3 million Medicare beneficiaries.

Additionally, the Limited Income Newly Eligible Transition program—LI NET—is a safety net program for people who are not currently enrolled in a prescription drug plan but are eligible for extra help or have Medicaid or supplemental security income.

We are pleased to endorse H.R. 3029, which would permanently authorize this critical program and we are grateful to Representatives Olson, Barragán, Marchant, and Lewis for championing this effort.

We also support continued funding for the National Quality Forum introduced by Representatives Chu, Engel, and Carter. H.R. 3031 would allow the National Quality Forum to build upon quality measurement, advancements already underway to create high-quality, high-impact, and more cost-efficient healthcare system.

Finally, as you develop an extender's package or otherwise look for opportunities to improve the Medicare program, we respectfully ask that you prioritize the bipartisan bicameral BENES Act, championed in the House of Representatives by Representatives Ruiz, Walorski, Schneider, and Bilirakis.

The BENES Act would, in part, simplify the Part B enrollment process and better inform those approaching Medicare eligibility about the responsibilities.

Thank you for your time and consideration. Again, healthcare and prescription drug affordability are ongoing challenges.

Adequately funding and making permanent these programs I've discussed today will help ensure that older adults and people with disabilities can access and afford high-quality care.

[The prepared statement of Mr. Riccardi follows:]

MEDICARE RIGHTS CENTER

Testimony of Frederic Riccardi
President
Medicare Rights Center

"Investing in America's Health Care"

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Committee on Energy and Commerce
Subcommittee on Health

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Washington, DC Office:
Medicare Rights Center
1444 I Street NW, Suite 1105
Washington, DC 20006

New York Office:
Medicare Rights Center
266 West 37th Street, 3rd Floor
New York, NY 10018

Introduction

Chairwoman Eshoo, Dr. Burgess, and members of the House Committee on Energy and Commerce, Subcommittee on Health: I am Fred Riccardi, president of the Medicare Rights Center (Medicare Rights). Medicare Rights is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. We provide services and resources to nearly three million people with Medicare, family caregivers, and health care professionals each year.

Thank you for the opportunity to speak with you today about several bipartisan initiatives that must be extended without delay if they are to continue to help Medicare beneficiaries' build their health and economic security.

Supporting Low-Income Medicare Beneficiaries

One such program encompasses the federal outreach and enrollment efforts originally authorized under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

MIPPA provides targeted funding for community-based organizations—including State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the Benefits Enrollment Centers (BECs) supported by the National Council on Aging's (NCOA) National Center for Benefits Outreach and Enrollment—to help low-income Medicare beneficiaries apply for assistance programs for which they are eligible, including two that make Medicare more affordable:[1]

1) The Medicare Part D Extra Help/Low-Income Subsidy (LIS/Extra Help), which helps beneficiaries pay for their Part D premiums and reduces their out-of-pocket prescription drug costs,[2] and
2) The Medicare Savings Programs (MSPs), which help eligible beneficiaries afford their Medicare Part B premiums and, if other requirements are met, may also pay additional cost-sharing.[3]

Currently, grantees in 50 states and the District of Columbia are carrying out MIPPA outreach and enrollment activities, with evidenced success.[4] Since 2009, MIPPA grantees have helped nearly three million Medicare beneficiaries with limited incomes obtain much-needed assistance with prescription drug and health care costs.[5]

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[1] National Council on Aging. "MIPPA at a Glance," available at: https://www.ncoa.org/wp-content/uploads/MIPPA-at-a-glance-2018.pdf.

[2] Medicare Rights Center, Medicare Interactive. "Extra Help Basics," available at: https://www.medicareinteractive.org/get-answers/cost-saving-programs-for-people-with-medicare/the-extra-helplow-income-subsidy-lis-program/extra-help-basics.

[3] Medicare Rights Center, Medicare Interactive. "Medicare Savings Program basics," available at: https://www.medicareinteractive.org/get-answers/cost-saving-programs-for-people-with-medicare/medicare-savings-programs-qmb-slmb-qi/medicare-savings-program-basics.

[4] National Council on Aging. "MIPPA at a Glance," available at: https://www.ncoa.org/wp-content/uploads/MIPPA-at-a-glance-2018.pdf.

[5] Based on 2019 grantee reports submitted to the Administration for Community Living and Centers for Medicare & Medicaid Services; obtained by the National Council on Aging.

Similarly, the Limited Income Newly Eligible Transition (LI NET) Program also helps low-income people with Medicare access the care they need, by providing them with temporary prescription drug coverage while they apply for Medicare Part D.[6] The program, which expires in September 2019, in 2018 alone helped almost 800,000 low-income beneficiaries avoid gaps in coverage.[7]

Together, these programs and resources support the health and well-being of older adults and people with disabilities. Absent this assistance, many people with Medicare would have no choice but to forego needed coverage and risk exposure to significant out-of-pocket costs.

Consider Ms. W, who is legally blind and receives around $1,000 a month from Social Security. When she first became eligible for Medicare, she reached out to an enrollment counselor because she was confused about her Medicare coverage and having difficulty affording it. Working with the counselor, she applied for the Medicare Savings Program (MSP) and Extra Help drug subsidy and was enrolled in the benefits—which now save her more than $6,500 each year on health care costs.

While Ms. W was able to obtain affordable coverage relatively seamlessly, not all low-income beneficiaries, including Mr. R, share her experience.

Mr. R, a recent Medicare Rights' client, could not afford Medicare Part B or Part D premiums—leaving him without coverage for outpatient care or prescription drugs. Facing a health crisis, he sought treatment at the ER, which he assumed his Part A would cover. Unfortunately for Mr. R, Medicare Part B, not Part A, pays for outpatient emergency room care. Though he has since applied for Medicare's low-income assistance programs, he's still on the hook for the full cost of his ER visit and remains uninsured while his applications are being processed.

Unmet and Growing Need

Ms. W and Mr. R are not alone in facing difficulty navigating and affording coverage. Health care and prescription drug affordability consistently present as top trends on Medicare Rights' National Consumer Helpline.[8] Given that many people with Medicare live on limited incomes that cannot keep pace with high and rising drug prices, the perennial nature of these calls is alarming, but not surprising. Medicare costs can be especially burdensome to low-income individuals, particularly those living on fixed incomes.

Currently, half of all Medicare beneficiaries—nearly 30 million older adults and people with disabilities—live on $26,200 or less per year, while one quarter have incomes below $15,250

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[6] Centers for Medicare & Medicaid Services. "Medicare Limited Income NET Program," available at: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/MedicareLimitedIncomeNET.html.

[7] Rep. Pete Olson office press release. "Reps. Olson, Barragan, Marchant & Lewis Act to Ensure Affordable Prescriptions for Low-Income Families," (May 28, 2019) available at: https://olson.house.gov/media-center/press-releases/reps-olson-barrag-n-marchant-lewis-act-to-ensure-access-to-affordable.

[8] Medicare Rights Center. "Medicare Trends and Recommendations: An Analysis of 2017 Call Data from the Medicare Rights Center's National Helpline" (April 2019) available at: https://www.medicarerights.org/pdf/2017-helpline-trends-report.pdf.

and less than $14,550 in savings.[9] At the same time, health care costs are taking up a larger and more disproportionate share of beneficiaries' limited budgets. In 2016, nearly 30% of Medicare households spent 20% or more of their income on health care, while only 6% of non-Medicare households did so.[10] Out-of-pocket costs for prescription drugs represent a significant share of this amount, accounting for nearly one out of every five beneficiary health care dollars.[11]

The consequences of health care and prescription drug unaffordability are significant, both for the Medicare program and those who rely on it. Beneficiaries who cannot purchase their medications or pay for coverage may be forced to go without care—leading to worse health outcomes and quality of life, hospitalizations, or even death. And the cost to the Medicare program is also extreme, as beneficiaries who forgo needed care and experience declining health as a result may need more costly interventions later, like emergency department or inpatient care.[12]

Troublingly, many low-income beneficiaries are not getting the assistance they need, and for which they are eligible:

- Almost three million Medicare beneficiaries eligible for the Part D Low-Income Subsidy (LIS/Extra Help) are not enrolled.[13] The LIS/Extra Help program helps low-income beneficiaries pay for their prescription drugs and is valued by the Social Security Administration as saving beneficiaries an average of $4,900 a year.[14] Improving enrollment in this important program is a critical component toward reducing out-of-pocket prescription drug costs for those who can least afford them.
- Less than half of eligible low-income beneficiaries receive help for assistance paying Medicare Part B monthly premiums ($135.50 in 2019) through a Medicare Savings Program (MSP).[15] These programs, including the Qualified Medicare Beneficiary [QMB] Program, Specified Low-Income Medicare Beneficiary [SLMB] Program, and Qualifying Individual [QI] Program help pay Medicare costs for people with limited income and savings.[16] [17] Absent this assistance, many are left un- or under-insured.

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[9] Jacobson, Gretchen et al., Kaiser Family Foundation. "Income and Assets of Medicare Beneficiaries, 2016-2035," (April 21, 2017), available at: https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/.

[10] Cubanski, Juliette et al., Kaiser Family Foundation. "The Financial Burden on Health Care Spending: Larger for Medicare Households than for Non-Medicare Households," (March 1, 2018), available at: https://www.kff.org/medicare/issue-brief/the-financial-burden-of-health-care-spending-larger-for-medicare-households-than-for-non-medicare-households/.

[11] Kaiser Family Foundation. "10 Essential Facts about Medicare and Prescription Drug Spending," (January 29, 2019), available at: https://www.kff.org/infographic/10-essential-facts-about-medicare-and-prescription-drug-spending/.

[12] Lee, Shinduk et al., "Attitudes, Beliefs, and Cost-Related Medication Nonadherence Among Adults Aged 65 or Older With Chronic Diseases," (December 6, 2018) Prev Chronic Dis 2018;15:180190, available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6292137/#.

[13] National Council on Aging 2019 internal data

[14] Social Security Administration. "Extra Help with Medicare Prescription Drug Plan Costs," available at: https://www.ssa.gov/benefits/medicare/prescriptionhelp/.

[15] MedPAC. "Medicare Savings Program Enrollees and Eligible Non-Enrollees," (June 2017) available at: https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf.

[16] For more information: https://www.medicareinteractive.org/get-answers/cost-saving-programs-for-people-with-medicare/medicare-savings-programs-qmb-slmb-qi/medicare-savings-program-basics.

[17] Medicare Rights Center. "Medicare Savings Program financial eligibility guidelines," available at: https://www.medicareinteractive.org/pdf/MSPFinancialEligibiltyGuidelines.pdf.

With health-related expenses projected to consume a greater share of beneficiaries' income over time, if left unaddressed these affordability challenges will only worsen.[18] At the same time, the pressures of a rapidly growing Medicare-eligible population, increasing amounts of debt among seniors, and a retiree savings shortfall are likely to further amplify the problem and underscore the importance of programs like MIPPA and LI NET.[19]

Improving Quality

I'd also like to speak to the importance of high-quality care in Medicare, which the National Quality Forum (NQF) helps to ensure.

A non-profit membership organization—of which the Medicare Rights Center is a longtime member and active participant—NQF recommends best-in-class quality measures for use in federal and private systems. Highly vetted and trusted NQF-endorsed measures operate in key Medicare programs, such as the Merit-based Incentive Payment Systems (MIPS), Accountable Care Organizations (ACOs,) and other reporting initiatives across settings.

NQF's critical work directly impacts national health outcomes. Federal improvement programs that use NQF-endorsed quality measures have reduced patient harm in hospitals by 21%, saving 125,000 lives and $28 billion in costs. The 3.1 million fewer harms to patients achieved from 2010-2015 include a 91% decrease in central line infections and a 16% decrease in surgical site infections. Hospital readmission rates for Medicare patients have decreased by 8% since 2012.[20]

As the health care landscape continues to evolve, it will be ever-more important that the right quality measures are in place across all payers and systems. The NQF is uniquely positioned to ensure the quality measures used in care delivery and payment reform continue to be reliable and effective.

Medicare-Related Extenders Legislation

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

H.R. 3039 would extend Medicare outreach and enrollment efforts to low-income beneficiaries for five years and increase annual funding from $37.5 to $50 million. We commend Reps.

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[18] Cubanski, Juliette et al., Kaiser Family Foundation. "Medicare Beneficiaries Out-of-Pocket Health Care Spending a Share of Income Now and Projections for the Future," (January 26, 2018), available at: https://www.kff.org/report-section/medicare-beneficiaries-out-of-pocket-health-care-spending-as-a-share-of-income-now-and-projections-for-the-future-report/.

[19] MedPAC. "The next generation of Medicare beneficiaries," (June 2015) available at: http://www.medpac.gov/docs/default-source/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-june-2015-report-.pdf?sfvrsn=0.

[20] National Quality Forum press release. "Reps. Chu, Engel, Carter Introduce Bipartisan Legislation to Continue Funding for National Quality Forum," (May 29, 2019) available at: http://www.qualityforum.org/News_And_Resources/Press_Releases/2019/Reps__Chu,_Engel,_Carter_Introduce_Bipartisan_Legislation_to_Continue_Funding_for_National_Quality_Forum.aspx.

Gomez (D-CA) and Dingell (D-MI) for recognizing the need for additional program funding and urge you to also pursue a permanent authorization.

As discussed earlier, the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 allocated funding for community-based organizations to connect low-income Medicare beneficiaries with programs that make their health care and prescriptions more affordable. MIPPA grantees also provide Part D counseling to Medicare beneficiaries who live in rural areas and promote Medicare's prevention and wellness benefits.[21] This work has led to important, proven results. To date, MIPPA resources have enabled grantees to:

- Assist 2.7 million individuals in need;[22]
- Help increase the number of low-income Medicare beneficiaries enrolled in the Medicare Savings Programs from 6.4 million in 2008 to 9 million as of June 2018;[23]
- Target rural communities and other high-need, hard-to-reach populations to improve access to help with rising Medicare prescription drug costs.

The infrastructure to successfully continue this work, including processes and a trained workforce, already exists. However, static, short-term funding allocations and looming program expirations fail to provide the assurances and stability necessary to conduct maximally effective outreach.

Adequate, stable funding would allow the community-based organizations and state agency partners who conduct these activities—including SHIPs, AAAs, ADRCs, and BECs—to dedicate the sufficient resources and permanent staff that is needed to best serve the growing number of older adults and people with disabilities who need help accessing affordable health care.

Earlier this month, thirty-five national organization members of the Leadership Council of Aging Organizations (LCAO)—including the Medicare Rights Center—endorsed additional, permanent funding.[24] Again today, we urge you to establish permanent annual funding of $50 million for these activities. Doing so is the best way to ensure the continued availability of critical supports that help Medicare beneficiaries with the greatest needs maintain and improve their health and financial well-being.

The Improving Low Income Access to Prescription Drugs Act (H.R. 3029)

Introduced by Reps. Olson (R-TX), Barragán (D-CA), Marchant (R-TX) and Lewis (D-GA), the Improving Low Income Access to Prescription Drugs Act (H.R. 3029) would permanently

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[21] Medicare Rights Center. "Medicare-covered preventive services," available at: http://www.medicarerights.org/fliers/Original-Medicare/Medicare-Covered-Preventive-Services.pdf?nrd=1.

[22] Based on 2019 grantee reports submitted to the Administration for Community Living and Centers for Medicare & Medicaid Services; obtained by the National Council on Aging.

[23] National Council on Aging. "Medicare Savings Program Enrollment Visualization," available at: https://www.ncoa.org/economic-security/benefits/visualizations/medicare-savings-program-visualization/.

[24] Leadership Council on Aging Organizations. "LCAO Letters on Medicare Outreach and Enrollment," (available at): https://www.lcao.org/lcao-letters-on-medicare-outreach-and-enrollment/.

authorize LI NET. The Medicare Rights Center is pleased to support this legislation, which would provide much needed certainty and assistance to low-income Medicare beneficiaries.

LI NET ensures that people with Medicare's Low-Income Subsidy who are not yet enrolled in a Part D prescription drug plan are still able to obtain immediate prescription drug coverage. The program provides these individuals with temporary Part D prescription drug coverage, covering all of a beneficiary's prescriptions—at any pharmacy—as long as the medication is not excluded from Part D coverage. Qualifying beneficiaries are covered by LI NET until they are enrolled in a standalone Medicare Part D prescription drug plan.

LI NET also offers retroactive prescription drug coverage for new "dual eligibles"—those individuals who are newly eligible for both Medicare and Medicaid, or Medicare and Supplemental Security Income (SSI).

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

Introduced by Reps. Chu (D-CA), Engel (D-NY), and Carter (R-GA), H.R. 3031 would reauthorize for five years current-level ($30 million) funding for the National Quality Forum for quality measure endorsement, input, and selection under the Medicare program. We endorse this legislation.

Through its multi-stakeholder membership of more than 430 organizations, NQF facilitates an open and thorough dialogue across the public and private sectors on health care measurement and improvement strategies, with the goal of improving health and health care quality for all Americans.

As an active member of NQF, the Medicare Rights Center urges this Committee and Congress to continue federal funding for the National Quality Forum so that we can continue to build upon the advancements already underway to create a high-quality, high-impact, and cost-efficient health care system.

Conclusion

Based on our work with people with Medicare and their families, we know that health care and prescription drug affordability are ongoing challenges. Every day on our National Consumer Helpline, we hear from older adults and people with disabilities who are struggling to cover these costs.

While an array of significant reforms to the current health care and drug pricing systems are needed to meaningfully lower prices and increase affordability, there are steps Congress can take right now to improve the health and economic security of current and future Medicare beneficiaries. This includes ensuring the permanent availability of resources and programs that support outreach and assistance to Medicare beneficiaries with limited incomes, as well as continued funding for those that promote high-quality care.

Thank you again for the opportunity to be here today. We look forward to working together to ensure that all people with Medicare have access to affordable, high-quality care.

Ms. ESHOO. Thank you very much, Mr. Riccardi, and to each one of the witnesses.

We have now concluded your statements for this panel. But there are votes on the floor. So what we are going to do is recess for about 25 minutes to a half hour. Depends on how long the votes are. I think there are three of them.

Let us just say we'll resume in 30 minutes, and to ask our questions of you. So you have a little bit of a break, and we are going to run over to the Capitol and we will see you in a bit, OK?

Thank you. The committee is in recess.

[Recess.]

Mr. BUTTERFIELD [presiding]. All right. I guess we need to proceed, if we can. We will now move to Member questions and I will recognize myself for 5 minutes.

Dr. Waldrum, thank you again for your testimony today and for the work that you do in eastern North Carolina, particularly for vulnerable populations. It has been very helpful to understand the potentially devastating impact onto Vidant Health if Medicaid DSH reductions were to take place this year.

The Affordable Care Act included DSH reductions with the expectation—the expectation that Medicaid expansion would lead to a decrease in hospital uncompensated care costs.

However, only 33 States and the District of Columbia have expanded Medicaid.

Dr. Waldrum, North Carolina has yet to expand Medicaid. Is that correct?

Dr. WALDRUM. Yes.

Mr. BUTTERFIELD. The majority of the counties that you serve are among the most economically distressed areas in our State. I can certainly say that for a fact.

Can you discuss the difficulties of being a safety net provider in a nonexpansion State?

Dr. WALDRUM. Thank you for the question.

Yes. So Medicaid expansion, clearly, is important to us and our region, and providing care in a distressed safety net organization and region is always a challenge.

As you know, we serve primarily a rural environment and North Carolina has the second largest rural population in the country and eastern North Carolina has 1.3 million citizens in rural environments.

And so we are always looking at how we provide care to those environments, and hospitals and providers in rural environments are challenged. You have had a lot of the discussion about that today as I listened to the deliberations this morning and we all know some of the issues.

There is a higher burden of disease in the citizens that live in rural environments with obesity, cancer, cardiovascular disease, and diabetes, as you have heard this morning, and the aging population in rural environments with a shrinking population.

And but people still live there, and in some services with some of the dialogue this morning, OB services, for instance, in a number of our hospitals we only have on average one baby a day. And so you have to have the infrastructure to provide services to those patients. But we do not get enough revenue to cover the cost for those services.

So that puts a burden on us. But if we didn't have those services, the mothers and babies would have to travel in some areas over an hour to have their baby.

Mr. BUTTERFIELD. So this is affecting your bottom line, to be sure.

Dr. WALDRUM. For sure.

Mr. BUTTERFIELD. And when your bottom line is impacted, other things are impacted as well?

Dr. WALDRUM. Well, it just compromises our mission to support our communities.

Mr. BUTTERFIELD. And you have a concentration in critical care. Can you discuss the impact that Medicaid expansion could have on access to critical healthcare services for your patients?

Dr. WALDRUM. Yes. I appreciate that.

So it would—it would give coverage for many types of services and critical care services. With uncovered care, which is a very high-cost service, which is my specialty—critical care—having coverage for those services would really help our institution provide and cover those costs, obviously.

But there are other important services such as behavioral health and we know that having covered lives with Medicaid expansion helps us cover things like behavioral health, which helps with the opioid epidemic.

And so it really goes from ambulatory services like behavioral health all the way to critical care.

Mr. BUTTERFIELD. Now, the Census Bureau has identified 386 counties in the United States as persistent poverty counties, which means that a county has been in poverty 20 percent or better for the last 30 years.

That's a persistent poverty county—486 in the U.S. and 12 are North Carolina. Six are in the area covered by your hospital.

Can you speak to the impact that poverty and hunger and nutrition and safe housing have on a person's health?

Dr. WALDRUM. I can speak to it because I've frequently visited our communities and one of the communities I think you're referring to is Bertie County, which we have a hospital in, and travel, food insecurity, access to care or coverage, but just to drive to get access the distance—so access to social services, I mean, you name it, it affects the people we serve.

Mr. BUTTERFIELD. Has your hospital or your association taken a position on Medicaid expansion in North Carolina?

Dr. WALDRUM. Yes. We support it fully.

Mr. BUTTERFIELD. OK. Thank you. I have some more, but I think I am going to yield back and pass it on to one of the other Members.

All right. To the ranking member, Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Butterfield.

Mr. Barker, let me be a little bit provocative. Do we still need DSH?

Mr. BARKER. I am sorry. Could you repeat?

Mr. BURGESS. Do we still need the disproportionate share funding?

Mr. BARKER. Oh, I think so.

Mr. BURGESS. And given that context, what about just the proposed removal of the proposed cuts, just DSH funding goes forward with no structural reforms? Good idea? Bad idea? Neutral idea?

Mr. BARKER. Well, I guess I would say, again, not speaking for MACPAC because I am not—technically, I am not yet on MACPAC. I will be tomorrow. But I do think that MACPAC had a very thoughtful approach toward the—ending DSH cuts.

I think that MACPAC was trying to be sensitive to the budgetary impact and that they were concerned that just flat out repeal of the DSH cuts would have a budgetary impact and so they proposed a more gradual implementation of the cuts combined with what I think is equally important and that is rebalancing the State DSH allocations with low income nonelderly population in a particular State.

The DSH caps were set at a time that—were set over 20 years ago and they weren't based at the time on poverty levels in a State, and I think maybe it is time to revisit how they're allocated.

Mr. BURGESS. So if the DSH cuts were wiped out in their entirety, the problems with the formula would still exist?

Mr. BARKER. Yes.

Mr. BURGESS. So—and I think you make this point in your testimony, in your written testimony, certainly—but maybe you can elaborate a little bit on the fact that historic spending in the disproportionate share funding may bear little or no relationship to the low income nonelderly population in a given State today?

Mr. BARKER. Yes, I think that is true because the way that the DSH caps were first established happened at a time when Congress and I think the—it was the George H. W. Bush administration were very concerned about the explosion in DSH spending.

I pointed out in my testimony that DSH spending went from a little over a billion dollars in 1990 to $17 billion in 1992, and something was going on and they wanted to get a handle on it.

And so they imposed a cap, but the cap was just based on what States were spending in DSH at that particular time. It really didn't bear any relationship to the low income or the—the low income rate or the poverty level in a State.

Mr. BURGESS. So I am going to ask you something because I've always been a little sensitive about this as a physician. I mean, you look at hospitals who get disproportionate share funding but, of course, the physician workforce in that area may also be taking care of a very low income population or uninsured or under insured population.

There has never really been anything that balances what it costs providers to be in that area versus what it costs hospitals. As we heard, one delivery a day doesn't fund the entire labor and delivery unit.

But it can also be very difficult for a provider to run a practice with that type of through put.

Mr. BARKER. Yes, absolutely.

Mr. BURGESS. And has there ever been anything looked at that would balance the equation for docs as well as hospitals?

Mr. BARKER. I think that is why you are seeing a lot of hospital acquisition of physician practices just because—that is one of the reasons that there has been a growth in hospital acquisition of physician practices because physicians can't manage it on their own.

Mr. BURGESS. Which brings us then to what I consider the great conundrum. It is OK for hospitals to own physicians but physicians can't own hospitals, right?

Mr. BARKER. That's—I think that is correct.

Mr. BURGESS. And we need to fix that. I wait for the judges' input and we will do that.

Do you think that a full repeal of the DSH cuts makes critical reforms of the program more or less likely?

Mr. BARKER. I think it would make it less likely just because the—there wouldn't be the political impetus.

Mr. BURGESS. And, ultimately, then that is to the detriment of those populations that DSH was set up to serve in the first place.

Mr. BARKER. Yes.

Mr. BURGESS. Is that—is that a fair assumption?

Mr. BARKER. Yes. Yes.

Mr. BURGESS. Thank you, Mr. Chairman. Oh, that struck——

Mr. BUTTERFIELD. Thank you, Dr. Burgess. Thank you so very much.

Mr. BURGESS. I had a hard time getting that out.

I will yield back.

Mr. BUTTERFIELD. Thank you.

At this time I will recognize the gentleman from New York, Mr. Engel.

Mr. ENGEL. Thank you, Mr. Chairman.

Medicaid DSH payments—I want to talk about those—they help hospitals and health systems, serve some of our Nation's most vulnerable communities.

In fiscal year 2017, Medicaid DSH payments amounted to $18.1 billion, allowing safety net providers to deliver free or subsidized care to millions of Americans.

In October, these vital payments will be cut by $4 billion for the upcoming fiscal year and $8 billion for the following year. That is not a good thing to do.

Safety net hospitals regularly operate on thin or negative margins. In fact, New York hospitals have some of the narrowest margins in the country. If Congress fails to delay Medicaid DSH cuts, some of our Nation's safety net providers will be forced to close, leaving our constituents in communities without access to an important source of care.

Fortunately, there is broad bipartisan support for addressing these cuts. On May 13th, 300 Members of the House joined Congressman Olson and me in pushing for a delay. I urge my colleagues to join me in helping preserve access to care for the most vulnerable among us.

Mr. Chairman, I also want to thank you and the committee for including legislation which would reauthorize funding for the National Quality Forum. I am pleased to sponsor this bipartisan legislation with Congresswoman Chu and Congressman Carter.

The National Quality Forum is one of the Nation's leaders when it comes to developing tools for improving healthcare quality and outcomes.

Before asking questions of our witnesses, I ask unanimous consent to submit two letters of support into the record, the first from the American Hospitals Association in support of the Patient Access Protection Act, and the second from the Friends of NQF, supporting H.R. 3031.

Mr. BUTTERFIELD. Without objection on both of those requests.

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

Mr. ENGEL. Thank you, Mr. Chairman.

Let me ask Mr. Riccardi—in recent years Medicare has made numerous efforts to move away from fee for service, instead toward a system that rewards value over volume. It is critical that we continue to find ways to measure and incentivize the highest quality of care.

So let me ask you, Mr. Riccardi, as we continue to pursue a healthcare system that pays for value instead of volume, what role do you see for the National Quality Forum's work?

Mr. RICCARDI. An increasingly important one. NQF—we need to ensure that they remain funded and sustainable for the direction of value-based care.

NQF has a membership of 450 organizations and the Medicare Rights Center is an active member of NQF. NQF facilitates dialogue across the private and the public sector, creating measures that operate throughout the Medicare program. In fact, hospital readmission rates have fallen by 8 percent and as States pursue value-based care arrangements and also focus on a variety of initiatives, these measures are key.

Increasingly, we are hearing beneficiaries calling our help line with questions about quality, and as CMS has improved tools for—to evaluate and determine the quality of a variety of different facilities and settings, these measure are also key in that in helping beneficiaries access valuable efficient care. Thank you.

Mr. ENGEL. Thank you. Hospitals use Medicaid DSH payments to support vital community health programs including initiatives to address opioid prescription abuse and improve maternal health.

Mr. Waldrum, could you please describe how your hospitals use Medicaid DSH payments to better care for your local community?

Dr. WALDRUM. I would say I don't have time and we partner with our communities. But I will tell you to deal with all of those issues.

But we support a number of local initiatives and I will tell you one that happens in Conetoe, North Carolina, with Reverend Richard Joyner.

And so we have funded an initiative because the burden of the disease in those folks was very high, and so we helped him engage with the community to build a sustainable model where they educate children about healthy lifestyles and give them employment on a farm, and that has brought the parents in and they have a sustainable model to sell their product in our hospitals, and that has created a college fund and those kids are going to college and are breaking the cycle of poverty and ill health that they have been burdened with for decades.

And Ms. Bush, who is a 72-year-old woman in that community, actually fought against it happening, and today, this morning, she was on that farm working and she's been working there for the last year and she is off 22 of her medicines because she has adopted the lifestyle and the habits that are being taught by that farm. So she is one example, and then these kids are the future of eastern North Carolina.

Mr. ENGEL. Well, thank you both. I think what you have said is very important and we all should heed it. Thank you.

Thank you, Mr. Chairman.

Mr. BUTTERFIELD. Thank you, Mr. Engel.

Richard Joyner is a dear friend of mine and I will let him know that you have acknowledged him today.

The Chair now recognizes the gentlelady from California, Ms. Matsui.

Ms. MATSUI. Thank you, Mr. Chairman.

Ms. Bohan, thank you for sharing with us how becoming a certified community behavioral health clinic has benefited your organization and community.

And we are hearing similar successes from clinics across the country where the demonstration has expanded treatment capacity and transformed their ability to meet the growing demands for community-based services.

Ninety-four percent of all CCBHCs have increased the number of patients they treat for addiction and nearly two-thirds have been able to decrease wait times.

With the June 30th funding expiration looming, our CCBHC demonstration States are now stressing the extreme financial threat they face to sustain operations and provide vital continuous care.

I was glad to hear Ranking Member Walden express his support for extending the Excellence in Mental Health demonstration for additional 2 years.

Just this morning, I heard from a CCBHC in Oregon how a sustained investment in the program would allow its providers to reach into the community to further extend access to behavioral health services for individuals with serious mental illnesses.

In the midst of an opioid epidemic, we should be supporting innovative approaches like CCBHCs to provide integrative primary and behavioral healthcare. That is why expanding the Excellence in Mental Health demonstration as the support of interdepartmental serious mental illness coordinating committee of SAMHSA has been endorsed by Dr. Sally Satel of the American Enterprise Institute and has the support of 14 of my Republican colleagues.

People struggling with mental illness and substance use disorder across the country should be able to benefit the same as patients in the eight States participating in the demo.

That is why I am fiercely advocating to extend this demonstration for the participating States and expand it to 11 more States in my bill with Representative Mullin, H.R. 1767.

In a new report entitled "Bridging the Treatment Gap," the National Council for Behavioral Health surveyed the CCBHCs and the results offer hope in our Nation's battle against the opioid crisis.

The report showed, among other things, nearly universal adoption of medication-assisted treatment—MAT—and decreased patient wait times for these lifesaving interventions.

There is strong evidence that the program is leading to reduced overdose deaths in upstate New York, and I am also encouraged that CCBHCs in Oklahoma are reporting huge reductions in hospital emergency room utilization.

With that as background, Ms. Bohan, I would like to ask you a few questions. First, I understand that in New Jersey CCBHCs have opened new service lines like the 24-hour emergency psychiatric care and medication-assisted treatment while serving patients who have never received care before.

With the sustained funding including in my bill, how can your CCBHC further integrate and expand services for vulnerable patient populations?

Ms. BOHAN. Thank you very much for your question and your support. Can you hear me? Yes. OK.

So you are absolutely right. We have expanded service lines across the State of New Jersey. Twenty-four-hour mobile crisis services that did not exist previously in counties like Monmouth County are now really an integral part of the delivery there and they have quickly become the—community resources have quickly become dependent on these services and being able to reach out directly to CCBHCs.

We are linked in with the Health Information Exchange so that community partners can really identify that someone belongs to a CCBHC and we are able to see if someone lands in an emergency room, and we can quickly get case management out and so forth to perhaps avoid a hospitalization and reengage them quickly.

Ms. MATSUI. That is wonderful.

Ms. BOHAN. And in terms of the opioid epidemic, many of the—including Rutgers, the programs are looking at bridge programs from local emergency departments directly to CCBHCs so that individuals can be started on medication-assisted treatment and bridged directly over to the CCBHC where they could be maintained on this really lifesaving intervention.

Ms. MATSUI. That's great. What risk would a lapse in demonstration funding have on your ability to provide holistic services that address the ongoing opioid epidemic?

Ms. BOHAN. It'll have a huge impact. As I said in my testimony, there are—all of us have expanded our services, which also means expanding our workforce.

So we have individuals in place. We've expanded our ability to prescribe MAT. We have all established ambulatory withdrawal management programs so the individuals can come in and be inducted on MAT safely, and we are also able to deal with other medications as well in that setting.

So that is a program that is at great risk across the State.

Ms. MATSUI. Well, thank you so much and I really appreciate your participation. Thank you so much, and I yield back.

Mr. BUTTERFIELD. The gentlelady yields back.

At this time, I will recognize the gentleman from Florida, my friend, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, my friend. Thank you, Mr. Chairman. I appreciate it.

Mr. Barker, the DSH program—and I know that this has been covered but it is so very important to my State and other States as well, taking care of the indigent—but the DSH program provides payments to hospitals, as you know, serving a disproportionate number of Medicaid patients and the uninsured.

ACA reduces this payment—the payments by $14 billion from 2014 to 2019. Additionally, due to an arbitrary cap on DSH payments frozen since the early 1990s, Florida has been inequitably funded, and I know we are not the only State—funded for DSH payments compared to other States with much lower uninsured populations, and this is a bipartisan issue.

So while I am supportive of delaying the cuts, certainly, I am concerned that simply repealing the cuts would not address the underlying issue.

The antiquated formula created in the early '90s that continues to negatively impact Florida and other good States, Florida's Medicaid patients and uninsured they are impacted by this and it is a real problem.

Should Congress update the DSH formula? Why or why not, sir?

Mr. BARKER. Mr. Bilirakis, were you directing that question at——

Mr. BILIRAKIS. The question is for Mr. Barker.

Mr. BARKER. Yes.

Mr. BILIRAKIS. Thank you.

Mr. BARKER. So Dr. Burgess raised this issue——

Mr. BILIRAKIS. Yes.

Mr. BARKER [continuing]. When he was here before, and I do think that repealing the DSH cuts in their entirety would remove the impetus to reform the DSH formula. Yes, I agree with that statement.

Mr. BILIRAKIS. OK. All right. Very good. Thanks for—you know, and, again, this is a time to get it done. So how might Congress consider reforming the DSH formula to better reflect the current patient population in States like Florida and South Carolina, North Carolina, but all over the country—New Jersey?

Mr. BARKER. So the DSH caps that are in the statute right now were based on how much States were spending on DSH in 1991 or 1992.

Mr. BILIRAKIS. Right.

Mr. BARKER. It doesn't bear any relationship to the number of low income or uninsured patients in the State whereas the whole purpose of DSH is to account for the situation of hospitals that treat a disproportionate number of low income individuals.

And so one idea would be that the DSH allocations be set based on a measure of low income nonelderly individuals in a State.

Mr. BILIRAKIS. Yes. I mean, again, it has affected so many States because things have changed since '91. So it is antiquated, and I appreciate—thank you for the input and hopefully we can get something done about it.

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

Mr. BUTTERFIELD. The gentleman yields back.

At this time I will recognize the gentleman from California, Dr. Ruiz.

Mr. RUIZ. Thank you, Mr. Chairman. There are many issues surrounding the outreach and enrollment for Medicare. So I would first like to thank my colleague and friend, Congresswoman Dingell, for her work on H.R. 3039, which provides the 5-year extension of funding for Medicare outreach, enrollment in education for low income beneficiaries.

This funding will help connect those most in need with critical assistant programs. But we know that difficulties with Medicaid enrollment extend beyond this much-needed targeted specific funding which this funding will help. There are still many who fall through the cracks through the Medicare enrollment and suffer because of that.

In fact, most people that are newly eligible for Medicare are automatically enrolled in Part B because they are collecting Social Security retirement at the age of 65 and there is that communication so they automatically enroll.

But a growing number are not, as they are working later in life and deferring their Social Security benefits. Many of them are in under insured or uninsured or very little benefits to cover health insurance in those type of employments.

So unlike those who are auto enrolled in Part B, these individuals make an active Medicare enrollment choice. So taking into consideration specific time lines and existing coverage.

Far too many seniors make honest mistakes when trying to understand and navigate this confusing enrollment system. The consequences of Part B enrollment mistakes are significant.

So if you are working, you are not automatically enrolled, you haven't enrolled, you don't have health insurance, you find out later that you don't have—you're not enrolled in Medicare, you missed the deadline and that includes—the penalties are late enrollment penalties, higher out-of-pocket healthcare costs, gas and coverage, and barriers to accessing needed services.

In 2018, an estimated 760,000 people—760,000 people with Medicare were paying a Part B late enrollment penalty with the average penalty amounting to a 28 percent increase in the monthly premium.

So I introduced a bill that will hopefully close this gap for seniors who are falling through and it is called the BENES Act, which will direct HHS to send enrollment notices to individuals approaching eligibility to educate them on how and when to enroll in Medicare Part B and close a coverage gap that currently exists for individuals that do not enroll at a specific time.

In other words, it gives these working seniors who deferred their Social Security a heads up proactively and giving them the opportunity to learn how and when to enroll so they don't miss that gap or fall through the cracks and miss the enrollment.

So, Mr. Riccardi, can you explain this underlying issue as well as the extent of the problem and what you are hearing from folks calling in to the Medicare Rights national help line?

Mr. RICCARDI. Yes. And thank you, and thank you for championing the BENES Act and also Representative Bilirakis for sponsoring the bill also.

This trend emerged on our help line as confusion abounds. Medicare rules are complicated and, as you mentioned, a majority of individuals are automatically enrolled into Medicare if they're collecting Social Security.

But 20,000 people are turning 65 every day, people are working longer, and they are waiting to also collect their Social Security retirement benefits since the full retirement age for Social Security benefits is now age 66 and it is continuing to increase.

And so confusion is found from people of all backgrounds, of all incomes, and all educational backgrounds, and in particular we are seeing problems with individuals who may have some other type of coverage since our healthcare system and health insurance is confusing, and HR specialists and employers are also confused about how to guide people through Medicare enrollment.

One barrier that could be easily addressed legislatively is to require that notice be sent to people before they're turning 65 to inform them about their eligibility for Medicare Part B and for Medicare.

And just remember, these individuals are entitled to the Medicare program but they are going without. This trend had emerged a few years ago on Medicare rights help line and to this day I still recall speaking to a client who had worked for a large company, and he had retiree coverage and he had worked for many years and contributed to Social Security and the Medicare program, but he was without Medicare Part B.

And for years, he had this retiree coverage. But it wasn't until he had stage four cancer that they no longer would pay for his cancer bills.

And so he was caught within this very catastrophic gap in coverage when you are waiting to enroll into Part B but you can't. And so he had to go, you know, close to 12 months, 14 months, without coverage and in his case, him and his wife had to take out a reverse mortgage.

And this was one of the first calls that we received on this issue, and every day we are hearing more and more from people who are missing their enrollment period through no fault of their own.

And so the BENES Act would do, as you had mentioned, three really important things. First, it would inform people about their Medicare eligibility as they are turning 65.

It would simplify the enrollment periods. Generally, people are very confused about when to enroll into Part B and prescription drug coverage. It would simplify these enrollment periods.

And lastly, it would do away with this catastrophic gap in coverage that is in place. So thank you for your support.

Mr. RUIZ. Well, thank you for that information and I too want to thank my good friend, Representative Bilirakis. We join efforts on a multitude of bipartisan bills together and this is one, I think, that we are going to pass through the House and get signed by the President.

Thank you.

Ms. ESHOO [presiding]. Thank you.

I was on the floor to handle a bill. So excuse me for not being here for a good part of your testimony and thank you again for really essentially being here all day with us.

Let me just circle back, Mr. Riccardi. I got the tail end of this. At one time, Social Security would notify an individual that they—that they would become—becoming eligible by whatever date and have an explanation, and I've always thought out of all the government agencies that Social Security materials are really understandable. They are written so clearly. It is not written in federalese and all of that.

So people are not notified anymore by Social Security that they are—that they are about to become eligible for their benefits?

Mr. RICCARDI. For individuals who are not collecting Social Security benefits there is no information or separate notice that is provided to individuals to inform them that they are turning 65 and that they're within the window of time to enroll into Medicare.

So, currently, that is not happening.

Ms. ESHOO. Maybe I am confusing Social Security with AARP because when you are 55 they start telling you that you are going to turn 65 in 10 years.

Thank you for that. And your legislation addresses this; it closes the gap. So they will get a notice?

I am sorry. You need to—he can't hear you.

Mr. RUIZ. So yes, correct. So for those who aren't drawing Social Security and retiring, they either continue to work and don't have health coverage or enough health coverage, then they don't get a notice.

So my bill will send—be proactive and let them know about their enrolling.

Ms. ESHOO. Let me ask this. Is there still going to be anyone left out, without a notice?

Mr. RICCARDI. The notice—the notice will improve people's—the information that they can access around enrolling, and with that information people should be able to make a more informed decision.

Going back to my earlier point, there are a number of beneficiaries who are living on very limited incomes. As I had mentioned, a quarter of people are living under, you know, $15,000 a year. So the cost of Medicare and the Part B premiums can still be prohibitive to some.

So that's why we encourage enrollment into the Medicare savings program because there are some reasons why somebody may not be enrolled in Medicare because they can't afford it.

Ms. ESHOO. We had—Mr. Barker, you have—I heard your testimony on disproportionate share of hospitals.

Mr. BARKER. Yes.

Ms. ESHOO. Yes. I would like to know if you know the following. And I don't recall exactly how many States decided not to participate in the expansion of Medicaid with the ACA. Were there 22 or something like that?

Mr. BARKER. I think 33 States have expanded Medicaid so——

Ms. ESHOO. Thirty-three States. Thirty-three States left—the expansion, right? And they left a great deal of money on the table. But, to me, the worst of it all was that the people that they represented in their States didn't have the opportunity to enroll.

Having said that, do you know of—in those States how those Disproportionate Share Hospitals have fared? Has their population—the people that they serve gone up and, if so, exponentially? Do you have any information on that?

I can't help but think that there is a nexus between the two. Do you know?

Mr. BARKER. I don't know. I actually think that Dr. Waldrum——

Ms. ESHOO. Does anyone on the panel know?

Mr. BARKER [continuing]. Might know more than I do because——

Ms. ESHOO. Dr. Waldrum?

Mr. BARKER [continuing]. His hospital is in a State that has not expanded Medicaid.

Dr. WALDRUM. Yes, I very much appreciate the question, and I think it is a very valid point. The States that did not expand Medicaid, the facts are pretty clear that we have had more rural hospital closures in those States than we have in States that expanded.

And so the burden that it has placed because of the issues, primarily rural nonexpansion States, that is where the hospitals are closing and there is literature to support that it has to do with the lack of——

Ms. ESHOO. Do you think that you could get that information to us?

Dr. WALDRUM. Yes, we would be happy to.

Ms. ESHOO. You know, around here rural is a big issue on—no matter what we do, whether it is telecommunications, technology, the digital divide, the homework divide, healthcare, transportation, you name it, rural areas in our country are affected and I that this is another one.

And when you say that a hospital has closed, that is a very big deal in Anyplace, USA, much less in a rural area. So I would really appreciate getting that information and my own sense is, understanding pretty well—very well—how DSH works that without another appropriation of those funds, what will happen to these places?

Dr. WALDRUM. I am certain that more——

Ms. ESHOO. What will happen to the people in these places?

Dr. WALDRUM. More hospitals will close. There will be reduction in services and we know that what happens is that services are curtailed initially. One that we mentioned earlier, OB services—so in a lot of rural hospitals they have gotten out of OB services because of the low volume and that limits access and that is contributing to the maternal and fetal—I mean, infant mortality crisis in rural America, and actually there is data that shows that when that happens the next thing is that the hospital closes and then the town, the community, suffers and in some cases actually goes away.

Ms. ESHOO. Wow. What a description. That doesn't belong in America. Thank you very, very much.

I now would like to recognize the gentleman from Oregon, Mr. Schrader, for his 5 minutes of questions.

Oh, I am sorry. Should I go to Mr. Guthrie then?

OK. Mr. Guthrie?

Mr. GUTHRIE. Thanks. Thank you very much. Appreciate it.

Ms. ESHOO. The gentleman from Kentucky. We need to introduce you appropriately. The gentleman from Kentucky, Mr. Guthrie.

Mr. GUTHRIE. Well, thank you. I appreciate that very much.

Thank you very much.

So, Mr. Barker, the—I know in one of the opening statements about the responsibility to stop the DSH cuts—the DSH cuts were implemented by—what legislation brought forth the DSH cuts? Do you know?

Mr. BARKER. The ACA.

Mr. GUTHRIE. And the concept—and I understand the question of my friend from California who was asking about States that didn't expand.

I am from Kentucky and we did expand Medicaid. We also set up exchanges that Kentucky fully embraced and I know our current Governor has made some changes but still essentially fully embraced the Affordable Care Act with—given some changes, going from State marketplaces to the Federal exchange, but still there.

And my hospitals still—well, first of all, to the hospitals you described closing the DSH cuts have never taken place. There has been no cuts in DSH is my understanding. Is that correct, I think, Dr. Waldrum?

Dr. WALDRUM. I believe that is correct.

Mr. GUTHRIE. It is correct. So this is——

Dr. WALDRUM. It is the lack—it is the lack of the covered lives by expansion.

Mr. GUTHRIE. Well, Kentucky is having similar issues and we have the same—we did expand. Do you know—Dr. Barker—Mr. Barker, so the concept was that you wouldn't have to have DSH because everybody is going to be covered if they expand and created the exchanges.

Kentucky expanded and created the exchanges, and our hospitals they'll have to close if they—some hospitals if they didn't have DSH. We are seeing consolidation.

Do you know why the premise of the Affordable Care Act in terms of DSH hasn't worked?

Mr. BARKER. My understanding was exactly what you said, which is that the thinking was that as the number of uninsured individuals declined, there would be less need for DSH—both Medicare DSH and Medicaid DSH.

Mr. GUTHRIE. Right. But so that didn't happen, did it? I mean, Kentucky expanded Medicaid. Kentucky created exchanges and still rely on DSH heavily.

So it seems like that didn't work. Whatever the concept was didn't work. Do you know why it didn't work? I understand the premise what was supposed to happen, but it didn't work.

Mr. BARKER. I can't comment on why it didn't work.

Mr. GUTHRIE. OK. So the second thing—so Mr. Waldrum, about DSH—it is something that, you know, I support. We are going to have to maintain because of what the effects on hospitals, particularly rural areas.

But let us see if we had a hypothetical to your delay and then Congress should update the formula to better align the relationship between DSH allotments in a State and the number of low-income nonelderly individuals.

So my question, Dr. Waldrum, would your State—would your hospital—how would—if we realigned that formula, would your hospital be affected positively and would all of you commit to working with us to find a long-term solution that can steer DSH funding to where it should do the most good?

So would you like to see a change in the formula? I mean——

Dr. WALDRUM. So I am not an expert in the complex calculations and how those are passed down to the States and then how that would be allocated locally. I am really——

Mr. GUTHRIE. It is to the hospitals. It would be the hospitals.

Dr. WALDRUM. To the local hospitals, correct. And so how that would flow I am not an expert from a technical perspective. I am a provider, a physician, and a hospital administrator that tries to provide services to these communities and cuts promulgated on, as you described, very fragile communities and how we serve those folks.

We wouldn't want and would oppose those cuts. And so I am not here to address the technicalities and I am not an expert in that area.

Mr. GUTHRIE. Any comment on that, Mr. Barker, on the formula of DSH and how DSH is allocated?

Mr. BARKER. On the Medicaid side, that's a State-by-State determination. So the Federal statute——

Mr. GUTHRIE. Right.

Mr. BARKER [continuing]. Sets a minimum threshold for classes of hospitals that have to be designated as DSH but then it is up to a State to decide within those parameters.

Mr. GUTHRIE. But there is a Federal formula that allots that money, correct? Like Tennessee doesn't get much DSH——

Mr. BARKER. Oh, you mean the overall DSH?

[Simultaneous speaking.]

Mr. BARKER. I am sorry, Congressman. I didn't understand your question. Yes, you are right. There is a statutory DSH cap.

Mr. GUTHRIE. Right.

Mr. BARKER. Tennessee was not getting any DSH funds back in 1992. But that DSH cap was set on the level of DSH spending in a State in 1991 or 1992, and the reason Tennessee doesn't have one is because they weren't using any DSH funding back——

Mr. GUTHRIE. Do you think that should be—I think that might have been when they had TennCare. I am not sure. I don't know if there are some Tennesseans who—so do you think that formula should be—to be fair, to other States, that it be reallocated instead of based on a 1991–92 number?

Mr. BARKER. I do think—Dr. Burgess raised this issue earlier. Yes, I do——

Mr. GUTHRIE. Sorry. I was in another meeting.

Mr. BARKER. No. No. No. No. I think that it would be a good idea to revisit the DSH allocations.

Mr. GUTHRIE. OK. Thanks. I appreciate that. With my last 10 seconds, you know, that DSH was a big pay for the Affordable Care Act and here we are, and we are going to need to do it. I am not saying we don't need to do it. But now reallocating money that has already been allocated to make sure that hospitals don't close.

So I appreciate the time, Madam Chair, and I yield back.

Ms. ESHOO. The gentleman—let us see. I now would like to recognize the gentleman, and he is a gentleman, from Oregon, Mr. Schrader, for his 5 minutes of questioning.

Mr. SCHRADER. Thank you again, Madam Chair. I appreciate it.

I will follow up a little bit on the line of concern that Congressman Guthrie and Congressman Burgess—Dr. Burgess—had talked about because it sounds like from what we have heard today that the DSH payment thinking with the ACA didn't work out quite as well as we had thought.

Charity care has decreased. That is a good thing. Medicaid care has increased and, as we all know, Medicaid doesn't pay full freight. So I think some of the hospitals, perhaps in Mr. Guthrie's district, are still having some trouble balancing the commercial rates, obviously, with the increase in Medicaid population.

But I think it gets to the central point that, you know, big proponent of making sure, you know, we make sure these hospitals and rural hospitals in particular stay in place. You know, prefigure, recontour this formula that is 20-plus, maybe 30-plus years old at this point in time makes sense.

I would put in though, as a person whose State actually did to the Medicaid expansion that whenever if we redo this formula we should take into account the fact that those States that stepped up and actually provided healthcare for our low income people there ought to be no penalty at least for them having done so.

The original Senate language, you know, that was finally implemented when this was all done many years ago, talked about low income and I think that should still be the major guiding force for how we approach these payments.

To me, you know, based on what we have heard today, the MACPAC stuff will be a great starting point in terms of how we deal with any gradual elimination or reduction—probably not elimination but reduction in the DSH payments with some tweaks to make sure that we take into account what's actually happened, you know, over the last 20 years and particularly since the ACA has put into effect.

Mr. Riccardi, just chat a little bit if you don't mind and follow up—I talked about this a little bit and it has been talked about with the previous panel, you know, how important the FQHCs and the CHCs are for delivering healthcare for a lot of folks that are uninsured or don't have access to healthcare, basically.

In trying to incentivize aligning the quality metrics, Oregon has gone a long way in trying to match up managed care metrics, you know, with those for FQHCs and trying to make all your guys' lives hopefully a little bit easier. You have enough widgets to count. Be nice just to count, you know, one widget for—one metric, if you will, for each of those widgets.

So while the States are starting to do some stuff—and I have some folks in my State rather it just be a State function. I don't know if that is the best way to go.

Would you support aligning these, you know, quality metrics between managed care, Medicaid basically, in the FQHCs and CHCs?

Mr. RICCARDI. Yes. In New York there is an example. I am a member of a work group where we are partnering with the public and the private sector, looking at, you know, a variety of quality metrics in determining, you know, what makes the most sense for patients and also for providers and other healthcare professionals to ensure that that information is readily understandable by the healthcare workforce and also the patients who need that information.

So I do see that collaboration happening. But I think there is, you know, more that can be done and that's something that we are supportive of.

Mr. SCHRADER. So I wonder if it is the role of the Federal Government to help provide an opportunity or incentivize that and then let the States, depending on their own culture, figure out what outcomes are most important to them to align themselves with and hopefully run through CMS, at the end of the day.

Mr. RICCARDI. Yes, and I think that's why it is so important that an organization like National Quality Forum is supportive because they are able to assist, you know, every State with these measures. And so agreed.

Mr. SCHRADER. Good. Well, that's all the questions that I had, Madam Chair. Thank you much and I will yield back.

Ms. ESHOO. The gentleman yields.

And I recognize the gentleman from Georgia, the only pharmacist in the Congress, Mr. Carter. How is that?

Mr. CARTER. That is very good. Thank you.

Ms. ESHOO. I know that. What was my first clue?

[Laughter.]

Mr. CARTER. Thank you, Madam Chair, and thank all of you for being here. This is certainly important and we appreciate your being here and helping us with this.

I wanted to start by saying that, you know, I am very honored to be the Republican lead on H.R. 3031, working with Representative Chu and Engel on the National Quality Forum.

I think it is very important. It is very important because it is a valuable resource for making sure that we have and that we achieve cost-efficient and high-quality and value-based healthcare that ensures that all Americans will have quality healthcare, and we certainly need to continue this program and that is why I am proud to be a part of that.

I will start with you, Mr. Riccardi, and just ask you, you mentioned it in your testimony and I wanted to ask you if you could just expand a little bit more on the value of the National Quality Forum, particularly as it relates to Medicare recipients.

Mr. RICCARDI. Thank you for that question, and to add, you know, the saying goes that it is important that an individual gets the right care at the right time at the right setting. You may want to add also at the right cost.

And the National Quality Forum has created the highest level of quality standards that are available to States and agencies and both, as I mentioned, the private the public sector.

And, in particular, with the Medicare program with the preventable readmissions program, we have seen some success and decrease in those admissions, and I know from my background I also am a lecturer at the Columbia School of Social Work, and a number of my students have been involved in some of those demonstration programs, helping prevent readmissions.

And the accessibility and the use of those quality measures have been key to ensure that people are receiving the right care at the right time in the right setting.

Mr. CARTER. I can't help but remember—I was a consultant pharmacist in long-term care for many years and we used to have the seven rights of drug administration—the right drug for the right patient in the right dose at the right time, the right administration, so on and so on.

So you are exactly right and I appreciate you reiterating that.

Mr. Barker, I want to change gears real quick and talk about DSH payments. I have got a very rural district in Georgia and south Georgia particularly—very rural area—and my district, certainly to the western portion of my district is very rural, and DSH payments are extremely important to our rural hospitals.

And some of them are totally reliant on this. So I understand that there are some hospitals or some States that aren't using their full DSH allotment and I find that hard to believe, and just wondered if you can—if you can explain how that can happen and what's going on there.

Mr. BARKER. So my understanding is that there are three States—if I am not mistaken, there are three States that are not using their full DSH allotments, and I assume that that is because that there is, as well as a State-specific cap, in DSH there is also a hospital-specific cap.

Medicaid DSH payments cannot exceed the amount of uncompensated care that a hospital has. And so the only thing that I can think of is in those three States those hospitals are being paid at least the cost of their uncompensated care.

Mr. CARTER. MACPAC had made some recommendations that—on potential reforms, and I think you may have mentioned some of these. Do you have any other ideas or any other suggestions on what we can do in Congress to make sure that this program is being utilized like it is supposed to be?

Mr. BARKER. Thank you for that question.

You are right, I did mention the MACPAC recommendations and one of them addresses exactly the issue that you mentioned, which is applying the DSH reductions to those States that have not expended their full allotment, which is—would sort of hold for at least a portion of the DSH cuts hold everyone harmless.

Another recommendation that MACPAC made is to rethink the way that the DSH caps are allocated right now because they don't really bear any relationship to low income or uninsured patients.

Mr. CARTER. That is important. Thank you for bringing that up because we do need to look at that, and if there is reform needed we need to address it.

Mr. BARKER. Thank you, sir.

Mr. CARTER. Well, again, thank all of you for being here. This is extremely important. We all understand that. I am concerned about how we are going to pay for all this.

But at the same time, there is no question that these are quality programs that need to be continuing on and, certainly, whereas we need to look at some reforms on certain programs like the DSH payment system, you know, I want to make sure that particularly the rural hospitals understand that we understand how important it is to them for their survival.

So thank you, Madam Chair, and I yield back.

Ms. ESHOO. The gentleman yields back, and I want to thank each one of the witnesses. I think you have given really high-value testimony today. I know that I have learned from you and, Ms. Bohan, the numbers in your program are really stunning—really stunning—and I think when the time comes that the secretary has to review your pilot I want to be able to lean in at that time because when you talk about those wait times being brought down and reaching out to people, it is exactly what we need in our country.

And while I am not going to say something to each one of your individually, I could—thank you. Congress is so dependent upon the experts that come here to answer our questions and I am proud of the members of the entire subcommittee because their questions were all serious and well directed, and you gave us answers and we can build on that foundation as we move forward to reauthorize.

So all of our thanks for your participation. I also would like to submit the following statements or letters for the record. There are several of them:

A statement from the American Osteopathic Association in support of H.R. 2815; a letter from American Federation of State, County, and Municipal Employees regarding certified community behavioral health clinics; a letter from Oregon AFSCME in support of H.R. 1767; a letter from AFSCME 1199(j) and Care Plus New Jersey regarding CCBHCs; a letter from the American Hospital Association in support of 1767; a letter from AHA in support of 3022; a statement from the Endocrine Society regarding the Special Diabetes Program; a letter from Representatives DeGette and Reed regarding the Special Diabetes Program; a letter from Friends of NQF in support of 3031; a letter from Healthcare Leadership Council regarding NQF and PCORI; a letter from the American Academy of Family Physicians regarding THCGME and CHCs; a letter from the Alliance of Community Health Plans regarding the Patient-Centered Outcomes Research Institute; a letter from the National Kidney Foundation regarding PCORI; a letter from Friends of PCORI Reauthorization regarding PCORI; a statement from the PCORI Board of Governors regarding PCORI; a letter from the Council of Academic Family Medicine in support of 2815; a letter from the Leadership Council of Aging Organizations regarding outreach and enrollment to low-income Medicare beneficiaries; a letter from the Children's Hospital Association regarding DSH; a letter from Representatives Engel and Olson regarding DSH; a letter from America's Essential Hospitals in support of 3022; a letter from Texas Parent to Parent in support of 2822; letters from Family-to-Family Health Information Centers regarding 2822; a letter from the Catholic Health Association in support of 3022.

So are there any objections to these letters and documents being placed in the record?

If not, so ordered.

[The information appears at the conclusion of the hearing.][1]

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[1] The information has been retained in committee files. The DeGette/Reed letter is available at https://docs.house.gov/meetings/IF/IF14/20190604/109583/HHRG-116-IF14-20190604-SD022.pdf. The Family-to-Family Health Information Centers letters are available at https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=109583.

Ms. ESHOO. And I think with that, remind Members—there are only two of us here, but staffers are still here—that, pursuant to committee rules, they have 10 business days to submit additional questions for the record to be answered by the witness who has appeared.

We know that you will be highly cooperative, and full answers in a straightforward way in a short period of time. How is that? Everyone agree to that?

I think so. So with that—yes, Dr. Burgess?

Mr. BURGESS. If I may——

Ms. ESHOO. Yes.

Mr. BURGESS. This afternoon marked the passage finally of the Pandemic All-Hazard Preparedness Act on the 100-year anniversary of the Spanish flu. So you are to be congratulated for this entire subcommittee that worked so hard on this for the past 3 years, and we have now gotten it across the finish line.

So I will be looking forward to seeing you at the signing ceremony down at the White House.

Ms. ESHOO. That will be wonderful, Mr. Burgess.

And huge, huge kudos to Representative Susan Brooks, who was and is, I think, just the best partner I could ever have on a bipartisan basis, and certainly to you, Dr. Burgess, to the chairman of the full committee, and to the ranking member of the full committee.

They say it takes a village. It takes a team here and——

Mr. BURGESS. And your staff.

Ms. ESHOO. I haven't finished. I haven't finished. You always want to correct me.

Certainly, to the staff, too. Catherine—is it Catherine Wallens or Willins—on Representative Brooks' staff, and Rachel Fybel on mine. They work late into many nights with the bouncy ball going over on what was taking place in the Senate.

But it is about our national security and public health and response to whatever God has in store for us. So kudos, and thank you for raising it.

So I don't think that there is anything else to come before the committee. It is quarter to 4 in the afternoon, and at this time the Health Subcommittee is adjourned.

Thank you, everyone.

[Whereupon, at 3:44 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

I

116TH CONGRESS
1ST SESSION

H. R. 1767

To increase the number of States that may conduct Medicaid demonstration programs to improve access to community mental health services, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 14, 2019

Ms. MATSUI (for herself, Mr. MULLIN, Mr. BLUMENAUER, Ms. BONAMICI, Mr. CARSON of Indiana, Ms. CLARKE of New York, Mr. COLE, Mr. RODNEY DAVIS of Illinois, Mr. DEFAZIO, Mr. DESAULNIER, Mrs. DINGELL, Mr. EMMER, Mr. FITZPATRICK, Mr. GOTTHEIMER, Mr. HIGGINS of New York, Ms. KENDRA S. HORN of Oklahoma, Mr. KATKO, Mr. KENNEDY, Mr. KING of New York, Mr. LUETKEMEYER, Mr. LUJÁN, Mr. LYNCH, Mr. SEAN PATRICK MALONEY of New York, Ms. MCCOLLUM, Ms. MENG, Mr. PETERSON, Miss RICE of New York, Ms. ROYBAL-ALLARD, Mr. SCHRADER, Mr. SERRANO, Mr. SIRES, Mr. STAUBER, Ms. STEFANIK, Mr. TONKO, and Ms. WILD) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To increase the number of States that may conduct Medicaid demonstration programs to improve access to community mental health services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Excellence in Mental Health and Addiction Treatment Expansion Act".

SEC. 2. COMMUNITY MENTAL HEALTH SERVICES DEMONSTRATION PROGRAM.

Section 223(d) of the Protecting Access to Medicare Act of 2014 (42 U.S.C. 1396a note) is amended—

(1) in paragraph (3)—

(A) by striking "Not more than" and inserting "Subject to paragraph (8), not more than"; and

(B) by striking "2-year" and inserting "4-year"; and

(2) by adding at the end the following new paragraph:

"(8) ADDITIONAL PROGRAMS.—In addition to the 8 States selected under paragraph (1), the Secretary shall, not later than one year after the date of the enactment of the Excellence in Mental Health and Addiction Treatment Expansion Act, select 11 States (which shall not include any States selected under paragraph (1)) to participate in 2-year demonstration programs, that meet the requirements of this subsection, and represent a diverse selection of geographic areas, including rural and underserved areas.".

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I

116th CONGRESS
1st Session

H. R. 1943

To provide funding for Federally qualified health centers and the National Health Service Corps.

IN THE HOUSE OF REPRESENTATIVES

March 28, 2019

Mr. Clyburn (for himself, Mr. Cleaver, Mr. Hastings, Mr. Richmond, Mr. Payne, Mrs. Demings, Ms. Johnson of Texas, Ms. Fudge, Ms. Omar, Mrs. Watson Coleman, Ms. Clarke of New York, Ms. Adams, Mr. Danny K. Davis of Illinois, Mr. Scott of Virginia, Mr. Thompson of Mississippi, Mr. Veasey, Mr. Jeffries, Mr. Horsford, Mr. Johnson of Georgia, Ms. Bass, Mrs. Beatty, Ms. Ocasio-Cortez, Mr. Engel, Mr. Rush, Mr. Cox of California, Mr. Luján, Mr. Bishop of Georgia, Ms. Barragán, Ms. Gabbard, Ms. Hill of California, Mr. Nadler, Mr. San Nicolas, Mr. Cárdenas, Mr. Sires, Mr. Soto, Mr. Cummings, Mr. DeFazio, Mr. Cisneros, Ms. Jackson Lee, Ms. Wilson of Florida, Mr. McEachin, Ms. Norton, Ms. Lee of California, Mr. Lewis, Mrs. Lawrence, Ms. Sewell of Alabama, Mr. Cohen, Mr. Sablan, Mrs. Trahan, Mr. Carson of Indiana, Ms. Schakowsky, Mr. Clay, Ms. Matsui, Mr. Garamendi, Mr. Khanna, Mr. Peters, Mr. Grijalva, Ms. Velázquez, Ms. Moore, Mr. Case, Ms. Kuster of New Hampshire, Mr. Moulton, Mr. Evans, Mr. Levin of California, and Ms. Blunt Rochester) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To provide funding for Federally qualified health centers and the National Health Service Corps.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Community Health Center and Primary Care Workforce Expansion Act of 2019".

SEC. 2. COMMUNITY HEALTH CENTER PROGRAM.

(a) IN GENERAL.—Section 10503(b)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(1)) is amended—

(1) in subparagraph (E), by striking "and" at the end;

(2) in subparagraph (F), by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

"(G) $6,189,174,200 for fiscal year 2020;

"(H) $6,808,091,620 for fiscal year 2021;

"(I) $7,488,900,782 for fiscal year 2022;

"(J) $8,237,790,860 for fiscal year 2023; and

"(K) $9,061,569,946 for fiscal year 2024; and".

(b) CAPITAL PROJECTS.—In addition to amounts otherwise appropriated under section 10503(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)), there is authorized to be appropriated, and there is appropriated, out of amounts not otherwise obligated, for the community health centers program under section 330 of the Public Health Service Act (42 U.S.C. 254b) for capital projects, $4,600,000,000 for the period of fiscal years 2020 through 2024.

(c) AVAILABILITY OF FUNDS.—Amounts appropriated under this section shall remain available until expended.

SEC. 3. NATIONAL HEALTH SERVICE CORPS.

(a) IN GENERAL.—Section 10503(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(2)) is amended—

(1) in subparagraph (E), by striking "and" at the end;

(2) in subparagraph (F), by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

"(G) $850,000,000 for fiscal year 2020;

"(H) $935,000,000 for fiscal year 2021;

"(I) $1,028,500,000 for fiscal year 2022;

"(J) $1,131,350,000 for fiscal year 2023; and

"(K) $1,244,485,000 for fiscal year 2024.".

(b) LIMITATION.—Amounts otherwise appropriated for National Health Service Corps may not be reduced as a result of the appropriations made under this section.

(c) AVAILABILITY OF FUNDS.—Amounts appropriated under this section shall remain available until expended.

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116TH CONGRESS
1ST SESSION

H. R. 2328

To reauthorize and extend funding for community health centers and the National Health Service Corps.

IN THE HOUSE OF REPRESENTATIVES

APRIL 15, 2019

Mr. O'HALLERAN (for himself and Ms. STEFANIK) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To reauthorize and extend funding for community health centers and the National Health Service Corps.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Community Health Investment, Modernization, and Excellence Act of 2019".

SEC. 2. EXTENSION OF FUNDING FOR COMMUNITY HEALTH CENTERS AND NATIONAL HEALTH SERVICE CORPS.

Section 10503 of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2) is amended—

(1) in subsection (b)(1)—

(A) in subparagraph (E), by striking "and" at the end;

(B) in subparagraph (F), by striking the period at the end and inserting "; and"; and

(C) by adding at the end the following:

"(G) for fiscal year 2020, $4,200,000,000;

"(H) for fiscal year 2021, $4,400,000,000;

"(I) for fiscal year 2022, $4,600,000,000;

"(J) for fiscal year 2023, $4,800,000,000; and

"(K) for fiscal year 2024, $5,000,000,000."; and

(2) in subsection (b)(2)—

(A) in subparagraph (E), by striking "and" at the end;

(B) in subparagraph (F), by striking the period at the end and inserting "; and"; and

(C) by adding at the end the following:

"(G) $325,000,000 for fiscal year 2020;

"(H) $340,000,000 for fiscal year 2021;

"(I) $355,000,000 for fiscal year 2022;

"(J) $370,000,000 for fiscal year 2023; and

"(K) $385,000,000 for fiscal year 2024.".

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116TH CONGRESS
1ST SESSION

H. R. 2668

To amend section 330B of the Public Health Service Act to reauthorize special programs for Type I diabetes, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 10, 2019

Ms. DEGETTE (for herself, Mr. REED, Mr. O'HALLERAN, and Mr. MULLIN) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend section 330B of the Public Health Service Act to reauthorize special programs for Type I diabetes, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Special Diabetes Program Reauthorization Act of 2019".

SEC. 2. REAUTHORIZATION OF SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.

Section 330B(b)(2)(D) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(D)) is amended after

"$150,000,000 for each of fiscal years 2018 and 2019" by inserting "and $200,000,000 for each of fiscal years 2020 through 2024".

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116TH CONGRESS
1ST SESSION

H. R. 2680

To amend section 330C of the Public Health Service Act to reauthorize special programs for Indians for providing services for the prevention and treatment of diabetes, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 10, 2019

Mr. O'HALLERAN (for himself, Mr. COLE, Ms. HAALAND, Ms. DEGETTE, Mr. REED, and Mr. MULLIN) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend section 330C of the Public Health Service Act to reauthorize special programs for Indians for providing services for the prevention and treatment of diabetes, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Special Diabetes Programs for Indians Reauthorization Act of 2019".

SEC. 2. REAUTHORIZATION OF SPECIAL DIABETES PROGRAMS FOR INDIANS FOR DIABETES SERVICES.

Section 330C(c)(2)(D) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)(D)) is amended after “$150,000,000 for each of fiscal years 2018 and 2019” by inserting “and $200,000,000 for each of fiscal years 2020 through 2024”.

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(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. 2815

To reauthorize section 340H of the Public Health Service Act to continue to encourage the expansion, maintenance, and establishment of approved graduate medical residency programs at qualified teaching health centers, and for other purposes.

May 16, 2019

IN THE HOUSE OF REPRESENTATIVES

Mr. RUIZ introduced the following bill; which was referred to the Committee on Energy and Commerce.

A BILL

To reauthorize section 340H of the Public Health Service Act to continue to encourage the expansion, maintenance, and establishment of approved graduate medical residency programs at qualified teaching health centers, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Training the Next Generation of Primary Care Doctors Act of 2019".

SEC. 2. FINDINGS.

Congress finds as follows:

(1) The program of payments to teaching health centers for graduate medical education under section 340H of the Public Health Service Act (42 U.S.C. 256h) was enacted in 2010 and reauthorized in 2015 and 2018 to address the crisis-level shortage of primary care physicians, especially in rural and medically underserved communities.

(2) Teaching health center residents and faculty will provide more than 1,000,000 primary care medical visits in 2019 to underserved communities.

(3) When compared with traditional Medicare GME residents, residents who train at teaching health centers are more likely to practice primary care and remain in underserved or rural communities.

(4) The teaching health center program not only plays a vital role in training the Nation's next generation of primary care physicians (including dentists), but helps bridge the Nation's physician shortfall and address the maldistribution of physicians across the United States.

(5) For these reasons, it is of vital importance to continue the program under section 340H of the Public Health Service Act (42 U.S.C. 256h) at a

sustainable level of funding per full-time equivalent resident, as recommended in the fact sheet of the Health Resources and Services Administration entitled "Cost Estimates for Training Residents in a Teaching Health Center".

SEC. 3. PAYMENTS.

(a) IN GENERAL.—Subsection (g) of section 340H of the Public Health Service Act (42 U.S.C. 256h(g)) is amended—

(1) by redesignating paragraph (2) as paragraph (4); and

(2) by inserting after paragraph (1) the following:

"(2) PAYMENTS TO APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAMS.—To carry out this section, for payments to approved graduate medical residency programs (as defined in paragraph (j)(1) of this section), there are appropriated $126,500,000 for fiscal year 2020, $128,000,000 for fiscal year 2021, $130,000,000 for fiscal year 2022, $133,000,000 for fiscal year 2023, and $136,000,000 for fiscal year 2024, to remain available until expended.

"(3) PAYMENTS TO NEW APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAMS.—To carry out this section, for payments to new approved graduate medical residency training programs (as defined in paragraph (j)(2) of this section), there are appropriated $8,500,000 for fiscal year 2021, $17,000,000 for fiscal year 2022, $34,500,000 for fiscal year 2023, and $44,000,000 for fiscal year 2024, to remain available until expended.''.

(b) NUMBER OF RESIDENTS.—In calculating the level of payments to each approved graduate medical residency training program pursuant to subsection (g)(2) of section 340H of the Public Health Service Act (42 U.S.C. 256h), the Secretary of Health and Human Services shall pay for the number of residents at a program at a number that is no lower than the highest number of residents in their programs for the period of fiscal years 2016 through 2018.

(c) LIMITATIONS.—The number of full-time equivalent residents for which a qualified teaching health center receives payments pursuant to subsection (a)(1)(C) of section 340H of the Public Health Service Act (42 U.S.C. 256h) for a fiscal year shall not exceed by more than 6 the number of full-time equivalent residents for which the center received such payments for the preceding fiscal year.

(d) REPORT ON EXPANSION AND TRAINING COSTS.—Not later than September 30, 2022, the Secretary of Health and Human Services shall submit to the Congress a report on the establishment of new approved graduate medical residency programs and expansion of existing approved graduate medical residency programs. The report shall include the locations of such programs, the number of residents, and statistics regarding the number of programs receiving priority under subsection (a)(3) of section 340H of the Public Health Service Act (42 U.S.C. 256h). The report shall examine the direct graduate expenses of approved graduate medical residency training programs; the indirect expenses associated with the additional costs of teaching residents; and determine and the current per resident per year cost of training residents at qualified teaching health centers.

(e) PUBLIC AVAILABILITY OF DATA.—The Secretary of Health and Human Services shall make available to the public the data reported by qualified teaching health centers pursuant to subsection (d) of this section and subsection (h)(1) of section 340H of the Public Health Service Act (42 U.S.C. 256(h)).

....

(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. 2822

To amend title V of the Social Security Act to provide for an extension of funding for family-to-family health information centers, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES
May 20, 2019

Ms. SHERRILL introduced the following bill; which was referred to the Committee on Energy and Commerce.

A BILL

To amend title V of the Social Security Act to provide for an extension of funding for family-to-family health information centers, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Family-to-Family Reauthorization Act of 2019".

SEC. 2. FIVE-YEAR EXTENSION OF FUNDING FOR FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

Section 501(c)(1)(A)(vii) of the Social Security Act (42 U.S.C. 701(c)(1)(A)(vii)) is amended by striking "and 2019" and inserting "through 2024".

....
(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. 3022

To amend title XIX of the Social Security Act to repeal the reductions in Medicaid DSH allotments, and for other purposes.

May 24, 2019

IN THE HOUSE OF REPRESENTATIVES

Mr. Engel introduced the following bill; which was referred to the Committee on Energy and Commerce.

A BILL

To amend title XIX of the Social Security Act to repeal the reductions in Medicaid DSH allotments, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Patient Access Protection Act".

SEC. 2. REPEAL OF REDUCTIONS IN MEDICAID DSH ALLOTMENTS.

(a) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) by striking paragraphs (7) and (8); and

(2) by redesignating paragraph (9) as paragraph (7).

(b) CONFORMING AMENDMENTS.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)), as amended by subsection (a), is further amended—

(1) in paragraph (1), by striking "paragraphs (2), (3), and (7)" and inserting "paragraphs (2) and (3)"; and

(2) in paragraph (3)(A), by striking "paragraphs (6), (7), and (8)" and inserting "paragraph (6)".

....
(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. 3029

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

May 28, 2019

IN THE HOUSE OF REPRESENTATIVES

Mr. OLSON introduced the following bill; which was referred to the Committee on ______________________________

A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Improving Low Income Access to Prescription Drugs Act of 2019".

SEC. 2. TRANSITIONAL COVERAGE AND RETROACTIVE MEDICARE PART D COVERAGE FOR CERTAIN LOW-INCOME BENEFICIARIES.

Section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) is amended—

(1) by redesignating subsection (e) as subsection (f); and

(2) by adding after subsection (d) the following new subsection:

"(e) LIMITED INCOME NEWLY ELIGIBLE TRANSITION PROGRAM.—

"(1) IN GENERAL.—The Secretary shall carry out a program to provide transitional coverage for covered part D drugs for LI NET eligible individuals in accordance with this subsection.

"(2) LI NET ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this subsection, the term 'LI NET eligible individual' means a part D eligible individual who—

"(A) is a subsidy eligible individual; and

"(B) has not yet enrolled in a prescription drug plan or an MA–PD plan, or, who has so enrolled, but with respect to whom coverage under such plan has not yet taken effect.

"(3) TRANSITIONAL COVERAGE.—For purposes of this subsection, the term 'transitional coverage' means with respect to an LI NET eligible individual—

"(A) immediate access to covered part D drugs at the point of sale during the period that begins on the first day of the month such individual is determined to be a subsidy eligible individual and ends on the date that coverage under a prescription drug plan or MA–PD plan takes effect with respect to such individual; and

"(B) in the case of an LI NET eligible individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a recipient of supplemental security income benefits under title XVI, retroactive coverage (in the form of reimbursement of the amounts that would have been paid under this part had such individual been enrolled in a prescription drug plan or MA–PD plan) of covered part D drugs purchased by such individual during the period that begins on the date that is the later of—

"(i) the date that such individual was first eligible for a low income subsidy under this part; or "(ii) the date that is 36 months prior to the date such individual enrolls in a prescription drug plan or MA–PD plan,

and ends on the date that coverage under such plan takes effect.

"(4) PROGRAM ADMINISTRATION.—

"(A) SINGLE POINT OF CONTACT.—The Secretary shall, to the extent feasible, administer the program under this subsection through a contract with a single program administrator.

"(B) BENEFIT DESIGN.—The Secretary shall ensure that the transitional coverage provided to LI NET eligible individuals under this subsection—

"(i) provides access to all covered part D drugs under an open formulary;

"(ii) permits all pharmacies determined by the Secretary to be in good standing to process claims under the program;

"(iii) is consistent with such requirements as the Secretary considers necessary to improve patient safety and ensure appropriate dispensing of medication; and "(iv) meets such other requirements as the Secretary may establish.

"(5) RELATIONSHIP TO OTHER PROVISIONS OF THIS TITLE; WAIVER AUTHORITY.—

"(A) IN GENERAL.—The following provisions shall not apply with respect to the program under this subsection:

"(i) Paragraphs (1) and (3)(B) of section 1860D–4(a) (relating to dissemination of general information; availability of information on changes in formulary through the internet).

"(ii) Subparagraphs (A) and (B) of section 1860D–4(b)(3) (relating to requirements on development and application of formularies; formulary development).

"(iii) Paragraphs (1)(C) and (2) of section 1860D–4(c) (relating to medication therapy management program).

"(B) WAIVER AUTHORITY.—The Secretary may waive such other requirements of titles XI and this title as may be necessary to carry out the purposes of the program established under this subsection.".

....

(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. 3030

To amend the Internal Revenue Code of 1986 and title XI of the Social Security Act to extend appropriations and transfers to the Patient-Centered Outcomes Research Trust Fund and to extend certain health insurance fees for such transfers.

May 28, 2019

IN THE HOUSE OF REPRESENTATIVES

Ms. DEGETTE introduced the following bill; which was referred to the Committee on ______________________________

A BILL

To amend the Internal Revenue Code of 1986 and title XI of the Social Security Act to extend appropriations and transfers to the Patient-Centered Outcomes Research Trust Fund and to extend certain health insurance fees for such transfers.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Patient-Centered Outcomes Research Extension Act of 2019".

SEC. 2. EXTENDING APPROPRIATIONS AND TRANSFERS TO THE PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND; EXTENSION OF CERTAIN HEALTH INSURANCE FEES.

(a) In General.—

(1) Internal revenue code.—Section 9511 of the Internal Revenue Code of 1986 is amended—

(A) in subsection (b)(1)(E), by striking "2014" and all that follows through "2019" and inserting "2014 through 2029";

(B) in subsection (d)(2)(A), by striking "2019" and inserting "2029"; and

(C) in subsection (f), by striking "2019" and inserting "2029".

(2) Title xi.—Section 1183(a)(2) of the Social Security Act (42 U.S.C. 1320e–2(a)(2)) is amended by striking "2014" and all that follows through "2019" and inserting "2014 through 2029".

(b) Extension of Certain Health Insurance Fees.—

(1) Health insurance policies.—Section 4375(e) of the Internal Revenue Code of 1986 is amended by striking "2019" and inserting "2029".

(2) Self-insured health plans.—Section 4376(e) of the Internal Revenue Code of 1986 is amended by striking "2019" and inserting "2029".

....
(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. 3031

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

IN THE HOUSE OF REPRESENTATIVES
May 28, 2019

Ms. JUDY CHU of California introduced the following bill; which was referred to the Committee on ______________________________

A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. EXTENSION OF FUNDING FOR QUALITY MEASURE ENDORSEMENT, INPUT, AND SELECTION UNDER MEDICARE PROGRAM.

Section 1890(d)(2) of the Social Security Act (42 U.S.C. 1395aaa(d)(2)) is amended—

(1) by striking “and $7,500,000” and inserting “$7,500,000”; and

(2) by striking “and 2019.” and inserting “and 2019, and $30,000,000 for each of fiscal years 2020 through 2024.”.

....

(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. 3039

To provide for a 5–year extension of funding outreach and assistance for low–income programs.

May 30, 2019

IN THE HOUSE OF REPRESENTATIVES

Mr. GOMEZ introduced the following bill; which was referred to the Committee on _______________________________

A BILL

To provide for a 5–year extension of funding outreach and assistance for low–income programs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note), as amended by section 3306 of the Patient Protection and Affordable

Care Act (Public Law 111–148), section 610 of the American Taxpayer Relief Act of 2012 (Public Law 112–240), section 1110 of the Pathway for SGR Reform Act of 2013 (Public Law 113–67), section 110 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93), section 208 of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10), and section 50207 of the Bipartisan Budget Act of 2018 (Public Law 115–123), is amended—

(1) in clause (vii), by striking "and" at the end;

(2) in clause (viii), by striking "and" at the end;

(3) in clause (ix), by striking the period at the end and inserting "; and"; and

(4) by inserting after clause (ix) the following new clause:

"(x) for each of fiscal years 2020 through 2024, of $15,000,000.".

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (vii), by striking "and" at the end;

(2) in clause (viii), by striking "and" at the end;

(3) in clause (ix), by striking the period at the end and inserting "; and"; and

(4) by inserting after clause (ix) the following new clause:

"(x) for each of fiscal years 2020 through 2024, of $15,000,000.".

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (vii), by striking "and" at the end;

(2) in clause (viii), by striking "and" at the end;

(3) in clause (ix), by striking the period at the end and inserting "; and"; and

(4) by inserting after clause (ix) the following new clause:

"(x) for each of fiscal years 2010 through 2024, of $5,000,000.".

(d) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2) of such section 119, as so amended, is amended—

(1) in clause (vii), by striking "and" at the end;

(2) in clause (viii), by striking "and" at the end;

(3) in clause (ix), by striking the period at the end and inserting "; and"; and

(4) by inserting after clause (ix) the following new clause:

"(x) for each of fiscal years 2020 through 2024, of $15,000,000.".

acofp AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS

ACOI AMERICAN COLLEGE OF OSTEOPATHIC INTERNISTS

AMERICAN COLLEGE OF OSTEOPATHIC OBSTETRICIANS & GYNECOLOGISTS

AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS

AOA AMERICAN OSTEOPATHIC ASSOCIATION
TREATING OUR FAMILY AND YOURS

Joint Statement for the Record

The Health Subcommittee of the Committee on Energy and Commerce Hearing
on
Investing in America's Health Care

June 4, 2019

On behalf of the more than 145,000 osteopathic physicians and medical students we represent, we applaud the committee's leadership and bipartisan effort to address the shortage in our health care workforce. In anticipation of the upcoming hearing: Investing in America's Health Care, we would like to highlight, and encourage the committee to support funding for growth in the reauthorization of the Teaching Health Centers Graduate Medical Education (THCGME) program to help address the shortage in our health care workforce.

The majority of THCGME programs are currently accredited by the AOA or are dually accredited (DO/MD) programs, supporting nearly 800 osteopathic resident physicians through their training since the program's inception. Located in 23 states and the District of Columbia, THCGME programs train residents in much-needed primary care fields that have the largest shortages nationally, including family medicine, internal medicine, pediatrics, obstetrics and gynecology, psychiatry, geriatrics, and dentistry. It is a vital source of training for primary care residents to help expand access to care in rural and underserved communities throughout the country. Additional funding for the THCGME program would provide the support needed for program expansion beyond the states that already have THCGME programs.

Osteopathic physicians (DOs) are fully-licensed to practice in all specialty areas of medicine, with nearly 57% of active DOs in primary care. Our training emphasizes a whole-person approach to treatment and care, where we partner with our patients to help them get healthy and stay well. Osteopathic medical education also has a long history of establishing educational programs for medical students and residents that target the health care needs of rural and underserved populations. Given this strong presence in primary care, osteopathic medicine aligns naturally with the mission and goals of the THCGME program that has proven successful in helping address the existing gaps in our nation's primary care workforce.

Residents who train in THC programs are far more likely to specialize in primary care and remain in the communities in which they have trained. Data shows that, when compared to traditional postgraduate trainees, residents who train at THCs are more likely to practice primary care (82% vs. 23%) and remain in underserved (55% vs. 26%) or rural (20% vs. 5%) communities. It is clear that a well-designed THCGME program not only plays a vital role in training our next generation of primary care physicians, but helps to bridge our nation's physician shortfall. The program also tackles the issue of physician maldistribution, and helps address the need to attract and retain physicians in rural areas and medically underserved communities. In the 2017-2018 academic year, nearly all residents received training in primary care settings and 82% of residents trained in Medically Underserved Communities (MUC)/rural community.

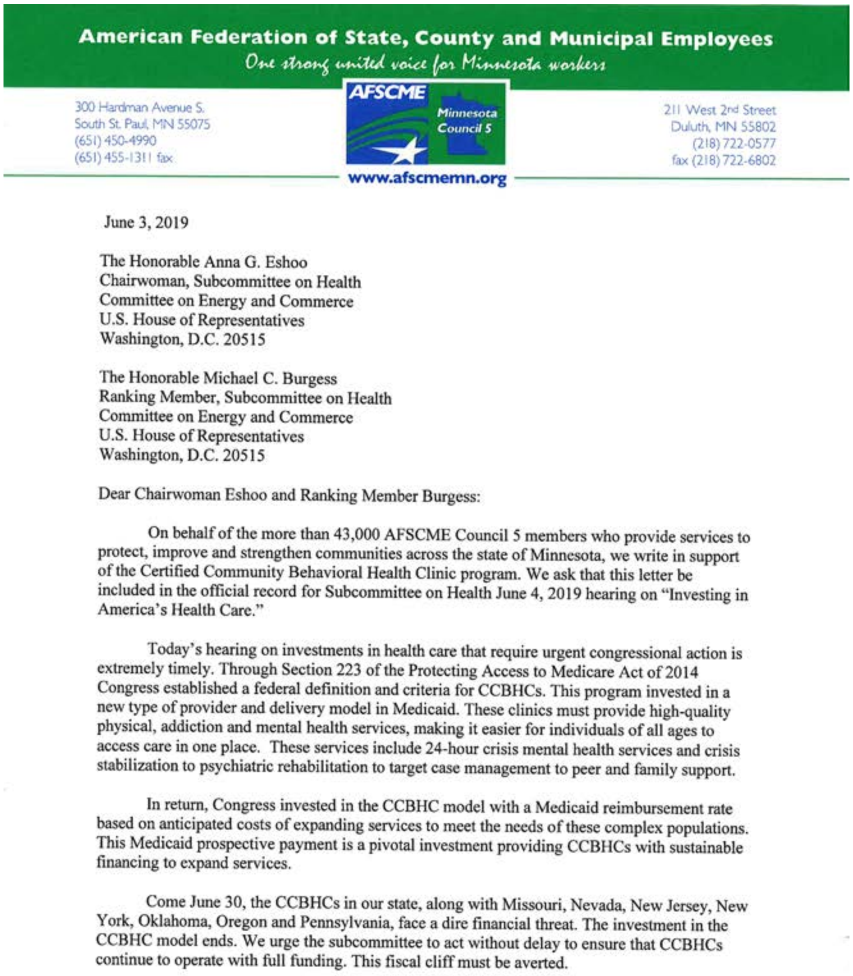
We respectfully ask the committee to consider H.R. 2815. This legislation, introduced by Representatives Raul Ruiz (D-CA), Cathy McMorris Rodgers (R-WA), Xochitl Torres Small (D-NM) and Phil Roe (R-TN), would reauthorize the THCGME program for the next five years. This bill also provides funding and a pathway for growth in the number of residents trained in underserved rural and urban communities. This represents a much needed expansion to address the physician shortages in our country.

We would also like to briefly highlight the broader role osteopathic physicians have in reducing our nation's physician shortage. Since 2010, the number of DOs has increased by 54%. Today, more than 65% of all DOs are under the age of 45, and if current enrollment trends continue, DOs are projected to represent more than 20% of practicing physicians by 2030. Because of the whole-person approach to patient care that is inherent in osteopathic medicine, the increasing share of DOs in the physician workforce, and the number of DOs in primary care specialties, we have a unique and important perspective on the needs of our nation's health care workforce and would welcome the opportunity to contribute to your work on this issue.

We appreciate your bipartisan effort to address the shortage in our country's health care workforce, and we stand ready to assist in your effort.

Sincerely,

American Osteopathic Association
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Osteopathic Obstetricians and Gynecologists
American College of Osteopathic Neurologists and Psychiatrists
American College of Osteopathic Pediatricians



American Federation of State, County and Municipal Employees
One strong united voice for Minnesota workers

AFSCME
Minnesota Council 5

300 Hardman Avenue S.
South St. Paul, MN 55075
(651) 450-4990
(651) 455-1311 fax

211 West 2nd Street
Duluth, MN 55802
(218) 722-0577
fax (218) 722-6802

www.afscmemn.org

June 3, 2019

The Honorable Anna G. Eshoo
Chairwoman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

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

Dear Chairwoman Eshoo and Ranking Member Burgess:

On behalf of the more than 43,000 AFSCME Council 5 members who provide services to protect, improve and strengthen communities across the state of Minnesota, we write in support of the Certified Community Behavioral Health Clinic program. We ask that this letter be included in the official record for Subcommittee on Health June 4, 2019 hearing on "Investing in America's Health Care."

Today's hearing on investments in health care that require urgent congressional action is extremely timely. Through Section 223 of the Protecting Access to Medicare Act of 2014 Congress established a federal definition and criteria for CCBHCs. This program invested in a new type of provider and delivery model in Medicaid. These clinics must provide high-quality physical, addiction and mental health services, making it easier for individuals of all ages to access care in one place. These services include 24-hour crisis mental health services and crisis stabilization to psychiatric rehabilitation to target case management to peer and family support.

In return, Congress invested in the CCBHC model with a Medicaid reimbursement rate based on anticipated costs of expanding services to meet the needs of these complex populations. This Medicaid prospective payment is a pivotal investment providing CCBHCs with sustainable financing to expand services.

Come June 30, the CCBHCs in our state, along with Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon and Pennsylvania, face a dire financial threat. The investment in the CCBHC model ends. We urge the subcommittee to act without delay to ensure that CCBHCs continue to operate with full funding. This fiscal cliff must be averted.

AFSCME Council 5 members who are certified peer recovery specialists, nurses, social workers, and other mental health practitioners provide behavioral health care services at the Ramsey County CCBHC. These workers are on the frontlines of the CCBHC program and provide flexible services to all individuals, including those who have not found recovery through traditional treatment. While any delivery model can be improved, our members see the services they provide at this CCBHC offer hope, change the trajectory of a person's life and help repair fractured families.

When a person is ready to recover from an opioid or other addiction, they need help now, not in months. AFSCME Council 5 members are ready to help our fellow Minnesotans begin that road to recovery, find resilience to come back from a relapse and support recovery. But to do so the Ramsey County CCBHC needs to maintain the federal investment in sustainable financing.

On behalf of our members who provide behavioral health care services and their clients and communities we urge you to act to avert the June 30 fiscal cliff facing all CCBHCs.

Sincerely,

Executive Director
AFSCME Council 5

June 3, 2019

Oregon
AFSCME
Council 75

The Honorable Anna G. Eshoo
Chairwoman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

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

Dear Chairwoman Eshoo and Ranking Member Burgess:

On behalf of the more than 25,000 Oregon AFSCME Council 75 members, we ask that this letter be included in the official record for Subcommittee on Health June 4, 2019 hearing on "Investing in America's Health Care."

We strongly support H.R. 1767, the Excellence in Mental Health and Addiction Treatment Act. This bill extends the Certified Community Behavioral Health Clinic (CCBHC) program. On June 30, the CCBHCs in our state, along with those in Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, and Pennsylvania, face extreme financial threat. We appreciate that you have worked together in bipartisan effort to avert the March 30 fiscal cliff in Oregon and Oklahoma. We ask that you, again, make sure CCBHCs continue to operate with full funding.

At Cascadia Behavioral Health, in Portland Oregon, AFSCME Council 75 members who are therapists, care coordinators, crisis counselors, residential counselors, support staff and other workers, deliver whole health care – integrated mental health and addiction services, primary care and housing – through the CCBHC program.

These health care workers never stop working to help those who want to get healthy and recover. It is not just a job, it's a calling. This work matters because it means something to help someone who has experienced trauma find that they already possess the courage to move forward on his or her own terms. This work matters because helping a person manage diabetes and their depression means really seeing a whole person, not just conditions and symptoms. This work matters because it means something to help someone find his or her own resilience to recover after a relapse. This work matters because it means something when someone can find their way out of the addiction and sustain recovery. In fact, it means everything.

That core commitment to helping people heal is why Alexandra Birch, a Qualified Mental Health Associate, cares deeply about the CCBHC program. It has helped innovate and improve the delivery of care. She was hired in 2017 as a Care Coordinator at Cascadia because of an investment Congress provided to the CCBHC program. In that role she is the glue that connects primary care with behavioral health care and makes sure care is focused on the whole-patient.

In her work, Ms. Birch treats clients with anxiety and very high blood pressure but who do not have an established doctor; she is able to connect them to a doctor. She cares for clients on certain anti-depressants that experienced weight gain as a result, which put them at higher risk of developing diabetes. Because of the investment Congress provided in establishing CCBHCs, Ms. Birch can direct those clients to in-house primary care to monitor and prevent diabetes.

For practitioners like Ms. Birch, Cascadia's capacity to bring primary care into the outpatient behavioral health care clinics is a game-changer. It enhances their delivery of services and outcomes for their clients. From the frontline perspective, the integration of behavioral health and primary care in a CCBHC removes logistical and other obstacles to consultation between providers. These consultations translate into improved identification of the best route of care for a client with complex physical and mental conditions with the result of getting a client on the road to wellness much quicker.

Cascadia's capacity to sustain and expand this level of high-quality coordinated care to a vulnerable population depends on the dedication and skills of workers like Ms. Birch and congressional action to continue investing in the CCBHC fiscal model that covers 100% of costs.

With the fiscal investment in CCBHCs, Congress allows Cascadia staff to reach into the community to expand access to behavioral health services for individuals with serious mental illnesses. Cascadia works with Portland's 24-hour mental health crisis emergency room, Unity Center Behavioral Health. Cascadia staff establish crisis patients with Cascadia primary care providers immediately after Unity hospital care. This enables patients to continue medications that ensure mental stability until they have fully connected with Cascadia's mental health providers.

We urge you to pass H.R. 1767 and extend the CCBHC program. It would be tragic to lose this funding that has sustained and expanded vital behavioral and medical services to our community.

Sincerely,

Stacy Chamberlin
Executive Director

cc: The Honorable Frank Pallone Jr., Chair, Committee on Energy and Commerce
The Honorable Greg Walden, Ranking Member, Committee on Energy and Commerce

DISTRICT 1199J

CarePlus
NEW JERSEY
Healthy minds, healthy bodies.

June 3, 2019

The Honorable Anna G. Eshoo
Chairwoman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

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

Dear Chairwoman Eshoo and Ranking Member Burgess:

On behalf AFSCME District 1199J, the National Union of Hospital and Health Care Employees, and CarePlus NJ, we applaud you for holding this timely hearing on programs that invest in health care delivery, such as the Certified Community Behavioral Health Clinic (CCBHC) program.

AFSCME 1199J members deliver many CCBHC services at CarePlus NJ. Both our organizations support the CCBHC model to provide a comprehensive range of addiction and mental health services to vulnerable individuals. Sixty-five AFSCME 1199J members who are therapists, case managers, administrative support staff, a Licensed Practical Nurse and a receptionist provide services in 14 clinical departments in Paramus, Fair Lawn and Hasbrouck Heights New Jersey. Their positions and the care they provided depend on the CCBHC funding.

These crucial employees see from the frontlines how the CCBHC program offers hope to individuals with severe mental health and substance use disorder conditions. With every new individual we help, we can strengthen families and communities. From July 2017-June 2018 the CCBHC fiscal model enabled CarePlus NJ to decrease wait times for care from an average of 45 days to 6 days with the CCBHC staff. We have an average of 1,000 patients a month being served in the CCBHC, and we have had the highest consumer satisfaction from 93% to 97% overall that has been reported.

While several factors make the programs at CarePlus NJ work, including a positive labor-management partnership, proper financing is a crucial investment to increase capacity and sustain the level of staff necessary to delivery high quality coordinated behavioral health services. Under the CCBHC model, the Medicaid reimbursement rate is not a fee for service payment, but a prospective payment based on the anticipated costs of expanding services to meet the needs of these complex populations.

Our organizations have decades of experience in health care and in working to strengthen communities across New Jersey. The CCBHC funding model is far more effective and less costly than when individuals in need of mental health services or addiction treatment instead find themselves in emergency rooms, county jails, homeless shelters and local law enforcement agencies.

We urge you to continue your bipartisan support for this program's funding model and ensure that the June 30 termination of funds does not occur.

Sincerely,

SUSAN M. CLEARY
President
AFSCME District 1199J

JOSEPH MASCIANDARO, MA
President and CEO
CarePlus NJ

cc: The Honorable Frank Pallone, Jr., Chairman, House Energy and Commerce Committee

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

June 3, 2019

The Honorable Eliot Engel
U.S. House of Representatives
2426 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Engel:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, our clinical partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, we are pleased to support H.R. 3022, the Patient Access Protection Act, your legislation to repeal the Medicaid Disproportionate Share Hospital (DSH) reductions.

The Medicaid DSH program was established to provide financial assistance to hospitals serving a disproportionate number of low-income patients to ensure Medicaid and uninsured patients would have access to health care services. These hospitals provide critical care for their communities, including trauma and burn care, neonatal care and disaster response capabilities. The patients they serve are among the most vulnerable citizens, including children, the poor, the disabled and the elderly.

Congress mandated reductions to Medicaid DSH program in the Affordable Care Act (ACA), reasoning that hospitals would have less uncompensated care as health insurance coverage increased. Unfortunately, the projected coverage levels were not realized, and the gains made under the ACA may be reversing. Consequently the need for the Medicaid DSH payments is still vital for the hospitals that rely on the program. Congress has, with bipartisan support, delayed the start of the cuts multiple times in the last six years, but $4 billion in reductions are scheduled to take effect Oct. 1, 2019. The cuts increase to $8 billion per year for fiscal years 2021-25.

Your legislation would eliminate the Medicaid DSH cuts and thereby help preserve patient access to their local hospitals. Thank you for your efforts to support the Medicaid DSH program. We look forward to working with you to advance this legislation.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

May 6, 2019

The Honorable Doris Matsui
United States House of Representatives
2311 Rayburn House Office Building
Washington, DC 20515

Dear Representative Matsui:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses, and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes in strong support of the Excellence in Mental Health and Addiction Treatment Expansion Act (H.R.1767). Your bipartisan legislation would renew and expand an innovative demonstration program that expands access to treatment of mental illnesses and substance use disorders through community-based clinics.

The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that more than half of adults with any mental illness and approximately one-third of adults with serious mental illness (SMI) did not receive treatment in 2017. Additionally, according to SAMHSA, in 2016, only 10 percent of the 21 million people age 12 or older who needed substance use treatment received treatment at a specialty facility. The opioid crisis, which is estimated to cost nearly 42,000 American lives each year, has exacerbated the need to expand treatment capacity.

To increase access to care, Congress, in Section 223 of the Protecting Access to Medicare Act (PAMA), authorized demonstration programs in up to eight states to improve community behavioral health services through certified community behavioral health clinics (CCBHCs), a new comprehensive treatment model that launched in 2017. These clinics provide a range of essential mental health and substance use disorder treatment services, including cognitive behavioral therapy, trauma-informed care and medication-assisted treatment (MAT).

In the initial SAMHSA report to Congress on this program, the agency estimated that the 67 CCBHCs will serve "more than 380,000 individuals across 372 locations in 190 counties." SAMHSA also noted that "a final report with recommendations for continuation, expansion, modification, or termination of demonstration projects under Section 223 will be submitted to Congress no later than December 2021." However, statutory authority for the CCBHC program will end in June 2019 unless Congress acts.

Your timely legislation would renew the CCBHC demonstration program in the original eight states (Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon and Pennsylvania) for two years and expand it to 11 additional states, enabling current patients to continue receiving comprehensive care, and increasing the number of individuals with access to vital services.

We commend you for introducing the Excellence in Mental Health and Addiction Treatment Expansion Act and look forward to working with you to secure its enactment.

Sincerely,

Thomas P. Nickels
Executive Vice President

ENDOCRINE SOCIETY

Testimony Submitted for the Record:
Investing in America's Health Care
United States House of Representatives
Energy and Commerce Health Subcommittee

The reauthorization of the Special Diabetes Program (SDP) is critical to finding a cure for diabetes and ensuring that the populations at greatest risk have access to prevention, treatment, and education programs in their communities. More than 114 million Americans are living with or at-risk for developing diabetes. Their lives have been fundamentally changed through the SDP, which has been funded since 1997 to advance research for type 1 diabetes and to address the disproportionate burden of type 2 diabetes in American Indians and Alaska Natives (AI/AN). The Endocrine Society represents over 18,000 basic and clinical researchers and physicians-in-practice worldwide, many who receive funding for type 1 diabetes research and have helped to develop evidence-based prevention and education programs for people with diabetes. We commend the Subcommittee for having this hearing and we urge you to reauthorize the SDP before it expires September 30.

SDP is comprised of two programs—the Special Diabetes Program for Type 1 Diabetes and the Special Diabetes Program for Indians. Funding for the Special Diabetes Program for Type 1 Diabetes is administered through the National Institute of Diabetes and Digestive and Kidney Disorders (NIDDK). Through this program, NIDDK has advanced research on how to delay the full onset of type 1 diabetes, better understand the underlying causes of the disease, and prevent, treat, and reverse complications associated with the disease. There are six overarching goals of the type 1 research program, which include:

- identifying the genetic and environmental causes of type 1 diabetes;
- preventing and reversing type 1 diabetes;
- developing cell replacement therapy;

- preventing or reducing hypoglycemia in type 1 diabetes;
- preventing or reducing the complications of type 1 diabetes; and
- attracting new talent and applying new technologies to research on type 1 diabetes.

This research has accelerated progress on an artificial pancreas, advanced therapies to reverse vision loss, and discovered nearly 50 genes that influence the risk of developing type 1 diabetes. SDP funding has also helped determine that hemoglobin A1C standardization improves care, identify new blood glucose monitoring tools for controlling blood glucose levels, advance islet transplantation as a therapeutic approach, and test novel prevention strategies. Moving forward, SDP-Type 1 seeks to identify molecular pathways of disease progression, therapeutic agents to target molecular pathways, pre-clinical drug development and testing, and promising therapies in people with type 1 diabetes. As a result of the past two decades of research, people with type 1 diabetes are living longer, healthier lives and experiencing lower rates of disease complications, but more needs to be done and there are great research opportunities that should be explored

Through the Special Diabetes Program for Indians (SDPI), more than 400 evidence-based treatment and education programs on type 2 diabetes have been implemented in AI/AN communities, who have the highest prevalence of diabetes. SDPI Community-Directed Diabetes Programs provide funds to the Indian Health Service's (IHS) Tribal and Urban Health Programs in all 12 IHS areas to begin or enhance local diabetes treatment and prevention programs. The SDPI Diabetes Prevention and Health Heart Programs translate current science on diabetes prevention and cardiovascular disease risk reduction to AI/AN communities.

These programs have implemented proven lifestyle change interventions to reduce the risk of diabetes in those at the greatest risk for being diagnosed. As a result, the SDPI has successfully reduced A1c levels, cardiovascular disease, and promoted healthy lifestyle behaviors. Diabetic eye disease has decreased 50%, reducing vision loss and blindness. Obesity and diabetes rates in youth have not increased in more than 10 years, while diabetes rates have not increased in adults since 2011. Kidney failure rates have decreased by 54%, reducing the need for dialysis. Data has shown that these positive clinical outcomes in program participants has reduced the risk for blindness, amputations, kidney failure, as well as preventing the onset of type 2 diabetes. Again, while we have seen great successes, if the program is not reauthorized, we risk going in the wrong direction for this patient population.

Together, these programs have proven to be a critical pathway to preventing and treating diabetes and its complications. SDP has enabled resources to go towards innovative research that has not only revolutionized care, but could lead to a cure to one of our most prevalent diseases.

We urge Congress to support the reauthorization of the program at $200 million per program, per year over a five-year period to expand on the successes of the program and to ensure continued research that will help to find a cure for diabetes.

FRIENDS
OF NQF

May 31, 2019

The Honorable Judy Chu
2423 Rayburn House Office Bldg.
Washington, DC 20515

The Honorable Buddy Carter
2432 Rayburn House Office Bldg.
Washington, DC 20515

The Honorable Eliot Engel
2426 Rayburn House Office Bldg.
Washington, DC 20515

Dear Representatives Chu, Engel and Carter,

As members of the Friends of NQF Steering Committee, we applaud your leadership and introduction of bipartisan legislation (H.R. 3031) continuing federal funding for the National Quality Forum.

Continued federal funding for the National Quality Forum (NQF) is foundational to efforts to achieve a cost-efficient, high-quality, value-based healthcare system that ensures the best care for Americans and the best use of the nation's healthcare dollars. The introduction of your bill to reauthorize federal funding for NQF helps ensure that quality measures used in care delivery and payment reform continue to be reliable, effective and drive measurable improvements for our nation's Medicare beneficiaries.

During the continued legislative process, we encourage the Committees on Energy and Commerce and Ways and Means to consider other changes to modernize and enhance the impact of NQF's contribution to our nation's continued commitment to value-based care. These changes would include:

- Improve public transparency and accountability regarding the use and implementation of measures, enabling public input into emerging Center for Medicare and Medicaid Innovation models;
- Advance quality improvement reforms that reduce administrative burden and foster alignment across programs and payers; and,
- Advance national health priorities and high-value, high-impact quality measures through innovations in measurement.

Thank you for your leadership and commitment to NQF. Continuing the nation's work to advance quality, safety, and cost-effective healthcare is one objective we all share.

Sincerely,

The Friends of NQF Steering Committee

American Academy of Family Physicians
American Academy of Orthopaedic Surgeons
American College of Physicians
American Society of Nephrology

America's Essential Hospitals
America's Health Insurance Plans
Blue Cross Blue Shield Association
Compassus
Federation of American Hospitals
Healthcare Leadership Council
Memphis Business Group on Health
National Partnership for Women & Families
Network for Regional Healthcare Improvement
PFCCpartners
Premier
The Health Collaborative
The Leapfrog Group

HEALTHCARE
LEADERSHIP
COUNCIL

June 4, 2019

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2107 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
2185 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Pallone and Ranking Member Walden:

Thank you for holding a hearing on “Investing in American’s Health Care.” The Healthcare Leadership Council (HLC) appreciates the opportunity to share its thoughts with you on the proposed legislation.

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 healthcare 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, post-acute care providers, home care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

Public Health Programs

HLC supports the proposed legislation to continue funding for several public health programs. These programs include funding for community health centers, workforce programs, special diabetes program, and the Patient-Centered Outcomes Research Institute (PCORI). We believe that a well-trained, fully resourced, and strategically deployed healthcare workforce is crucial for identifying, assessing, and treating individuals with chronic conditions or functional limitations. Care and health outcomes can be improved, and the costs of care reduced, through an adequate physician workforce and expanded training and deployment of allied health professionals and community health workers. Additionally, we have long supported increased funding for

PCORI. This institute has proven to be a leading edge organization in helping patients, clinicians, and policy makers make informed health decisions.

Medicare and Medicaid Programs

Medicare and Medicaid both serve as vital programs to provide health insurance for seniors, the disabled, and people of low income. HLC appreciates the effort to extend funding for entities' such as the National Quality Forum, that support quality measurement and performance improvement, and outreach and assistance for low income programs. Additionally, we support the repeal of Medicaid disproportionate share hospital reductions.

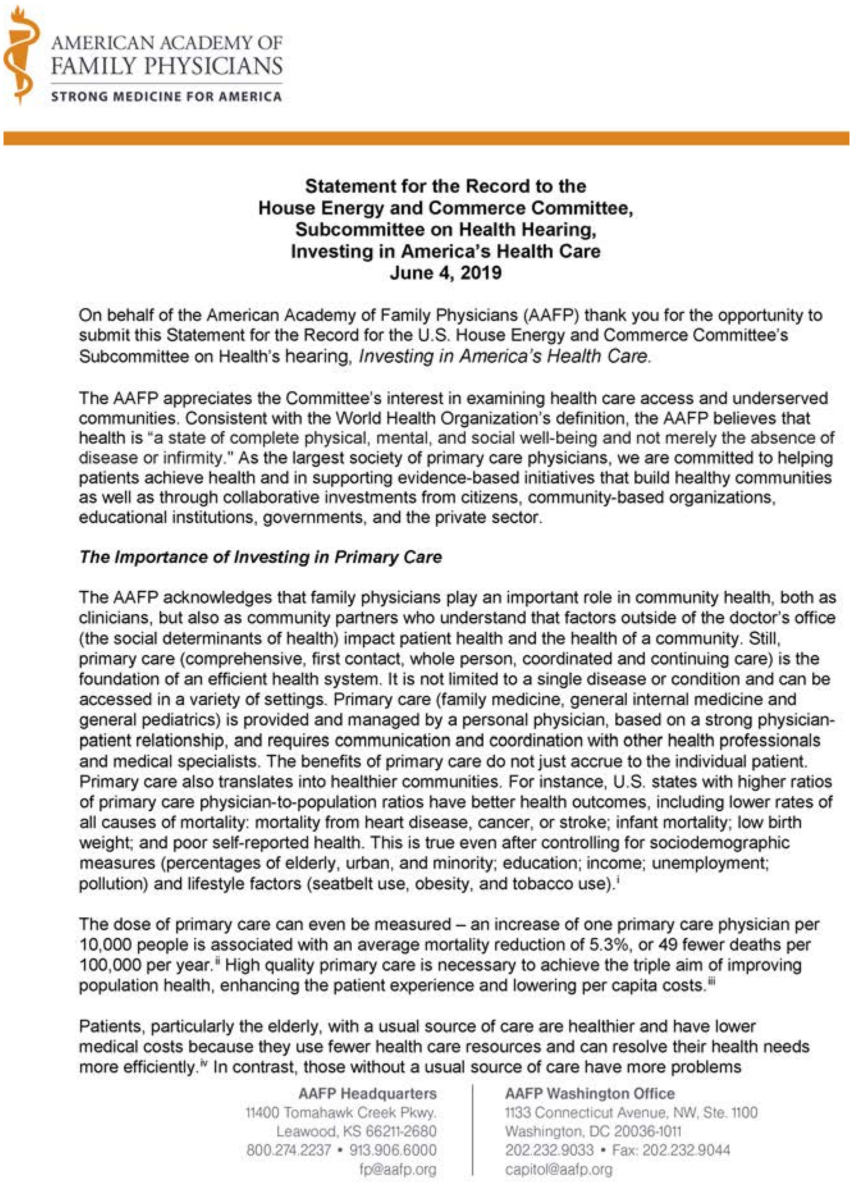
We believe that the proposed legislation is beneficial to improve the healthcare of all Americans. The extension of these programs protects individuals who need healthcare the most, specifically, high-need patients who account for over 50 percent of healthcare spending. These proposed bills will improve the overall health of high-need patients, along with reducing healthcare costs. HLC urges Congress to consider these proposed legislative bills as a solution to improve and strengthen our healthcare system going forward.

Thank you for the opportunity to comment on the proposed legislation. HLC looks forward to continuing to collaborate with you on these important issues. If you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435 or dwitchey@hlc.org.

Sincerely,

Mary R. Grealy

Mary R. Grealy
President



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Statement for the Record to the
House Energy and Commerce Committee,
Subcommittee on Health Hearing,
Investing in America's Health Care
June 4, 2019

On behalf of the American Academy of Family Physicians (AAFP) thank you for the opportunity to submit this Statement for the Record for the U.S. House Energy and Commerce Committee's Subcommittee on Health's hearing, *Investing in America's Health Care*.

The AAFP appreciates the Committee's interest in examining health care access and underserved communities. Consistent with the World Health Organization's definition, the AAFP believes that health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." As the largest society of primary care physicians, we are committed to helping patients achieve health and in supporting evidence-based initiatives that build healthy communities as well as through collaborative investments from citizens, community-based organizations, educational institutions, governments, and the private sector.

The Importance of Investing in Primary Care

The AAFP acknowledges that family physicians play an important role in community health, both as clinicians, but also as community partners who understand that factors outside of the doctor's office (the social determinants of health) impact patient health and the health of a community. Still, primary care (comprehensive, first contact, whole person, coordinated and continuing care) is the foundation of an efficient health system. It is not limited to a single disease or condition and can be accessed in a variety of settings. Primary care (family medicine, general internal medicine and general pediatrics) is provided and managed by a personal physician, based on a strong physician-patient relationship, and requires communication and coordination with other health professionals and medical specialists. The benefits of primary care do not just accrue to the individual patient. Primary care also translates into healthier communities. For instance, U.S. states with higher ratios of primary care physician-to-population ratios have better health outcomes, including lower rates of all causes of mortality: mortality from heart disease, cancer, or stroke; infant mortality; low birth weight; and poor self-reported health. This is true even after controlling for sociodemographic measures (percentages of elderly, urban, and minority; education; income; unemployment; pollution) and lifestyle factors (seatbelt use, obesity, and tobacco use).[i]

The dose of primary care can even be measured – an increase of one primary care physician per 10,000 people is associated with an average mortality reduction of 5.3%, or 49 fewer deaths per 100,000 per year.[ii] High quality primary care is necessary to achieve the triple aim of improving population health, enhancing the patient experience and lowering per capita costs.[iii]

Patients, particularly the elderly, with a usual source of care are healthier and have lower medical costs because they use fewer health care resources and can resolve their health needs more efficiently.[iv] In contrast, those without a usual source of care have more problems accessing health care and more often do not receive appropriate medical help when it is necessary.[v] Patients with a usual source of care have fewer expensive emergency room visits, unnecessary tests and procedures. They also enjoy better care coordination.[vi] We believe it is in the national interest to support programs with the potential to help improve patient access for primary medical care, particularly for vulnerable populations.

Primary Care Workforce and Health Care Programs

The current physician shortage and uneven distribution of physicians impacts population health. A U.S. Centers for Disease Control and Prevention study indicated that patients in rural areas tend to have shorter life spans, and access to health care is one of several factors contributing to rural health disparities.[vii] The report recommended greater patient access to basic primary care interventions such as high blood pressure screening, early disease intervention, and health promotion (tobacco cessation, physical activity, healthy eating).[viii] The findings highlighted in the CDC's report are consistent with numerous others on health equity, including a longitudinal study published in *JAMA Internal Medicine*, indicating that a person's zip code may have as much influence on their health and life expectancy as their genetic code.[ix] Therefore, it is imperative that primary care by a physician is accessible to all.

The current primary care physician shortage and maldistribution remain significant physician workforce challenges. An Annals of Family Medicine study projects that the changing needs of the U.S. population will require an additional 33,000 practicing primary care physicians by 2035.[x] A 2017 Government Accountability Office (GAO) report indicates that physician maldistribution significantly impacts rural communities.[xi] The patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas.[xii] According to the GAO, one of the major drivers of physician maldistribution is that medical residents are highly concentrated in very few parts of the country. The report stated that graduate medication education (GME) training has remained concentrated in the Northeast and in urban areas, which continue to house 99% of medical residents.[xiii] The GAO also indicated that while the total number of residents increased by 13.6% from 2001 to 2010, the number expected to enter primary care decreased by 6.3%.[xiv]

Current Reauthorization Priorities

Primary care workforce programs, such as the Teaching Health Center Graduate Medical Education Program and the National Health Service Corp Program, are essential resources to begin to increase the number of primary care physicians and to ensure they work in communities that need them most. The AAFP is urging Congress to act swiftly to reauthorize these programs.

The THCGME program appropriately trains residents who then stay in the community. THCGME residents are trained in delivery system models using electronic health records, providing culturally competent care, and following evidence-based care coordination protocols.[xv] Some are also able to operate in environments where they are trained in mental health, drug and substance use treatment, and chronic pain management.[xvi] Residents who train in underserved communities are likely to continue practicing in those same environments.[xvii]

We appreciate the leadership of Representatives Raul Ruiz and Cathy McMorris Rodger' and their efforts to introduce ***Training the Next Generation of Primary Care Doctors Act of 2019 (*****HR 2815.** The legislation authorizes the THCGME program for over five years and supports the creation of new programs with a priority for those in rural and underserved communities. The bills would also increase funding from $126.5 million per year (current law) to an average of $151 million/year.

The legislation not only reauthorizes the program; it provides enhanced funding and a pathway for increasing the number of residents trained. Most important, the legislation will continue to build the primary care physician pipeline necessary to reduce costs, improve patient care, and support underserved rural and urban communities. **This is an important and productive program; it must receive greater funding over a longer period in order to train residents in a sustainable fashion.. Congress should provide for the Teaching Health Center Graduate Medical Education (THCGME) program immediately to prevent a disruption in the pipeline of primary care physician production.** Given the importance of the THCGME program, permanent funding should be the ultimate outcome pursued by Congress as one part of an overall effort to assure an adequate primary care physician workforce.

American Medical Association Physician Masterfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location.[xviii] By comparison, **fewer than 5% of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas.[xix] 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 to train them in these settings.** Similarly, the National Health Service Corps (NHSC) offers financial assistance to recruit and retain health care providers to meet the workforce needs of communities across the nation designated as health professional shortage areas (HPSAs). The NHSC is vital for supporting the needs of our nation's vulnerable communities. The AAFP believes building the primary care workforce is an important return on investment. We also believe that workforce programs help ensure high quality, efficient medical care is more readily available. By reducing physician shortages and attracting physicians to serve in communities that need them, these programs also help improve the way care is delivered and help meet the nation's health care goals.

Community health centers (CHCs) play an important role in primary care graduate medical education as well. The nation's 9,800 CHCs provide care for 25 million patients, 71 percent of whom are low-income.[xx] CHC facilities, along with other safety net providers, are also 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.[xxi] Some are also able to operate in environments where they are trained in mental health, drug and substance use treatment, and chronic pain management.[xxii] Residents who train in underserved communities are likely to continue practicing in those same environments.[xxiii] An important, but unique element within the THCGME program is that its accountability measures require an evaluation of the number of physicians who continue practicing after residency and if they continue serving in rural and underserved communities.

Conclusion

The AAFP appreciates the opportunity to share these comments on health access and vulnerable communities and welcomes the opportunity to work with policy makers to achieve positive outcomes on these and other policies. For more information, please contact Sonya Clay, Government Relations Representative, at 202-232-9033 or sclay@aafp.org.

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ACHP
ALLIANCE OF COMMUNITY HEALTH PLANS

May 17, 2019

The Honorable Frank Pallone
Chairman
House Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
House Committee on Energy & Commerce
2322-A Rayburn House Office Building
Washington, DC 20515

The Honorable Richard Neal
Chairman
House Committee on Ways & Means
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
House Committee on Ways & Means
1139 Longworth House Office Building
Washington, DC 20515

Dear Chairmen Pallone and Neal and Ranking Members Walden and Brady:

I am writing to express the Alliance of Community Health Plans' (ACHP) support for reauthorization of PCORI and its funding mechanism. Over its first seven years of operation, PCORI-funded research has produced trustworthy information geared toward the kinds of questions patients and their clinicians face every day. It is one of the few organizations dedicated to helping patients and those who care for them make informed health care decisions.

As the health sector continues its evolution toward value-based care, and as consumers take a more active role in decision-making about their care, the need for scientific evidence that is meaningful and actionable has never been greater. Continued production of the kind of evidence coming out of PCORI is vital to nearly every approach for addressing the quality, cost and experiences associated with American health care.

As an association representing 24 of the nation's highest performing health plans and provider organizations, ACHP appreciates the evidence generated by PCORI. For our members – all community-based, non-profit organizations – patient-centered, publicly available and outcomes oriented research is especially critical.

ACHP has also partnered with PCORI in its work in ways that have directly benefitted the members our plans serve. Starting in 2017, with funding from the Eugene Washington PCORI Engagement Award, ACHP set out to document how community health plans disseminate timely, relevant research to enable physicians to improve care delivery and ultimately, health. The research was conducted with 21 of ACHP's member health plans and their affiliated provider organizations, all proven leaders in implementing innovations in quality of care, patient experience and affordability. The results, included in the attached report, show that when high-performing health plans collaborate closely with health systems and communities, evidence-based decision-making increases. As a result, care improves, costs go down and patients experience better outcomes. ACHP begins a new grant-funded project in collaboration with PCORI in July of this year, and will be working to disseminate evidence on innovative peer-led approaches to managing mental illness. This work will advance our plans' understanding about proven innovations in providing care that are more effective at engaging patients, achieving desired outcomes and managing costs, as well as their understanding about how to operationalize them.

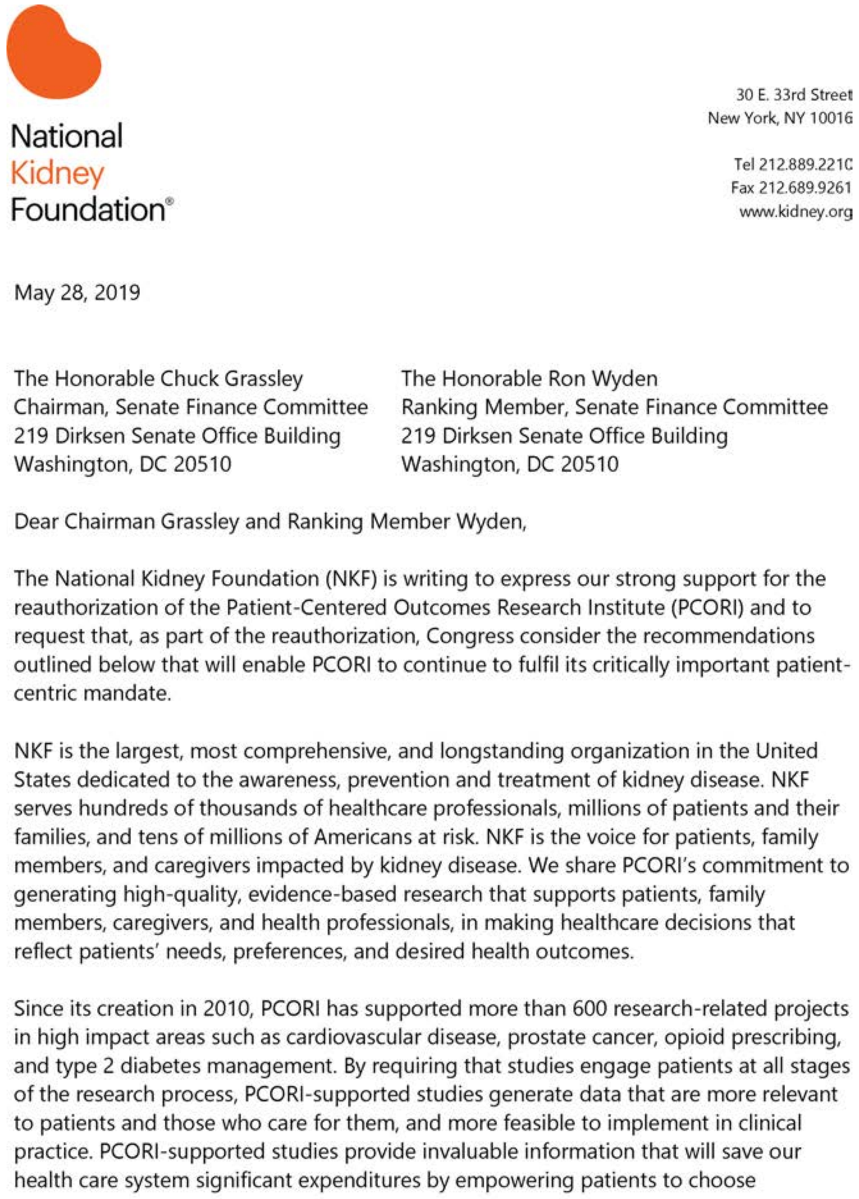
Through the creation of PCORI, Congress committed to build the evidence base for improved health decisions, seeking to empower patients and drive innovation and value in health care. While much has been accomplished, this work is far from done. To ensure that PCORI is able to continue its important research without interruption, ACHP urges Congress to reauthorize PCORI before it expires on September 30, 2019.

I would be happy to answer any questions you might have about ACHP's work with PCORI. Thank you for your time and consideration of my request.

Sincerely,

Ceci Connolly

Ceci Connolly
President and CEO



National
Kidney
Foundation®

30 E. 33rd Street
New York, NY 10016

Tel 212.889.2210
Fax 212.689.9261
www.kidney.org

May 28, 2019

The Honorable Chuck Grassley	The Honorable Ron Wyden
Chairman, Senate Finance Committee	Ranking Member, Senate Finance Committee
219 Dirksen Senate Office Building	219 Dirksen Senate Office Building
Washington, DC 20510	Washington, DC 20510

Dear Chairman Grassley and Ranking Member Wyden,

The National Kidney Foundation (NKF) is writing to express our strong support for the reauthorization of the Patient-Centered Outcomes Research Institute (PCORI) and to request that, as part of the reauthorization, Congress consider the recommendations outlined below that will enable PCORI to continue to fulfil its critically important patient-centric mandate.

NKF is the largest, most comprehensive, and longstanding organization in the United States dedicated to the awareness, prevention and treatment of kidney disease. NKF serves hundreds of thousands of healthcare professionals, millions of patients and their families, and tens of millions of Americans at risk. NKF is the voice for patients, family members, and caregivers impacted by kidney disease. We share PCORI's commitment to generating high-quality, evidence-based research that supports patients, family members, caregivers, and health professionals, in making healthcare decisions that reflect patients' needs, preferences, and desired health outcomes.

Since its creation in 2010, PCORI has supported more than 600 research-related projects in high impact areas such as cardiovascular disease, prostate cancer, opioid prescribing, and type 2 diabetes management. By requiring that studies engage patients at all stages of the research process, PCORI-supported studies generate data that are more relevant to patients and those who care for them, and more feasible to implement in clinical practice. PCORI-supported studies provide invaluable information that will save our health care system significant expenditures by empowering patients to choose treatments that work best and, by doing so, limiting adverse events such as hospitalization and multiple courses of treatment.

For the kidney community (patients, family members, caregivers, healthcare professionals, payers, government, and other stakeholders), PCORI is having an impact on the lives of approximately 30 million Americans living with the disease, including the 115,000 patients who will develop complete kidney failure each year. Chronic kidney disease is a tremendous burden for patients and the healthcare system. PCORI is helping to address this public health crisis through the support of 18 kidney comparative effectiveness studies to help patients, their families, and their providers make better-informed decisions. For example, results from a study to test interventions that improve patient access to kidney transplant may improve health outcomes for end-stage renal disease (ESRD) patients and thus reduce overall healthcare spending.

NKF strongly encourages Congress to reauthorize PCORI and in doing so, to consider the following recommendations that we believe are essential to furthering PCORI's patient-centric research mission.

Reauthorize PCORI and its current funding mechanism for at least an additional 10 years

Stability in PCORI funding is imperative for the ongoing investment in PCORI-supported research to be most impactful. Research is a long-term endeavor, and some high quality CER studies can take 4-5 years to complete. Stable funding will allow for ample time to conclude studies, disseminate the findings, develop implementation tools, and drive implementation where appropriate. Reaffirming the commitment to PCORI for another 10 years will allow the institute to build on its success in changing the culture of research to be more patient-centric, and to enhance its work in partnership with other agencies and stakeholders to support a sustainable infrastructure for disseminating and implementing research outcomes meaningfully into practice.

Continue to exclude cost-effectiveness and extend the exclusion quality-adjusted life years from PCORI-supported studies

NKF believes the reauthorization legislation should continue to specifically prohibit PCORI from conducting cost-effectiveness analyses. NKF supports PCORI's view of cost-effectiveness research, namely that it is not an outcome of direct importance of patients. NKF further requests that Congress exclude quality-adjusted life years (QALY) as a potential outcome evaluated by PCORI-supported studies. QALY is <u>not</u> a patient-centric metric and patients have a long history of opposing its use in health research. By assigning value to perfect health, QALY leads to bias and discrimination against patients with chronic conditions and/or disabilities in seeking access to care that may improve their quality of life.

NKF applauds PCORI's ongoing efforts to support promising interventions that bring together patients and those who care for them to engage in meaningful research that can improve patient outcomes while improving the efficiency of the healthcare system. **Unless Congress acts, however, all this work will cease at the end of September 2019.**

NKF looks forward to engaging with you throughout the reauthorization process. Thank you considering our recommendations.

Sincerely,

Kevin Longino	*Holly Mattix-Kramer*
Kevin Longino CEO and Transplant Patient	Holly Mattix-Kramer, MD President

cc: The Honorable Bill Cassidy
The Honorable Mark Warner
The Honorable Shelley Moore Capito
The Honorable Chris Van Hollen

Friends of pcori
reauthorization

May 13, 2019

The Honorable Frank Pallone Chairman House Committee on Energy and Commerce 2125 Rayburn House Office Building Washington, DC 20515	The Honorable Greg Walden Ranking Member House Committee on Energy and Commerce 2322-A Rayburn House Office Building Washington, DC 20515
The Honorable Richard Neal Chairman House Committee on Ways and Means 1102 Longworth House Office Building Washington, DC 20515	The Honorable Kevin Brady Ranking Member House Committee on Ways and Means 1139 Longworth House Office Building Washington, DC 20515

Dear Chairmen Pallone and Neal and Ranking Members Walden and Brady,

The undersigned are writing to express our strong support for the reauthorization of the Patient-Centered Outcomes Research Institute (PCORI). Our health care system requires solutions that are both evidence-based and patient-centered, to improve care while also addressing health care spending. PCORI is uniquely set up to meet this challenge, as it is the only organization dedicated to funding comparative clinical effectiveness research (CER) studies comparing which treatment approaches work best, for which patients, given their needs and preferences. The goal is to help health care providers and payers better understand health care treatment options and to help patients and those who care for them make better informed health and health care decisions. Delivering care that is most clinically effective and incorporates outcomes that matter to patients is both cost effective and essential to our well-being as a nation.

As of December 2018, PCORI has awarded more than $2.4 billion in grants to more than 600 research-related projects in 44 states across the U.S. In 2014, PCORI saw the first large number of research results from its funded studies reported in major medical journals. Several of these projects generated particularly promising evidence for improving care and patient outcomes in key areas, such as cardiovascular disease, prostate cancer, opioid prescribing, and type 2 diabetes management.

PCORI-funded research also supports personalized care by discouraging ineffective and low-value care. In fact, the U.S. Government Accountability Office concluded in its March 2018 report that PCORI is fulfilling its Congressional mandate to develop and promote the application of solid methodology standards for conducting trustworthy CER.

Unless Congress acts, however, all of this work will cease at the end of September 2019. To build on the momentum to date and to enable PCORI to continue its work toward achieving smarter and more efficient health care spending, we ask you to consider the following recommendations.

Reauthorize PCORI and its current funding mechanism for at least an additional 10 years.
Among PCORI's signature achievements in its first 10 years has been the creation of a new paradigm for conducting research that better integrates patient perspectives. PCORI uniquely funds patient-centered outcomes research that engages patients throughout the research process, including in the research design, so that it captures outcomes that matter to patients to improve health care decisions. This is a vitally important function, and PCORI research provides a wealth of valuable data for patients and health care providers, while also informing how the health care system can be more efficient. Research is a long-term endeavor, and some high quality CER studies can take 4-5 years to complete. Even after the completion of these studies, additional time is needed to develop and implement clinical decision support and shared decision-making tools.

For the ongoing investment in PCORI-funded research to be most impactful, stability in PCORI funding is imperative to allow ample time to conclude studies, disseminate the findings, develop implementation tools, and drive implementation where appropriate. Reaffirming the commitment to PCORI for another 10 years will allow the institute to build on its success in changing the culture of research to be more patient-centered, and to enhance its work in partnership with other agencies and stakeholders to support a sustainable infrastructure for disseminating and implementing research outcomes meaningfully into practice.

Ensure PCORI stays true to its mission of patient-centered research by maintaining its mandate to conduct comparative clinical effectiveness research.
All stakeholders agree that high-quality, evidence-based care is crucial to reducing costs in the health care system. PCORI is the only research organization dedicated to funding studies that compare care approaches to determine what works best, for whom, and under which circumstances. By providing feedback on what care is going to provide the best result to each patient, PCORI is generating invaluable information that will save our health care system significant expenditures by empowering patients to choose treatments that work best and therefore limit adverse events such as hospitalization and multiple courses of treatment.

In creating PCORI, Congress committed to build the evidence base for improved health decisions, seeking to empower patients and drive innovation and value in health care. Reauthorization is an opportunity for Congress to ensure that PCORI continues to uphold this commitment and serve the needs of an evolving health care system.

We look forward to engaging with you throughout the reauthorization process. Thank you for your consideration of our recommendations.

Sincerely,

Organizations
Academy of Managed Care Pharmacy
AcademyHealth
AfricanAmericansAgainstAlzheimer's Network
Alliance for Aging Research
American Academy of Family Physicians
American Academy of Neurology
American Academy of Pediatrics
American Association for Dental Research

American Association for Respiratory Care
American Association for the Study of Liver Diseases
American Association of Colleges of Pharmacy
American Association of Neurological Surgeons and Congress of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Association on Health and Disability
American Chiropractic Association
American College of Physicians
American College of Surgeons
America's Essential Hospitals
American Heart Association
American Liver Foundation
American Lung Association
American Medical Informatics Association
American Multiple Endocrine Neoplasia Support
American Parkinson Disease Association
American Psychological Association
American Society for Transplantation and Cellular Therapy
American Society of Hematology
American Society of Nephrology
American Thoracic Society
American Urological Association
Arthritis Foundation
Associated Medical Schools of New York
Association for Clinical and Translational Science
Association for Community Affiliated Plans
Association of American Medical Colleges
Association of American Universities
Association of Departments of Family Medicine
Association of Family Medicine Residency Directors
Association of Pathology Chairs
Association of Public and Land-grant Universities
Association of Rehabilitation Nurses
Association of Schools and Programs of Public Health
Association of University Centers on Disabilities
Asthma and Allergy Foundation of America
Better Medicare Alliance
Brain Injury Association of America
BrightFocus Foundation
Caregiver Action Network
Cedars-Sinai
Celiac Disease Foundation
Children's Hospital of Philadelphia
Cholangiocarcinoma Foundation
Cincinnati Children's Hospital Medical Center
Clinical Research Forum
Coalition for Clinical and Translational Science
Coalition for Disability Health Equity

Coalition to Transform Advanced Care (C-TAC)
Columbia University Irving Medical Center
COPD Foundation
Creighton University School of Medicine
Crohn's & Colitis Foundation
Cure HHT
Dartmouth Hitchcock Health
Davis Phinney Foundation
Digestive Disease National Coalition
Dorney-Koppel Foundation
Duke University School of Medicine
Dystonia Advocacy Network
Dystonia Medical Research Foundation
Epilepsy Association of North Carolina
Epilepsy Foundation
Families USA
FasterCures
Fight Colorectal Cancer
Friends of Cancer Research
GBS|CIDP Foundation International
Genetic Alliance
Global Healthy Living Foundation
Global Liver Institute
Go2Foundation for Lung Cancer
Harvard Medical School
Healthcare Leadership Council
Healthcare Research Associates LLC/ The S.T.A.R. Initiative
Heart Valve Voice US
Hydrocephalus Association
ICAN, International Cancer Advocacy Network
Indiana University
Infectious Diseases Society of America
International Foundation for Gastrointestinal Disorders
International Pemphigus and Pemphigoid Foundation
Interstitial Cystitis Association
Johns Hopkins University & Medicine
Lakeshore Foundation
LatinosAgainstAlzheimer's Network
Louisiana Public Health Institute
Lupus and Allied Diseases Association Inc.
Lymphatic Education & Research Network
Mended Hearts
Men's Health Network
METAvivor
Muslims for Evidence Based Healthcare
National Alliance on Mental Illness
National Alopecia Areata Foundation
National Ataxia Foundation

National Blood Clot Alliance
National Fibromyalgia and Chronic Pain Association
National Health Council
National Hispanic Medical Association
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders (NORD)
National Pancreas Foundation
National Partnership for Women & Families
National Psoriasis Foundation
NEC Society
Nemours Children's Health System
NephCure Kidney International
Neuropathy Action Foundation
NHMH - No Health without Mental Health
North American Primary Care Research Group
NYU School of Medicine
Ochsner Health System
Parkinson’s Foundation
Partners Healthcare
Partnership to Improve Patient Care
Patient-Centered Primary Care Collaborative
Phelan-McDermid Syndrome Foundation
Planetree International
Powerful Patient Inc.
Prisma Health
Project Sleep
Public Sector HealthCare Roundtable
Pulmonary Fibrosis Foundation
Pulmonary Hypertension Association
PXE International
Research!America
Restless Legs Syndrome Foundation
Scleroderma Foundation
Sleep Research Society
Society of General Internal Medicine
Society of Teachers of Family Medicine
Stanford University School of Medicine
Sterling Health IT
Sturge-Weber Foundation
The Marfan Foundaton
The Michael J. Fox Foundation for Parkinson’s Research
The Robert Larner MD College of Medicine at The University of Vermont
The Society of Thoracic Surgeons
Tulane University School of Medicine
UC San Francisco (UCSF)
University Hospitals, Cleveland, Ohio
University of Alabama at Birmingham

University of California System
University of Colorado Anschutz Medical Campus
University of Florida
University of Hawaii John A. Burns School of Medicine
University of Kansas Medical Center
University of Maryland, Baltimore
University of New Mexico Health Sciences Center
University of Pennsylvania Health System (Penn Medicine)
University of Pittsburgh
University of Virginia Health System
USCOPD Coalition
US Hereditary Angioedema Association
UW Medicine
Vanderbilt University Medical Center
Virginia Commonwealth University
Wake Forest School of Medicine
Washington University, St. Louis
Weill Cornell Medicine

PCORI Ambassadors
Bill Adams, PCORI Ambassador, Erhard, Minnesota
Peter Anderson, PCORI Ambassador, Charleston, West Virginia
Sonya Ballentine, PCORI Ambassador Chicago Health Disparities Center, Illinois
Rosie Bartel, Patient Advocate, Chilton, Wisconsin
James Beck, MD, Vice Dean for Government Affairs and Health Care Policy, Marshall University Joan C. Edwards School of Medicine, Huntington, West Virginia
Jennifer Canvasser, PCORI Ambassador, Davis, California
Martie Carnie, PCORI Ambassador, Senior Patient Experience Advisor, Center for Patients and Families, Brigham and Women's Hospital, Boston, Massachusetts
Thomas Carton, Chief Data Officer, Principal Investigator, Louisiana Public Health Institute
Matt Cheung, PCORI Ambassador, Los Gatos, California
Kimerly Coshow, PhD, PCORI Ambassador, Parkinson's Disease Patient & Research Advocate, Blue Ridge, Georgia
Maureen Fagan, PCORI Patient Experience Panelist and Chief Experience Officer, University of Miami Health System
Venus Gines, President & Founder, Dia de la Mujer Latina, Manvel, Texas
Lawrence Goldberg MD, PCORI Ambassador, Philadelphia, Pennsylvania
Regina Greer- Smith, PCORI Ambassador, Illinois
Heather Guidone, PCORI Ambassador, Atlanta, Georgia
James Harrison, PCORI Ambassador, Assistant Professor, University of California, San Francisco
Jill Harrison, Director of Research, Planetree International, Derby, Connecticut
Marcia Horn, PCORI Ambassador, Phoenix, Arizona
Matthew Hudson, Ph.D., M.P.H, Director of Cancer Care Delivery Research, Greenville, South Carolina
Wenora Johnson, PCORI Ambassador, Illinois
Leslie MacGregor Levine PhD, VMD, JD, PCORI Ambassador, advisory panel member and merit reviewer, patient advocate, Neuropathy Action Foundation, Boston, Massachusetts
Susan Lin, PCORI Ambassador, Advisory Panel member, and Merit Reviewer, Round Hill, Virginia

Donald A. McClain, Senior Associate Dean for Clinical Research Director, Clinical and Translational Science Institute, Wake Forest School of Medicine
Seth Morrison, PCORI Patient Reviewer and patient advocate, Las Vegas, Nevada
James Pantelas, PCORI Ambassador, Howell, Michigan
Maria Pellerano, PCORI Ambassador, New Brunswick, New Jersey
Philip Posner, PCORI Ambassador, Arlington, Virginia
Joan D. Powell, MDS Patient Advocate, Laguna Niguel, California
Ting Pun, PCORI Ambassador and Stanford Healthcare PFAC, Portola Valley, California
Bobbie Reed, PCORI Ambassador, Wexford, Pennsylvania
Anita Roach, M.S., PCORI Ambassador, Arlington, Virginia
Brendaly Rodriguez, MA, CPH, University of Miami Miller School of Medicine
Beverly Rogers, PCORI Ambassador, Indianapolis, Indiana
Carol Schulte, PCORI Ambassador, Red Bank, New Jersey
Norah Schwartz, Ph.D., PCORI Ambassador, San Diego, California
Sandra Sufian, Associate Professor; University of Illinois, College of Medicine and Applied Health Science
Jeff Taylor, PCORI Ambassador, Palm Springs, California
Rachelle Tepel PhD, PCORI Ambassador, Arlington, Virginia
Beverly Watkins, PCORI Ambassador, New York, New York
David White, PCORI Ambassador and Chair, Advisory Committee on Patient Engagement, Prince George's County, Maryland
Freddie White-Johnson, President & CEO, Fannie Lou Hamer Cancer Foundation Director, Mississippi Network for Cancer Control and Prevention
Ron Wincek, PCORI Ambassador, Atlanta, Georgia

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Statement for the Record
by Dr. Grayson Norquist, M.D., M.S.P.H., Chairperson, PCORI Board of Governors, on Behalf of the Patient-Centered Outcomes Research Institute (PCORI)
Hearing Before the Energy and Commerce Health Subcommittee On "Investing in America's Health"
June 4, 2019

On behalf of the Patient-Centered Outcomes Institute (PCORI), we appreciate the opportunity to submit this statement for the record in support of PCORI reauthorization and commend Chairwoman Eshoo, Ranking Member Burgess, and the Members of the Energy and Commerce Health Subcommittee for focusing on this critically important issue, including legislation recently introduced by Rep. DeGette and Rep. Beyer, H.R. 3030, which would extend PCORI's authorization. We look forward to continuing to work with the Committee in a bipartisan way to extend the work of the Institute beyond the current fiscal year.

I am Doctor Grayson Norquist, Chairperson of the Board of Governors for the Patient-Centered Outcomes Research Institute (PCORI). I am currently the Vice Chair of the Emory Department of Psychiatry and Behavioral Sciences and Chief of Psychiatry Service at Grady Health System in Atlanta. As a psychiatrist in Atlanta, I treat people every day who struggle with a range of serious mental illnesses. I have been caring for patients for almost forty years and I have practiced both in large urban areas like Atlanta and Los Angeles as well as in rural communities in the Mississippi Delta. I have treated patients from a wide range of social and economic backgrounds, including poor underserved areas as well as highly educated affluent communities. I have been a clinician, a researcher, division director at the National Institutes of Health (NIH), and held leadership positions at several major academic medical centers as well as the National Institute of Mental Health (NIMH). I have been a member of the PCORI Board of Governors for almost 9 years and served as the Chair of the Board for the past 6 years.

The patients I have cared for all have one thing in common – they are individuals in need of empathic, effective and individualized medical care. They are people with lives, families to care for, and jobs they depend on to support their families. To care for my patients and help them achieve the health outcomes that matter to them, the care I provide must begin and end with their priorities and values and incorporate their needs and perspectives. And that is PCORI's sweet spot – transforming the clinical research enterprise by putting patients, and their real-world needs, at the center of everything we do and designing research to answer real world questions that matter to patients and the physicians who care for them.

I recently treated a woman suffering from severe depression, with episodes of uncontrolled crying, detachment from her world, and feelings that she no longer wanted to live. She had times when she heard voices telling her she was a terrible and unlivable person. I knew there were multiple medications that could help improve her mood and address the occasional hallucination. But each of these medications has side effects which could potentially worsen other medical problems she suffers from. It was unclear which of these medications might work for her – given that response to an antidepressant is very individual – and whether she would benefit from, or be harmed by, an additional medication to address her hallucinations.

My patient is a wife and mother of young children whom she needs to care for and has a job she needs to maintain to help support her family. I had multiple treatment options to choose from, with a wide range of effectiveness and associated side effects of varying severity. The research studies that evaluated these treatment options were largely designed to answer questions of interest to the investigators, or to the manufacturers sponsoring the trial. They often excluded patients with multiple co-morbid conditions, like my patient, and looked at a narrow set of outcomes for the "average patient" in the trial. To achieve the best clinical outcome for my patient I needed the results of a different kind of research, research that captured and assessed the outcomes that matter to patients and include in the research design patients with a variety of co-morbid conditions.

This is, in fact, PCORI's mandate – to play this unique role the country's research enterprise. Our work over the last nine years has focused on filling the evidence gap, and providing patients and clinicians with research results that enable a shared and informed decision about the right treatment option for an individual patient – research that begins with questions that matter to patients and clinicians, that incorporates patient values and priorities in the research design, and delivers results that are useful and impactful at the point of care.

Today I want to share with you PCORI's accomplishments in providing meaningful information to empower patients and clinicians to make truly informed and individualized decisions. I will also speak to what PCORI will be able to achieve if reauthorized by Congress.

I. PCORI's Role in the Healthcare System – *Research Dane Differently*

Just like the woman in my office, patients work with their doctors and other clinicians every day to make choices about care in medical offices, clinics, and hospitals across our nation. Other healthcare stakeholders do the same. All want to know which treatment or care options might be best for individual patients, so they can make the most informed decisions possible. Too often, though, those decisions are made in the absence of complete or relevant evidence for the person who presents for help.

That's why PCORI was authorized by Congress – to fund research that fills gaps in knowledge and enables patients, working with their doctors and other clinicians, to choose the care options best for them, based on their personal circumstances, values, and desired outcomes. PCORI is there to inform the decisions that patients and clinicians make together by funding research that is relevant and responsive to their needs. At the heart of PCORI's work is our commitment to involving patients and other healthcare stakeholders, including caregivers, researchers, clinicians, insurers, health systems, policy makers, and employers, every step of the way from topic selection and research question design to dissemination of results and support for implementation and uptake into practice. We engage patients and other stakeholders in all aspects of our work and require our funded researchers do the same.

We seek to ensure we ask the right research questions, study the outcomes that matter most to patients and produce useful and relevant results that will be implemented in practice. By engaging the end users of study results throughout the research process, we are funding research that will produce results that are more likely to be used in practice. This approach is called patient-centered outcomes research, or PCOR.

II. A Robust Portfolio Designed for a High Impact

PCORI funds a robust portfolio of patient-centered outcomes research that addresses a variety of high-priority conditions and topics. Focus areas include some of the most common medical problems such as cancer, cardiovascular disease, dementia, diabetes, kidney disease, mental illness and substance abuse, multiple sclerosis, obesity, pain care and opioid abuse. Other areas of focus include specific populations, such as veterans, older adults, children, patients with rare disorders, and patients with multiple chronic conditions and advanced illnesses. Our funded research also explores new and emerging approaches to care, such as telehealth, community health workers, transitional care and other system level interventions. **Exhibit A** provides an overview of our research portfolios in each of these areas.

We also have a broad geographic reach, funding research in a wide variety of communities. Overall, we have funded more than 600 research studies across 44 states. In Texas, for example, we support the BEST-MSU Study which is comparing two ways to provide rapid brain-saving emergency care for patients who appear to be having a stroke. This research team from the Memorial Hermann Health System and Medical Center is comparing mobile stroke treatment in an ambulance with care that starts in the emergency room. Another study in Texas looked at whether a patient decision aid could provide the evidence to help heavy smokers make better and more informed decisions about lung cancer screening.

In California, the BCSC-ADVANCE Study is looking at how women can use information about breast density to improve their decisions for breast cancer screening and diagnostic testing. And in the face of the crisis in maternal mortality, PCORI is partnering with the University of California, San Francisco to compare group-based and one-on-one approaches to enhanced prenatal care in an effort to identify the best way to improve maternal and child health outcomes.

III. Hitting Our Stride and Building Momentum

PCORI has spent nine years establishing a transparent and efficient infrastructure, building trust and buy-in with stakeholders across the health sector, and developing its portfolio. We have built momentum, and exciting and practical results are coming in from our 600-plus research projects funded to this point. PCORI-funded research results are publicly available on our website, written in clear language for both professional and lay audiences. These studies have also been featured in 1,947 peer-reviewed journal articles. In addition to the 278 fully completed studies, 354 studies are still underway in our pipeline. PCORI also supports efforts to drive implementation of impactful findings into practice in real-world settings. Here are some highlights of our funded research studies that have delivered results of interest to stakeholders.

One PCORI-funded study found that programs implemented in community mental health centers can help people with serious mental illness improve the management of their health conditions and prevent later health problems. This study examined two models of behavioral health homes and found that both intervention models improved patients' quality of life, involvement in their healthcare and satisfaction with this care.

Another PCORI funded study resulted in findings that support options to reduce risky opioid prescribing. This study compared rates of opioid use in clinics in Washington State that implemented an initiative focused on encouraging and supporting more-cautious prescribing of opioid drugs with clinics that did not use such strategies. This health system-based initiative led to reductions in high-dose opioid prescribing, and importantly, patients did not report less ability to control their pain.

Yet another PCORI-funded study found that an intervention using a simple questionnaire enhanced decision making by emergency department physicians caring for patients experiencing chest pain. A questionnaire called the Chest Pain Choice was found to help people who go to the emergency department with chest pain, decide whether to immediately have follow-up tests or go home and have the tests later when they can be routinely scheduled. People who used the aid were much more likely to go home from the emergency department, with no increase in later heart-related problems and fewer out-of-pocket costs. Over five years, 9.4 million people could benefit from using this decision aid that decreases time spent in the hospital and reducing the need for unnecessary and potentially risky tests.

These are just a few examples of the real difference PCORI-funded research is making for patients, their doctors, other clinicians and the healthcare system. In a number of these studies, we found that providing care in a more patient-centered way not only improved their outcomes, but also cut down on the future use of medical resources like re-hospitalization and emergency department usage and increased time at home. In addition, other studies completed or underway will provide patients, their caregivers, and providers with evidence-based information to make decisions focused on what matters most to them and incorporating their personal preferences, values, circumstances, and the outcomes they care most about.

That's PCORI's guiding principle: putting the patient first. It is the Country's first and only independent research organization that gives everyone in the healthcare community a seat at the table, so patients—alongside clinicians, insurers, and others—drive the research agenda, identifying the questions to be studied and getting the information they need to make care decisions that are right for them.

PCORI does more than just generate new scientific results, we are also deeply engaged in disseminating these results and getting them adopted into clinical practice. Our Patient-Centered Outcomes Research Translation Center works with researchers to produce easy-to-read summaries for patients and the public describing research results and separate summaries for clinicians and researchers with study technical details and findings. We prepare Evidence Updates in concise, accessible formats and deliver them in partnership with patient organizations and others. We also work with a variety of stakeholders to communicate findings and promote their use in practice through dissemination and implementation awards.

IV. Delivering Value to Patients, Clinicians, and the Health System

Thanks to the initial Congressional investment in PCORI in 2010, today we are delivering meaningful results for patients, clinicians, payers and the broader health system. PCORI funds research that is answering critical clinical questions – different questions than those typically studied by other research funding agencies. When patients have the information needed to make more informed choices about their care, they are more likely to have improved health outcomes and avoid unnecessary treatments that could be of low value or lead to undesirable outcomes such as needing to be hospitalized or having adverse side effects.

Of course, PCORI's value should not be measured by the number of studies we fund or the reports we have published. PCORI is best measured in the ways in which we have impacted the health of patients and improved the healthcare system. We expect the results of the research we support will be used by patients, clinicians and the health system to improve decisions about health care. We believe research done differently will empower patients to obtain the health care outcomes they most desire and provide more meaningful information to clinicians as they struggle to decide what treatments are best for the patients with whom they work every day.

PCORI's work is also strengthening the wider health system in the United States, particularly as the US health system explores innovative delivery and payment methods. Our work to put the patient at the center of everything we do affects the dialogue in healthcare – shifting the focus towards patient-centered outcomes.

We are improving the efficiency and speed of conducting health research through PCORnet, a PCORI-funded initiative to enable patient-centered clinical research to be conducted on a larger scale in a more efficient manner. For example, PCORnet has just completed recruitment of 15,000 persons who are known to have heart disease for a clinical trial of the very important question of "what is the right dose of aspirin to prevent another heart attack or stroke without increasing risks for bleeding". PCORnet currently includes more than 45 large health care delivery systems and draws on clinical and electronic health record data of more than 30 million persons in the U.S. It can reach out directly to these patients and to their clinician. It is well suited to conduct both clinical trials and "big data" studies that observe how clinical outcomes occur in everyday practice across large numbers of diverse people. These are "real-world" data and come from routine care through electronic health records (EHRs), patient-reported outcomes, health claims, and other sources. By leveraging health information collected in everyday healthcare situations and settings, the evidence that PCORnet produces reflects realistic information about the comparative clinical effectiveness of therapies, diagnostics, and prevention strategies. The large size of PCORnet's database is critically important for understanding differences among patient populations, and also for identifying enough patients to allow studies of those with rare diseases, for measuring healthcare use and outcomes, and for conducting ongoing evaluations of the safety of drugs after they're approved. PCORnet unites patients, clinicians, researchers, health systems, and health plans to expedite research that can improve healthcare and patient outcomes.

V. Going Forward

The past two years have brought significant achievements to PCORI in the form of 278 completed studies that promise to change clinical practice. Today, though, I would like to speak not only to what PCORI has done since it was created in 2010, but what we are poised to do with further funding following Congressional reauthorization. During 2019, PCORI plans to invest an additional $400 million in research and other initiatives on high priority areas, including opioids and cancer, identified by patients and other stakeholders. We continue to work closely with our stakeholders to study to identify the important research questions that need to be answered by decision-makers and patients. With re-authorization of funding for PCORI, we will be able to fund larger landmark studies of innovative treatments and their health impact on patients that will provide answers to the most pressing questions facing patients and clinicians on what treatment interventions are best and inform health systems and payers on what interventions are of greatest value. This is especially true for the many new—and typically high-burden—therapies and technologies that may have the potential to revolutionize treatments for certain conditions. PCORI's style of research asks, specifically, "who" will benefit from these new treatments. PCORI will continue to take advantage of the infrastructure made available through infrastructure initiatives like PCORnet. For example, PCORI will work with the rare disease community to use the large populations available through PCORnet to advance research that can help answer questions on what works best for patients with rare diseases.

As results from many more of our funded studies become available, we will continue to focus on making those findings available to the public as widely and quickly as possible and promote the use of this information in practice. To leverage the important potential of PCORI funded research findings, we will continue to work with patients and clinicians, health plans, integrated delivery systems, employers and others to implement these research findings at the point of care and decision making. Enhancing and supporting the crucial bond between a patient and their clinician has always and will continue to be a major focus of PCORI's efforts. This is why payers and employers; physicians and patient groups support reauthorization.

PCORI was created to fund research that fills gaps in evidence on different health treatments and enables patients, working with their doctors, to choose the care options best for them, based on their personal circumstances, values, and desired health outcomes.

PCORI has spent nine years establishing a transparent and efficient infrastructure for funding patient-centered outcomes research, building trust with stakeholders across the health sector, and developing its research portfolio based on their information needs. And PCORI's research has made a real impact—demonstrating how to improve patient outcomes and increase value for patients and society —including many of our country's most pressing health care challenges, such as addressing the opioid epidemic, heart disease, mental and behavioral health, cancer, obesity, and diabetes. Importantly, PCORI funded research is all publicly available in understandable language.

Going forward, PCORI will build on that foundation to continue funding user driven research in high priority areas and supporting the decisional needs identified by patients and other stakeholders. This includes:

- **Supporting Landmark Research on Innovative Therapeutics–** As new and innovative treatments and therapies continue to be developed, PCORI is best situated to assess the health impact of those options in real-world settings to help patients make informed decisions about their choices. This is especially true when we consider the many new—and typically high-burden—therapies and technologies that potentially have great promise to revolutionize treatments for certain conditions that were previously untreatable.
- **Addressing Issues of Importance to Americans:** PCORI will continue to make significant research contributions to help answer pressing questions about best ways to treat and ameliorate the opioid epidemic, manage multiple chronic conditions so patients can have the best quality of life and independence, and addressing emerging public health needs.
- **Leveraging Real-World Data using Efficient and Re-usable Research Networks –** PCORI's investment in the Patient-Centered Outcomes Research Network (PCORnet) is leveraging real-world data to conduct research more efficiently and at much lower cost while ensuring the quality of that data is reliable. Additionally, PCORnet makes doing research on rare diseases more efficient because PCORnet represents over 30 million patients. PCORI will continue to expand our partnerships with existing databases, both public and private, such as NIH's *All of Us*, FDA's Sentinel Initiative and patient registries, to harness the power of real-world data to support research that leads to knowledge about new innovations and advances personalized and patient-centered care.
- **Advancing Patient-Centered and Value-Based Care while Improving Health Outcomes –** Unique among research funders, PCORI not only invests in patient-centered research that is user driven so that PCORI-funded research is uniquely responsive to everyday health care questions. PCORI funded research is already improving the health outcomes of patients, including those with serious mental illness and diabetes. Earlier, I described a simple decision aid can help people who go to the ER with chest pain better understand their risk of having a heart attack and decrease unnecessary hospitalizations for testing. Over five years, this could benefit 9.4

million Americans and save $4.8 billion nationwide. As more research findings become available, PCORI will continue to be a leader in making research findings available to the public and the health care system. Our investment in inventive dissemination and implementation of results and partnering with patients, clinicians, and health care systems to get the research to the right patient and the right time. PCORI will work with patients, stakeholders from across the health sector, and policymakers to advance patient-centered and value-based care through the practical implementation and use of Shared Decision Making. The time that it takes for research to make its way into practice takes a very long time and PCORI will be dedicated to shortening that period, so the research investments can have the biggest positive impact on individuals and the health care system.

Thank you for this opportunity to submit written testimony about PCORI's important work and future potential. I look forward to the day when I will have enough information to help patients like the woman I saw with depression, so they can obtain quickly the outcomes they desire from the treatments we have to offer them. I urge Congress to renew its investment in patient-centered research, so we can attain that opportunity.

EXHIBIT A

Highlights of PCORI-Funded Research Results

A growing number of PCORI-funded studies have produced important results that are being reported in leading medical journals and have the potential to improve patient care and outcomes. Here are some examples:

For Many with Type 2 Diabetes, Daily Finger Sticks Offer Little Health Benefit

People with type 2 diabetes who are not using insulin are often advised to check their blood sugar levels using daily finger sticks, which can be painful and inconvenient, as well as run up out-of-pocket costs for test strips. This study suggests that for these patients, daily self-monitoring does not help control diabetes or delay the need to start insulin compared with not doing so. Young L et al. *JAMA Intern Med*. 2017 Jul 1; 177(7).

Initiative to Reduce Risky Opioid Prescribing Works

This study compared rates of opioid use in clinics in Washington State that implemented an initiative focused on more-cautious prescribing of opioid drugs with clinics that did not use such strategies. This health system-based initiative led to reductions in high-dose opioid prescribing, and patients did not report worse pain control. Von Korff M et al. *J Pain*. 2016 Jan; 17(1).

Engaging Parents in Hospital Rounds to Ensure Patient Safety

Improving communication among patients and staff in the hospital can help reduce harmful medical errors, a leading cause of death. A PCORI-funded research team found that using a program called I-PASS, which includes parents as active participants in clinicians' rounds of pediatric units, reduced preventable adverse events by 38 percent. Landrigan C et al. *BMJ*. 2018 Dec 5; 363:k4764.

Bypass Shown to Be Most Effective Weight-Loss Surgery Procedure

This study, the largest to date to compare weight-loss surgeries, analyzed 46,000 patients' outcomes using PCORnet. Adults who had Roux-en-Y gastric bypass, a long-used approach, lost more weight and kept it off better than those who had the newest procedure, sleeve gastrectomy. Both bypass and sleeve were more effective than adjustable gastric banding. Risks of major adverse events shortly after surgery were small for all three surgeries but were highest for bypass. Arterburn D et al. *Ann Intern Med*. 2018 Oct 30;169(9).

Simple Questionnaire Enhances Shared Decision Making about Chest Pain

A questionnaire called Chest Pain Choice can help people who go to the emergency department with chest pain, but who are found to not be having a heart attack, decide whether to be admitted to the hospital for follow-up tests or go home and have the tests later. People who used the aid were much more likely to go home from the emergency department, with no increase in later heart-related problems. Hess E et al. *BMJ*. 2016 Dec 5; 355.

For Earaches and Strep Throat in Children, Narrow-Spectrum Antibiotics Are Better
Narrow-spectrum antibiotics did just as well for clearing up ear infections and sore throats caused by bacteria as more-expensive broad-spectrum antibiotics did. Broad-spectrum drugs caused more side effects, such as vomiting. Unnecessary use of broad-spectrum antibiotics is associated with increasing bacterial drug resistance. Gerber JS et al. *JAMA*. 2017 Dec 19;318(23)

Oral Antibiotics Work as Well as IV, with Fewer Costly Complications
In preventing a recurrence of infection, children discharged from the hospital after a serious bacterial infection did just as well on oral antibiotics as those sent home with an IV line to deliver antibiotics intravenously. They also had none of the frequent complications that IV lines can cause. Keren R et al. JAMA Pediatr. 2015 Feb; 169(2) Shah S et al. *Pediatrics*. 2016 Dec; 138(6) Rangel S et al. Ann Surg. 2017 Aug; 266(2).

Disadvantaged Patients with Chronic Pain Benefit from Tailored Nondrug Therapies
Chronic pain occurs more frequently in people with lower education and income levels. In this study, both cognitive behavioral therapy and pain educational material, each tailored to match patients' education levels, significantly lessened pain and improved physical function compared with usual care. These nondrug approaches can help manage chronic pain and reduce the need for opioids. These findings show such approaches can be effective in patients with low incomes and limited reading skills. Thorn B et al. *Ann Intern Med*. 2018 Apr 3;168(7).

Findings Help Men Choose among Prostate Cancer Treatment Options
Two PCORI-funded studies provided men with up-to-date information about the rates of several major side effects associated with current treatments for prostate cancer. The information applies to robot-assisted surgery and newer forms of radiation therapy, as well as active monitoring instead of immediate treatment. These results will help men with prostate cancer and their families better weigh the benefits and risks of each treatment in consultation with their clinicians. Barocas D et al. JAMA. 2017 Mar 21; 317(11) Chen R et al. *JAMA*. 2017 Mar 21; 317(11).

Blood Thinner Keeps Stroke Survivors in Their Homes
Using the blood thinner warfarin helped stroke survivors reduce future hospitalizations and stay in their homes—on average 46 more days at home over two years — compared with those who didn't take the drug after being discharged from the hospital. The drug also lowered the rates of stroke recurrence and heart attack, but staying at home rather than having to go to a nursing home or hospital was the outcome that mattered most to patients. Xian Y et al. BMJ. 2015; 351 O'Brien EC et al. *Circulation*. 2015 Oct 13; 132 (15).

Shared Decision Making Helps Decisions Related to Advanced Heart Failure
Surgically implanting a left ventricular assist device (LVAD) can prolong the lives of people with end-stage heart failure. But the surgery and device carry significant risk for harms, such as infections and stroke. Using a shared decision-making tool improved patients' knowledge about the potential benefits and risks of an LVAD compared with typical educational pamphlets. The

aid also helped them make initial decisions better aligned with their values. Allen LA et al. *JAMA Intern Med*. 2018 Apr 1; 178(4).

Behavioral Health Homes Improve Outcomes for People with Mental Illness
Behavioral health homes, a patient-centered way of coordinating care for patients with both mental and physical health needs, can help people with serious mental illnesses manage their conditions and possibly live longer, healthier lives. Two ways of providing a behavioral health home—a patient self-directed approach and a healthcare provider-supported approach—both significantly increased patients' knowledge and confidence to manage their own care and increased their engagement in care, but the provider-supported approach did so faster. Schuster J et al. *Health Aff*. 2018 Feb; 37(2).

CAFM Council of Academic Family Medicine

Society of Teachers of Family Medicine
Association of Departments of Family Medicine
Association of Family Medicine Residency Directors
North American Primary Care Research Group

Statement for the Record

House Energy and Commerce Subcommittee on Health

Investing in America's Health Care

June 4, 2019

The member organizations of the Council of Academic Family Medicine (CAFM) represent teachers of and researchers in family medicine. In anticipation of the upcoming hearing on "Investing in America's Health Care" there are two programs for which we would like to share our views and opinions: Teaching Health Centers (THC) Graduate Medical Education Program and the Patient Centered Outcomes Research Institute (PCORI). We ask that this be included in the statement record of the hearing.

Teaching Health Centers:
We are pleased to have worked with Congressmen Raul Ruiz (D-CA) and Cathy McMorris Rodgers (R-WA) as they developed HR 2815, to reauthorize section 340H of the Public Health Service Act to continue to encourage the expansion, maintenance, and establishment of approved graduate medical residency programs at qualified teaching health centers, and for other purposes. The Teaching Health Center Graduate Medical Education (THCGME) program will expire on September 30, 2019, and we applaud the committee for holding a hearing on reauthorizing this and other programs today. We hope the committee will quickly reauthorize the THCGME program by passing HR 2815.

This legislation is an important step to providing sustainable funding and growth for a critical program that helps address the primary care physician shortage in our country. We appreciate this committee's leadership and the leadership of Congressmen Ruiz and McMorris Rodgers on this issue and give our whole-hearted support for the legislation. To help sustain this important graduate medical education program this legislation provides suitable funding for current Teaching Health Center Graduate Medical Education (THCGME) programs to help address the crisis-level shortage of primary care physicians. The funding level included in the bill will allow for a per resident amount to be paid for training that is on par with the Heath Resources and Services Administration (HRSA) funded study[1] identifying a median cost of approximately $157,600 per trainee. It allows for programs to regain previous losses of residency positions due to lower funding levels and instability. We are particularly pleased that the legislation would provide a five year reauthorization, giving the program some much needed financial stability.

In addition, we are gratified that the proposed legislation supports and funds the creation of new programs and/or centers. Evidence shows that the THC program graduates are more likely to practice in rural and medically underserved communities. Recognizing the importance of growing this successful program to help address geographic maldistributions of physicians across the country is significant.

To all observers, the program has been an outstanding success! Its purpose was to help address the crisis-level shortage of primary care physicians, especially in rural and medically underserved communities. Since the THCGME program began, 880 new primary care physicians and dentists that represent an expansion over and above current training caps have graduated and entered workforce. HRSA notes that "As the national average of physicians going into primary care is approximately 33 percent, [we know it is much smaller] the THCGME

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[1] https:/ / bhw.hrs a.gov/ sites/ default/ files/ bhw / grants/ thc-costing -fact-sh eet.pdf

Hope R Wittenberg
Director, Government Relations
1133 Connecticut Ave. NW, Suite 1100 Washington, DC 20036 Ph: 202.986.3309 Fax: 202.232.9044 hwittenberg@stfm.org

program has evidenced much stronger results.[2]" Data show 64 percent of graduates are currently practicing in a primary care setting and approximately 58 percent are currently practicing in a MUC and/or rural setting.

We believe there are four areas of concern that HR 2815 addresses: 1) the lack of opportunity to bring new centers or programs into the THC program since 2015, 2) the need for additional funding to allow for current programs to "backfill" up to their previously approved number of FTEs, 3) the need for appropriate funding to allow for increased costs of training since 2010 when the program began, and 4) the need for a lengthier reauthorization of five years. This last piece is critically important to increasing the stability of the program.

Without quick legislative action, the expiration of this vital program would mean an exacerbation of the primary care physician shortage and a lessening of support for training in underserved and rural areas. This committee has been instrumental in keeping this program alive. We are grateful for its exceptional leadership in supporting and sustaining this vital program by holding this hearing and hopefully shepherding this bill toward enactment.

Patient Centered Outcomes Research Institute (PCORI)

Like the Teaching Health Center program, the authorization for the PCOR Trust Fund and PCORI is set to expire on September 30, 2019. The CAFM organizations support PCORI for several reasons.

PCORI is the principal federal organization that supports patient-centered research. Their mandate includes participatory research and patient engagement both of which are prime goals of primary care research. NAPCRG was the first high-level research organization to adopt a policy promoting [participatory research] PR[3] with its adoption of the 1998 Policy Statement on Responsible Research with Communities. It continues its efforts to promote such research and train researchers in the latest and most appropriate methodologies for participatory research and patient engagement. The funding and support for this work by PCORI is fundamental as our health system moves more toward value-based and patient-centered care.

PCORI funds research that supports engaging patients and community members to prioritize their research agenda, and make sure the research is relevant. As such, they require research teams to keep patients and community stakeholders engaged throughout the research process. This assures their work is truly patient-centered. Their first decade has them on track to continue to do excellent work, and we hope this committee can support its continued work in this area in the coming years.

As we look to the future, as PCORI is reauthorized, we would like to see more attention paid by PCORI to primary care. Data show that much of PCORI's research, while patient-centered, has focused on rare diseases, rather than on the place where most people get most of their care, most of the time – in primary care settings. A recent study by Balster, Merenstein et al. shows that, while over half of all physician visits occur in primary care, only about one-quarter of PCORI trials had any relation to primary care, and less than one-third of the $1.1 billion

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[2] https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/program-highlights/2018/teaching-health-center-graduate-medical-education-program-2018.pdf

[3] *Family Practice*, Volume 34, Issue 3, 1 June 2017, Pages 256–258 https://doi.org/10.1093/fampra/cmw117

investment in PCORI is applicable to primary care patients[4]. We have had many communications with PCORI leadership over the years to try to move them toward more recognition of the needs of primary care research. They have been receptive to our concerns, but we would like to see more action in this regard. We would like to see PCORI's work align more fully with the needs of the millions of Americans who access primary care every day.

Lastly, a portion of the PCOR trust fund is designated for the Agency for Health Care Research and Quality (AHRQ). This funding makes up approximately a quarter of AHRQ's annual budget and has been instrumental in supporting clinical primary care research within the Agency. AHRQ has proved to be uniquely positioned to support best practice primary care research and to help disseminate the research nationwide. However, reduced levels of AHRQ funding in the past have exacerbated disparities in funding primary care research. Important primary care research initiatives have been unfunded in recent years such as research for patients with Multiple Chronic Conditions (MCC) and the statutorily authorized Center for Primary Care Research. Funding from the PCOR trust fund has been able to help address some of the shortfall in funding and we are concerned that should the PCOR trust fund not be reauthorized that other, critical primary care research support will go unfunded and unsupported, leaving a lack of development of new knowledge to help primary care physicians address the needs of their patients.

On behalf of the organizations which make up the Council of Academic Family Medicine, the North American Primary Care Research Organization, the Society of Teachers of Family Medicine, the Association of Departments of Family Medicine and the Association of Family Medicine Residency Directors, we applaud the Committee for holding today's hearing and hope the committee will quickly move to pass HR 2815, which reauthorizes the Teaching Health Center Graduate Medical Education Program, and to reauthorize the Patient Centered Outcomes Research Institute and the trust fund that supports it.

For more information or should you have any questions regarding this statement, please feel free to contact Hope R. Wittenberg, CAFM Director of Government Relations, at hwittenberg@stfm.org or 202-986-3309.

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[4] J Gen Intern Med DOI: 10.1007/s11606-019-04990-z https://link.springer.com /article/10.1007/s11606-019-04990-z

Leadership Council
of Aging Organizations

Richard J. Fiesta, Chair

May 14, 2019

The Honorable Richard Neal, Chairman
The Honorable Kevin Brady, Ranking Member
House Ways and Means Committee
Washington, DC 20515

The Honorable Frank Pallone, Chairman
The Honorable Greg Walden, Ranking Member
House Energy and Commerce Committee
Washington, DC 20515

Dear Chairman Neal, Ranking Member Brady, Chairman Pallone and Ranking Member Walden:

The undersigned members of the Leadership Council of Aging Organizations (LCAO) are writing to urge you to include in the fall "Extenders Package" a provision to make funding permanent for Medicare outreach and enrollment efforts to low-income beneficiaries, and increase annual funding from $37.5 to $50 million.

Low-income seniors and people with disabilities living on fixed incomes are often forced to make difficult trade-offs—cutting back on necessary medications and doctor visits in order to afford basic living necessities—to the detriment of their health and well-being. Federal outreach and enrollment efforts, originally authorized under the 2008 Medicare Improvements for Patients and Providers Act (MIPPA), enable many of our nation's most vulnerable, low-income Medicare beneficiaries to access assistance for prescription drug coverage and other essential health programs for which they are eligible. These seniors and people with disabilities on Medicare generally have annual incomes below $18,735 and non-housing assets of less than $12,890. They need help in affording rising health care costs, but, in many cases, are not getting that needed assistance:

- Almost 3 million Medicare beneficiaries eligible for the Part D Low-Income Subsidy (LIS/Extra Help) are <u>not enrolled</u>. The LIS/Extra help program helps low-income beneficiaries pay for their rising prescription drug costs and is valued by the Social Security Administration at saving beneficiaries an average of $4,900 a year. **Improving enrollment in this important program is a critical component toward reducing out-of-pocket prescription drug costs for those who can least afford them.**
- <u>Less than half</u> of eligible low-income beneficiaries receive help for assistance paying Medicare Part B monthly premiums ($135.50 in 2019) through a Medicare Savings

Program (Qualified Medicare Beneficiary [QMB] Program, Specified Low-Income Medicare Beneficiary [SLMB] Program, and Qualifying Individual [QI] Program).

- A rapidly growing Medicare-eligible population, increasing amounts of debt among seniors (especially for medical expenses), and a retiree savings shortfall highlight the increased need for these assistance programs.

Recognizing the growing need for low-income assistance as 10,000 Americans turn 65 every day, Section 208 of the 2015 Medicare Access and CHIP Reauthorization Act (MACRA) include a modest but important increase in annual funding for these outreach and enrollment activities from $25 million to $37.5 million for FY16 and FY17, which continued through the Bipartisan Budget Act (BBA) for FY18 and FY19. In further recognition of these continuing needs and challenges, we request a similar modest increase in annual funding going forward, from $37.5 million to $50 million.

Previous allocations for these critical low-income outreach and enrollment activities have led to important, proven results. MIPPA resources have enabled state-agency partners and community-based organizations to:

- Assist 2.5 million individuals in need;
- Increase the number of low-income Medicare beneficiaries enrolled in the Medicare Savings Programs from 6.4 million in 2008 to 9 million as of June 2018;
- Support a network of 87 Benefits Enrollment Centers (BECs) in 43 states through grants from National Council on Aging's (NCOA) National Center for Benefits Outreach and Enrollment (Center); and
- Target rural communities and other high-need, hard-to-reach populations to improve access to help with rising Medicare prescription drug costs.

Resources for these Medicare low-income outreach and enrollment efforts has been shared among State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the Center. In addition to providing technical assistance to the grantees, the Center offers competitive grants of up to $100,000 to develop state and local BECs to support and identify the most innovative, cost-effective, person-centered outreach and enrollment strategies for low-income beneficiaries, which can be replicated by many entities.

Additional, stable funding will enable organizations to dedicate sufficient resources and permanent staff to accomplish their goals. Static short-term allocations and looming funding expirations have failed to provide the assurances needed to hire full-time staff and degrades the year over year stability necessary to conduct effective outreach.

The infrastructure to successfully continue this work, including processes and a trained workforce, already exists. But without sufficient reliable funding, these efforts to assist disadvantaged Medicare beneficiaries will be unable to serve the growing number of seniors and people with disabilities unable to afford and access needed health care.

MIPPA funding offers a significant return on investment in local communities. Assisting low-income beneficiaries to receive the extra help they are eligible for enables them to spend those extra dollars at local pharmacies, grocery stories, and providers to quickly meet their needs, which has a multiplier effect on the economy.

We urge you to support permanent, annual funding of $50 million for low-income outreach and enrollment activities that provide critical supports to maintain and improve the health and financial well-being of Medicare beneficiaries with the greatest needs.

Sincerely,

AARP
AFL-CIO
Aging Life Care Association
Alliance for Aging Research
Alliance for Retired Americans
AMDA: The Society for Post-Acute and Long-Term Care Medicine
American Association of Service Coordinators
American Society on Aging
Association for Gerontology and Human Development in HBCU's
Caring Across Generations
Center for Medicare Advocacy
Community Catalyst
Easterseals
International Association for Indigenous Aging
The Jewish Federations of North America
Justice in Aging
LeadingAge
Lutheran Services in America
Medicare Rights Center
National Academy of Elder Law Attorneys (NAELA)
National Adult Day Services Association (NADSA)
National Adult Protective Services Association
National Alliance for Caregiving
National Association for Home Care and Hospice
National Association of Nutrition and Aging Services Programs (NANASP)
National Association of Social Workers (NASW)
National Association of States United for Aging and Disabilities (NASUAD)
National Committee to Preserve Social Security and Medicare (NCPSSM)
National Consumer Voice for Quality Long-Term Care
National Council on Aging (NCOA)
National Caucus and Center on Black Aged (NCBA)
PHI
Program to Improve Care, Altarum

The Gerontological Society of America
WISER

CHILDREN'S HOSPITAL ASSOCIATION

Champions for Children's Health

Children's Hospital Association Statement for the Record

Energy and Commerce Health Subcommittee Hearing
"Investing in America's Health Care"
June 4, 2019 — 10:00 a.m.

The Children's Hospital Association thanks the Subcommittee for holding this hearing which, among other topics, will examine the importance of Medicaid disproportionate share hospital (DSH) payments. Medicaid DSH payments are vital to children's hospitals and their ability to care for all children. Without congressional action, major cuts to the DSH payment program will occur Oct. 1, 2019. We call on Congress to protect patient access to care and ensure that these cuts do not take effect as scheduled.

Congress created the Medicaid DSH program to provide financial help to hospitals that treat large numbers of Medicaid and uninsured patients. The program has been, and will continue to be, crucial in helping children's hospitals address Medicaid underpayment.

Medicaid is the single largest health insurer for children in the United States, covering 37 million children in a year. The Children's Health Insurance Program (CHIP) covers an additional 9 million. Together, Medicaid and CHIP are the foundation of our national commitment to providing coverage and access to care for children.

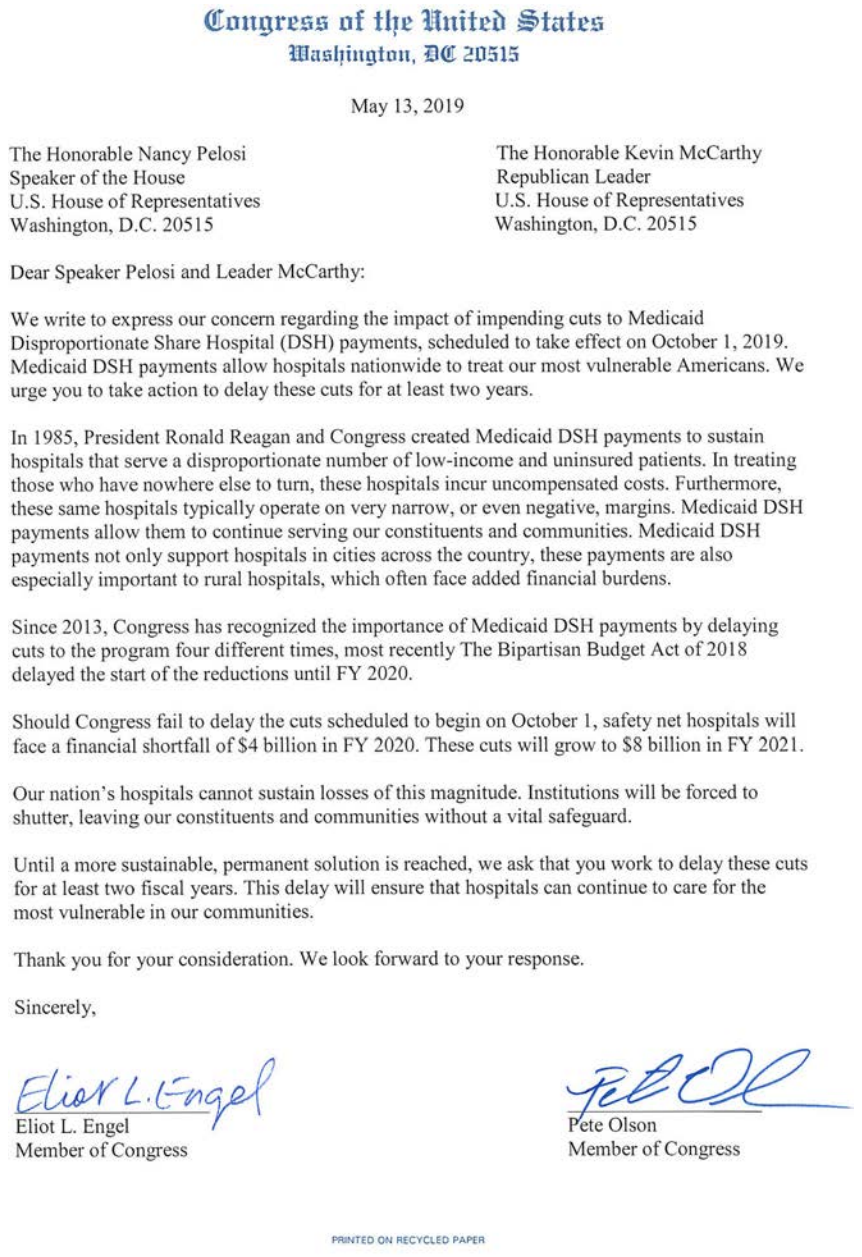
Children's hospitals are major Medicaid providers. Although they account for less than 5% of all hospitals, children's hospitals care for almost half of all children in the nation who require inpatient care. The majority of these children's hospitals' patients are covered by Medicaid.

Medicaid DSH payments supplement inadequate Medicaid reimbursement to children's hospitals. Including DSH payments, Medicaid reimburses children's hospitals an average of only 80% of the costs of providing care; Medicaid reimbursement to children's hospitals would fall even lower without vital DSH payments. These payments help children's hospitals sustain specialized pediatric care services and training programs that benefit all children.

In short, Medicaid DSH payments are important for the viability of children's hospitals across the country and their ability to care for our nation's children. We call on Congress to put patient care first and ensure DSH cuts do not take effect later this year as scheduled.

Additionally, we thank the Subcommittee for examining a number of necessary reauthorizations for key programs, including Community Health Centers, Family to Family Health Information Centers, and the Certified Community Behavioral Health Clinics and Community Health Center demonstration program. We look forward to working with Congress to ensure that these and other programs continue to serve children and families well.

Contact us: public.policy@childrenshospitals.org
600 13th St., NW | Suite 500 | Washington, DC 20005 | 202-753-5500
16011 College Blvd. | Suite 250 | Lenexa, KS 66219 | 913-262-1436
www.childrenshospitals.org | © Children's Hospital Association



Congress of the United States
Washington, DC 20515

May 13, 2019

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kevin McCarthy
Republican Leader
U.S. House of Representatives
Washington, D.C. 20515

Dear Speaker Pelosi and Leader McCarthy:

We write to express our concern regarding the impact of impending cuts to Medicaid Disproportionate Share Hospital (DSH) payments, scheduled to take effect on October 1, 2019. Medicaid DSH payments allow hospitals nationwide to treat our most vulnerable Americans. We urge you to take action to delay these cuts for at least two years.

In 1985, President Ronald Reagan and Congress created Medicaid DSH payments to sustain hospitals that serve a disproportionate number of low-income and uninsured patients. In treating those who have nowhere else to turn, these hospitals incur uncompensated costs. Furthermore, these same hospitals typically operate on very narrow, or even negative, margins. Medicaid DSH payments allow them to continue serving our constituents and communities. Medicaid DSH payments not only support hospitals in cities across the country, these payments are also especially important to rural hospitals, which often face added financial burdens.

Since 2013, Congress has recognized the importance of Medicaid DSH payments by delaying cuts to the program four different times, most recently The Bipartisan Budget Act of 2018 delayed the start of the reductions until FY 2020.

Should Congress fail to delay the cuts scheduled to begin on October 1, safety net hospitals will face a financial shortfall of $4 billion in FY 2020. These cuts will grow to $8 billion in FY 2021.

Our nation's hospitals cannot sustain losses of this magnitude. Institutions will be forced to shutter, leaving our constituents and communities without a vital safeguard.

Until a more sustainable, permanent solution is reached, we ask that you work to delay these cuts for at least two fiscal years. This delay will ensure that hospitals can continue to care for the most vulnerable in our communities.

Thank you for your consideration. We look forward to your response.

Sincerely,

Eliot L. Engel
Eliot L. Engel
Member of Congress

Pete Olson
Member of Congress

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Donald M. Payne, Jr.
Member of Congress

Alan Lowenthal
Alan Lowenthal
Member of Congress

Vicente Gonzalez
Member of Congress

Debbie Mucarsel-Powell
Member of Congress

Debbie Dingell
Debbie Dingell
Member of Congress

Bradley Byrne
Member of Congress

Madeleine Dean
Madeleine Dean
Member of Congress

Josh Harder
Josh Harder
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Daniel T. Kildee
Dan Kildee
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Jimmy Panetta
Member of Congress

Gottheimer
Josh Gottheimer
Member of Congress

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Charlie Crist
Charlie Crist
Member of Congress

Michael Waltz
Michael Waltz
Member of Congress

Val B. Demings
Val Demings
Member of Congress

Ro Khanna
Member of Congress

Dan Scott
David Scott
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Haley M St
Haley M. Stevens
Member of Congress

Andy Levin
Andy Levin
Member of Congress

Alexandria Ocasio-Cortez
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Jesús G. "Chuy" García
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Deb Haaland
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Joseph Morelle
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Member of Congress

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Member of Congress

Jimmy Gomez
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Kurt Schrader
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Greg Stanton
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A. Donald McEachin

A. Donald McEachin
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Ralph Norman
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Glenn GT Thompson

Glenn "GT" Thompson
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Jared Golden
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Member of Congress

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John Rose
Member of Congress

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Cheri Bustos
Member of Congress

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Abigail D. Spanberger
Member of Congress

Anthony G. Brown
Member of Congress

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Joe Neguse
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Brad Schneider
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Dusty Johnson
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Member of Congress

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Member of Congress

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Member of Congress

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Ted S. Yoho, DVM
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Ken Calvert
Member of Congress

Tom Reed
Member of Congress

Joyce Beatty
Joyce Beatty
Member of Congress

Don Young
Don Young
Member of Congress

Joe Courtney
Joe Courtney
Member of Congress

Chris Smith
Christopher H. Smith
Member of Congress

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Rosa L. DeLauro
Member of Congress

Austin Scott
Austin Scott
Member of Congress

Rick Crawford
Member of Congress

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K. Michael Conaway
K. Michael Conaway
Member of Congress

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Steve Watkins
Member of Congress

John Carter
Member of Congress

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Kay Granger
Member of Congress

Hank Johnson
Henry C. "Hank" Johnson, Jr.
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Tom Malinowski
Member of Congress

Tim Burchett
Member of Congress

Mike Kelly
Mike Kelly
Member of Congress

Chrissy Houlahan
Chrissy Houlahan
Member of Congress

Jennifer Wexton
Member of Congress

Blaine Luetkemeyer
Member of Congress

Michael Cloud
Michael Cloud
Member of Congress

Mike Simpson
Member of Congress

Xochitl Torres Small
Member of Congress

Dan Newhouse
Dan Newhouse
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Don Bacon
Don Bacon
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David E. Price
Member of Congress

Alma Adams
Alma S. Adams, Ph.D.
Member of Congress

Joe Cunningham
Member of Congress

John P. Sarbanes
Member of Congress

G.K. Butterfield
Member of Congress

AMERICA'S
ESSENTIAL
HOSPITALS

Statement for the Record
House Committee on Energy and Commerce
Subcommittee on Health
"Investing in America's Health"
June 4, 2019

America's Essential Hospitals appreciates the opportunity to submit a statement for the record as the committee considers legislation to invest in America's health. The association is pleased the committee is considering H.R. 3022, the Patient Access Protection Act, to repeal damaging reductions in Medicaid disproportionate share hospital (DSH) payment allotments to states.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to providing high-quality care to all. Our 300 hospitals and health systems form the very fabric of the nation's health care safety net. They care for vulnerable people and anchor communities across the country, from the largest cities to expansive rural regions. They are sources of lifesaving care, jobs, and vital public health services that influence the social, economic, and environmental circumstances of a person's life. Essential hospitals serve communities where need is greatest and in areas that might otherwise lack health care access. They reach outside their walls to care for communities where 23.9 million people live below the federal poverty line, 17.1 million lack health insurance, 10 million have limited access to nutritious food, and 360,000 are homeless. In 2017, three-quarters of patients at essential hospitals were uninsured or covered by Medicaid or Medicare. Commercial insurance covered only about a quarter of inpatient discharges and outpatient visits in 2017.

These hospitals often are their community's largest employer. The average essential hospital employs more than 3,000 people and, through its spending, drives more than $1 billion in statewide economic output. These 300 hospitals alone house 31 percent of the nation's level I trauma centers and 39 percent of burn-care beds. They also train an average of nearly 240 physicians annually, more than three times that of other U.S. hospitals.

Embracing this mission comes with a cost, and our member hospitals depend on every available source of federal support. Essential hospitals provided approximately $6.7 billion of uncompensated care in 2017, or nearly 17.4 percent of all uncompensated hospital care nationally. That number includes $5.5 billion in charity care, or about 23 percent of all charity care across the country. This explains, in part, why members of America's Essential Hospitals operate with margins just one-fifth that of other U.S. hospitals—1.6 percent versus 7.8 percent, respectively.

In March 2011, the Congressional Budget Office estimated that 21 million people would be uninsured in 2017. U.S. Census data now puts that number at 28.5 million. Additionally, Medicaid expansion has not lived up to expectations for changing uncompensated care costs. In its report to Congress this spring, the Medicaid and CHIP Payment and Access Commission estimated that although uncompensated care costs decreased in 2014, the first year of Medicaid expansion, Medicaid shortfalls—the difference between what Medicaid pays and a hospital's true costs—rose at a higher rate. In that year, uncompensated care costs declined by only $1.6 billion, while Medicaid shortfalls rose by $4 billion. Hospitals are losing ground, even with greater access to coverage.

Congress established Medicaid DSH to partly offset the high uncompensated costs essential hospitals sustain caring for a disproportionate number of Medicaid and low-income patients and providing public health and social services to their patients and the wider community. However, essential hospitals now are staring down a $4 billion cut to Medicaid DSH payments in fiscal year (FY) 2020—a third of annual program funding—and $8 billion in FY 2021. Unless Congress acts, the $4 billion cut October 1 would undermine this important work and put access to care and lifesaving services at risk in struggling communities across the country. In fact, without Medicaid DSH, essential hospitals have an average operating margin of *negative* 3 percent, likely forcing them to cut services, programs, and jobs. The effect of the cuts would ripple far beyond an essential hospital's walls.

This is not the first time essential hospitals have faced severe threats to Medicaid DSH funding. However, Congress has recognized the harm DSH cuts could inflict on America's health care safety net and, with bipartisan votes, delayed these cuts four times:

- The Bipartisan Budget Act of 2013 delayed the cuts until 2016;
- The Protecting Access to Medicare Act of 2014 delayed the cuts until 2017;
- The Medicare Access and CHIP Reauthorization Act of 2015 delayed the cuts until 2018; and
- The Bipartisan Budget Act of 2018 delayed the cuts until 2020.

The need for similar bipartisan action this year is urgent: The October 1 cut would hit hospitals already weakened by two years of sharp reductions in Medicare payments for care at off-campus outpatient clinics. These so-called "site-neutral" cuts created new financial pressures that, combined with rising uncompensated care costs, leave no cushion to absorb Medicaid DSH cuts.

We call on Congress to act now to stop these damaging cuts. Essential hospitals struggle with high uncompensated care costs, Medicaid payment shortfalls, and ongoing Medicare payment reductions—they could not withstand additional deep cuts to a critical funding source. The Medicaid DSH cuts would put millions of Americans at risk of losing access to health care services.

America's Essential Hospitals appreciates the opportunity to submit a statement for the record on this vital issue. The association looks forward to working with the committee to find a sustainable solution to ending the Medicaid DSH reductions.

Texas Parent to Parent

Providing support and information for families of children
with disabilities, chronic illness and other special health care needs

February 6, 2019

The Honorable Michael Burgess, MD
United States House of Representatives
Washington, DC 20515

Dear Representative Burgess,

I understand there will be a hearing before the Energy & Commerce Health Subcommittee on June 6, and that one of the subjects of the hearing will be the Family-to-Family Reauthorization Act of 2019 (H.R. 2822). As the Executive Director of the Family-to-Family Health Information Center (F2F) in Texas, I would like to provide you with some information about our F2F, Texas Parent to Parent.

Texas Parent to Parent (TxP2P) is a free-standing family-led nonprofit organization and an affiliate of the national organizations, Family Voices and Parent to Parent USA, located in Austin. We serve over 8,000 families across the state. Our federal grant is $95,000 per year.

Like other F2Fs, we are staffed by family members of children or youth with disabilities, chronic illness and children with special health care needs (CYSHCN) and young adults with disabilities. My son was born at 24 weeks gestation, 33 years ago. As a physician, you know the odds for a 24-weeker that long ago. Fortunately, my boy surprised everyone and not only survived, but thrived and only has mild Cerebral Palsy and learning difficulties. He even got his Texas driver's license. Unfortunately, most families are not this fortunate. Because of all we went through (6 months in the NICU, another 8 months of medical fragility, etc.), I knew I needed to help other families by the time he was 3-years-old. I have worked in family support for 30 years now.

Our F2F assists families whose children have special health care needs or disabilities of any sort, including developmental disabilities, serious or chronic health conditions and mental illness. We help them navigate the complex health care system so they can get the care their children need and find ways to cover the often very-high costs of that care. We serve families in a culturally and linguistically appropriate manner, and reach out to underserved communities. We have four Spanish bilingual staff. We also serve military families and have done some outreach to Ft. Hood.

Examples of assistance we have provided:

> TxP2P provides one statewide 2-day conference and three 1-day conferences, with local partners, across the state each year using funding from our F2F grant. We had one in Fort Worth for the past seven years. We had 75 to 175 parents and professionals attend over the years with some great speakers, both parents and professionals. We provide specialized child care, Sibshop

and lunch during the conferences. Here is what some of the parents had to say about the conference:

-*Thank you for not having a cost associated with these conferences!!! Great exhibitors and speakers.*

-*As an educator, I enjoy coming to these conferences. Keep up the good work.*

-*This event always delivers on information and resources. Good networking opportunity.*

-*The event was very informed and obtain a wealth of knowledge*

We are also available each workday to help families on the phone and email with insurance concerns, information on caring and advocating for their child, helping a new parent navigate their stay in the NICU or finally coming home with their baby, getting healthcare assistance in schools, etc. All our families receive information on the services available to their children, including the Medicaid waivers. We also have 40+ social media venues for parents who wish to communicate that way.

TxP2P also has a transition program, Pathways to Adulthood, for parents whose children are reaching 14-years-old or over. We provide a 1-day training covered the pertinent topics parents need to consider in transition, including what to do when school ends, insurance and financial issues, where will your child live, work and play, etc. We take this across the state to help families prepare for a transition to a good life for their young adult.

We are also available to assist congressional caseworkers when they are contacted by constituents trying to secure assistance for their children with special health care needs. Another excellent resource is the state website, Navigate Life Texas. TxP2P also assists with resources and family stories on this website.

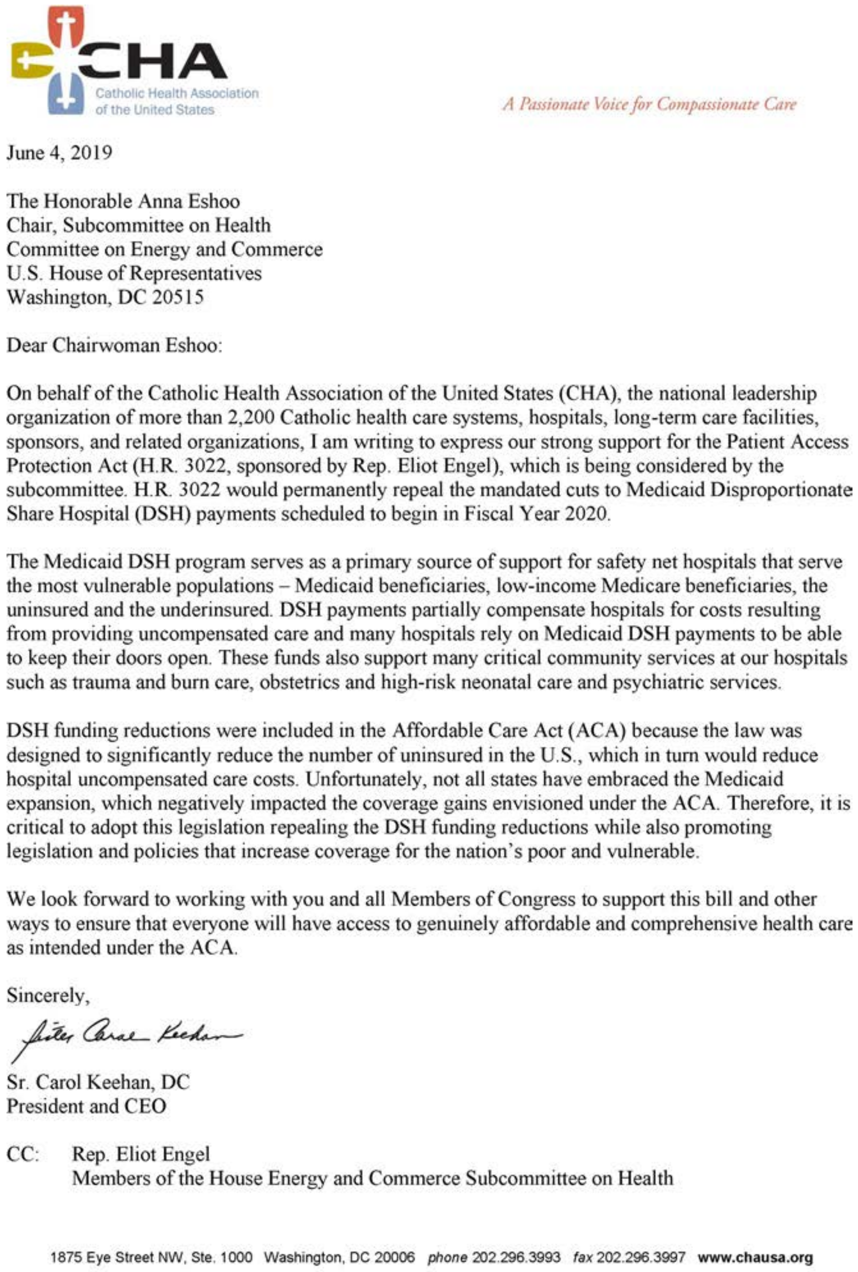
TxP2P website is www.txp2p.org; our F2F page is https://www.txp2p.org/services/family-to-family-health-info. On these sites, you can find some of the resources available to your constituents. Data about our F2F's services can be found at http://familyvoices.org/wp-content/uploads/2018/02/2016_TX_StateDataReport_final.pdf. You can find more information about children and youth with special health care needs and F2Fs in general on the Family Voices website. I would more than happy to provide additional information about our F2F. I can be reached at laura@txp2p or 512-458-8600, direct line: 737-484-9040

Sincerely,

Laura J. Warren

Laura J. Warren, Executive Director

cc:
The Honorable Frank Pallone
The Honorable Greg Walden
The Honorable Anna Eshoo



CHA
Catholic Health Association
of the United States

A Passionate Voice for Compassionate Care

June 4, 2019

The Honorable Anna Eshoo
Chair, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairwoman Eshoo:

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,200 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations, I am writing to express our strong support for the Patient Access Protection Act (H.R. 3022, sponsored by Rep. Eliot Engel), which is being considered by the subcommittee. H.R. 3022 would permanently repeal the mandated cuts to Medicaid Disproportionate Share Hospital (DSH) payments scheduled to begin in Fiscal Year 2020.

The Medicaid DSH program serves as a primary source of support for safety net hospitals that serve the most vulnerable populations – Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and the underinsured. DSH payments partially compensate hospitals for costs resulting from providing uncompensated care and many hospitals rely on Medicaid DSH payments to be able to keep their doors open. These funds also support many critical community services at our hospitals such as trauma and burn care, obstetrics and high-risk neonatal care and psychiatric services.

DSH funding reductions were included in the Affordable Care Act (ACA) because the law was designed to significantly reduce the number of uninsured in the U.S., which in turn would reduce hospital uncompensated care costs. Unfortunately, not all states have embraced the Medicaid expansion, which negatively impacted the coverage gains envisioned under the ACA. Therefore, it is critical to adopt this legislation repealing the DSH funding reductions while also promoting legislation and policies that increase coverage for the nation's poor and vulnerable.

We look forward to working with you and all Members of Congress to support this bill and other ways to ensure that everyone will have access to genuinely affordable and comprehensive health care as intended under the ACA.

Sincerely,

Sister Carol Keehan

Sr. Carol Keehan, DC
President and CEO

CC: Rep. Eliot Engel
Members of the House Energy and Commerce Subcommittee on Health

1875 Eye Street NW, Ste. 1000 Washington, DC 20006 *phone* 202.296.3993 *fax* 202.296.3997 **www.chausa.org**

Attachments—Additional Qnestions for the Record

Subcommittee on Health
Hearing on
"Investing in America's Health Care"
June 4, 2019

Mr. Dean Germano

The Honorable Morgan H. Griffith (R-VA)

1. Can you explain to me how the National Health Service Corps determines where medical professionals are most needed?
    - Which states have the most placements?
    - Which states have the lowest placements?

The Health Resources and Services Administration (HRSA) within the U.S. Health and Human Services Department (HHS) has an Office of Shortage Designation which determines eligible sites for National Health Service Corps placements. All NHSC placements are made federally-designated Health Professional Shortage Areas (HPSAs). These areas can be geographic regions, subsets of populations, and facilities experiencing a shortage of primary care, dental health, and/or mental health professionals.

HRSA also identifies specific facilities, which include health centers, tribally-run clinics, Urban Indian Organizations, Rural Health Clinics, federal and state correctional institutions, state and county mental hospitals, and public or non-profit medical facilities as National Health Service Corps (NHSC) eligible sites. In order to become an NHSC site, the facility must provide services to everyone, regardless of ability to pay, on a sliding fee scale. The facility must also possess a minimum HPSA score, which ranges from 0 to 25. The HPSA score is primarily based on the ratio of population to providers (but other factors including the percentage of the population below 100% FPL and travel time to the nearest source of care outside the HPSA designation are also considered). HPSA scores are used for granting awards to NHSC loan recipients: HRSA first funds applicants who are working in facilities with the highest score (25), and works its way down until it distributes all available funding. Last year HRSA was able to fund NHSC loan repayment applications at organizations with a HPSA score of 16. Similarly, NHSC Scholars are eligible to serve only at sites with the highest HPSA scores.

States with the most NHSC placements as of September 2018 are:
1. California (979)
2. New York (632)
3. Illinois (565)
4. Arizona (471)

5. Michigan (469)

States with fewest placements, as of September 2018 are:
1. New Hampshire (17)
2. Delaware (22)
3. Vermont (33)
4. Wyoming (35)
5. New Jersey (45)

However, many of the U.S. Territories have even fewer placements (except Puerto Rico, which has 129)

The Honorable Gus M. Bilirakis (R-FL)

1. Mr. Germano- FQHCs, federally qualified health centers, are important to the care people in my district receive. They are especially vital for Medicaid patient patients and others with complex and chronic health conditions. Recognizing the need to improve quality and our efforts to enhance quality specifically under the Medicaid program, what resources and incentives can we provide to enable Qualified Health Centers to be better equipped to provide the highest levels of quality in delivery?

Community Health Centers are undertaking a wide range of efforts to ensure they are delivering the highest quality care to 28 million patients across the country, and in communities like yours. Section 330 dollars allocated by Congress have enabled health centers across the country to achieve lower rates of babies born at low birth weight compared to other care providers, despite serving more at risk patients, especially those served by Medicaid. Additionally, due to the continued support provided via Section 330, health centers continue to perform better on several ambulatory quality measures compared to private practitioners including higher rates of: blood pressure screenings, prescribing beta blockers to patients with coronary artery disease, and prescribing ace inhibitors to patients with congestive heart failure.

To continue to enable health centers to advance initiatives like these, one of the most basic, yet important needs, is long-term and stable funding. While funding for state Medicaid programs and their related quality efforts are effectively automatically funded by Congress each year, CHCs must receive timely funding from Congress to enable health centers to continue to serve some of the most vulnerable and underserved patients, including those on Medicaid. That's why it's so important that Congress pass legislation as soon as possible to extend, and increase funding for, the Community Health Center Fund.

Lastly, ensuring robust and sustained federal support for state Medicaid programs will help to support the great work health centers are already doing around the country. In conjunction with Section 330 dollars, a strong Medicaid program has served as a lynchpin of their success in expanding access to mental health services, boosting rates of substance use disorder treatment, and increasing patient engagement and community outreach.

Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Investing in America's Health Care"
June 4, 2019

Lisa A. Cooper, MD, MPH

July 10, 2019

Thank you for the opportunity to respond to these questions. My response has been prepared with assistance from staff at the Patient-Centered Outcomes Institute (PCORI).

The Honorable Nanette Barragan (D-CA)

1. During the hearing we discussed what steps PCORI taken to address racial disparities in its research agenda, and how does PCORI believe its finding can address systemic racial disparities. Would you please be able provide any additional specific information regarding PCORI's working to address racial disparities beyond what we discussed during the hearing?

PCORI has identified the need to address health care disparities as one of its national priorities for research. Understanding that there are a number of factors that lead to disparities in care, including racial, socioeconomic and gender, PCORI has 88 comparative effectiveness research studies and related projects to help patients at risk for disparities and those who care for them make better informed decisions about their options to improve their health.

For example, one PCORI-funded study considered methods to help Latino parents learn skills to manage their children's mental health care. These illnesses can affect a child's physical health and overall well-being. Children with mental illnesses may also struggle to do well in school. Latino children with mental illnesses are half as likely to get mental health care as white non-Latino children. Latino families often report that they have a hard time getting care. When they do get care, they may be unhappy with it. This study showed that utilizing a tailored educational program could improve parent activation skills and their skills for working with their children's school systems and became more involved in their children's school lives.

Another example is a PCORI-funded study focused on helping doctors understand racial/ethnic minority patients' treatment preferences to improve their health care experiences. Patients from racial and ethnic minority groups in the United States more often report negative experiences with health care, such as discrimination from providers, than do non-Hispanic white patients. Doctors may not realize how past experiences shape their patients' views. When doctors don't understand what their patients want and why, patients may not get the treatment that is right for them. In this study, the research team is developing a survey doctors can use to ask patients about their past experiences with care and treatment preferences and to plan treatment with their patients.

As a clinician and a researcher, I have devoted my career to improving quality and addressing disparities in care delivered within the U.S. health care system — specifically the ways race and socioeconomic factors shape these disparities, and the ways our health systems might help eliminate them. PCORI's leadership in this field is supporting relevant and impactful research on how to address systemic racial disparities. I can attest to PCORI's strong and consistent support of this work because my own research has benefitted from it: https://www.pcori.org/research-results/2015/comparing-ways-reduce-high-blood-pressure-people-different-backgrounds-rich .

The Honorable Lisa Blunt Rochester (D-DE)

1. For many reasons, communities of color are often distrustful of the medical community, and particularly of medical research and clinical trials. What steps has PCORI taken to account for these concerns and build trust with minority populations?

One important factor in PCORI's success is their effort to build the capacity for stakeholders to actively engage in their research and to fund studies relevant to them. In PCORI-funded research, patients and other health care stakeholders are equitable partners—as opposed to research subjects—who leverage their lived experience and expertise to influence research to be more patient centered, relevant, and useful. Their early and continued involvement throughout a study can lead to greater use and uptake of research results by patients and stakeholders within the healthcare community.

For example, one PCORI-funded project seeks to engage African-American faith communities to address mental health disparities. This project is designed to increase the capacity of faith communities, youth, and stakeholders to lead, design, and conduct their own patient-centered outcomes research (PCOR) and comparative effectiveness research (CER) studies. By directly engaging the community, PCORI is building the capacity for communities of color to proactive partners as opposed to research studies.

Another example of PCORI's efforts to break down certain barriers is to fund research on how clinicians can best communicate with patients in minority populations or who don't look like them. One PCORI-funded study is studying whether educational videos can help African-American patients make decisions about treatment to prevent sudden cardiac death. African-Americans have the highest rates of sudden cardiac death but are much less likely than whites to receive an ICD. Research studies also show that African-Americans are more likely than whites to refuse recommended heart procedures or surgeries. The study is also looking at whether patients who view a video featuring people of their same race have different results than patients who view a video showing people of a different race.

In my own PCORI-funded study, we explore address issues of mistrust in racial and ethnic minority communities by engaging persons from these communities in the design, implementation, interpretation, and dissemination of findings. We also explore the degree to which trust in health professionals and healthcare organizations influences uptake of programs designed to enhance the self-managements skills of persons with hypertension. Additionally, focus on enhancing patient-centered communication skills and practices in all of the health professionals and health systems involved in our study.

The patient-centered nature of PCORI's mission, as exemplified in the studies described above, has truly changed the culture of research and has led to more meaningful and useful research.

The Honorable Susan W. Brooks

1. What does PCORI see as its role in the nation's efforts to address the opioid epidemic? What has PCORI done so far and what do you anticipate doing moving forward if reauthorized?

As the country grapples with the opioid epidemic, PCORI understands the importance of identifying evidence-based practices that can help patients, caregivers and policymakers make informed decisions about how to address this crisis. To date, PCORI has funded a broad portfolio of research on opioids use – $169 M to fund 36 CER studies related to opioid use across the care spectrum. This includes research on:

- Prevention and preventing inappropriate opioid use from the start, including looking at non–opioid medication and alternative therapies;
- Long-term therapies looking at ways to improve pain management while reducing risk to patients; and
- Opioid Use Disorder to evaluate ways to reduce harm among opioid-dependent patients, including studies on medication-assisted treatment (which combines medications such as buprenorphine with counseling) and add-on nonmedication treatments.

One recent PCORI-funded study found alternative therapies for opioid-treated chronic lower back pain that produce better results for patients. It gives patients more control of the pain management process and lowers their risk of addiction.

With a successful reauthorization, PCORI will be able to fund larger landmark studies of innovative treatments and their health impact on patients – including focusing on addressing the opioids epidemic – that will provide answers to the most pressing questions facing patients and clinicians on what treatment interventions are best and inform health systems and payers on what interventions are of greatest value.

Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Investing in America's Health Care"
June 4, 2019

Thomas Barker, JD

The Honorable Gus M. Bilirakis (R-FL)

1. Mr. Barker- As we look for ways to invest in America's health care, it's important to remember that Congress has yet to provide relief from ACA's taxes, including the health insurance tax. These taxes, which represent billions of dollars that could otherwise be reinvested into patient care, affect Medicare and Medicaid patients in addition to those with commercial plans, have a direct impact on the cost of healthcare for consumers and the ability of payers and providers to deliver the most comprehensive and innovative level of care to beneficiaries. How do you think the health insurance tax impacts healthcare costs and the ability to invest in America's health care?
2. RESPONSE FROM TOM BARKER: My understanding is that the health insurance tax is an issue that may be addressed by the Committee on Ways and Means. Although I do not have any particular expertise with the tax generally, I am aware that there is some question as to the applicability of the tax to Medicaid managed care plans that has prompted litigation in the United States District Court for the Northern District of Texas (*State of Texas v. United States*, Civil Action No. 7:15-cv-00151-O (N.D. Tex. 2018)). One of the arguments advanced by the states in that case is that Congress never intended for states to be subject to the tax, but to the extent that Medicaid managed care plans included the cost of the tax in their rates, Medicaid's actuarial soundness principles required the cost of the tax to be passed on by the states to the plans, in violation of Congress's stated intent. Late last year, the Court partially agreed with the state's arguments and ordered that the states be refunded the cost of the tax, but refused to enjoin it. To the extent that a health insurance payer lacks the market power to do so, the health insurance tax cannot be passed on to its customers, which may have the effect of raising healthcare costs.

Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Investing in America's Health Care"
June 4, 2019

Ms. Mary-Catherine Bohan

The Honorable Debbie Dingell (D-MI)

1. Ms. Bohan, can you explain how your range of services improved after becoming a CCBHC?

   Congresswoman Dingell, thank you for your questions. At Rutgers University Behavioral Health Care (UBHC), the service delivery system has been very positively impacted since becoming a CCBHC. Some specific examples of system improvements include:

   - Institution of Same Day/Next Day Access; clients are able to enter treatment immediately
   - Decreased wait times; average wait time to first appointment has decreased from 21 days to less than 4 days and continues to improve
   - Integration of Case Managers and Peer Support Specialist into treatment team
     - Active members of the Intake team; engaging with clients on admission
     - Able to engage with clients in the community; conduct wellness checks on at-risk individuals
     - Address social determinants of health with client during clinic visits, allowing clinicians and medical staff to operate at the top of their licensure
   - Expansion of Substance Use Disorder Services
     - Development of Ambulatory Withdrawal Management Program
     - Intensive Outpatient Level of Care
     - Expansion of Medication Assisted Treatment (MAT)
   - Physical Health Integration
     - Health Survey completed on admission that informs pathways of care, identifies level of involvement with primary care/specialty care and participation in preventative health screens/procedures
     - Coordination of Care between CCBHC and primary/specialty care
     - Assessment of Body Mass Index (BMI) and Metabolic Syndrome

2. Can you share how many more patients you were able to serve as a CCBHC?

- Three clinics, serving a total of 3314 patients, were transitioned to CCBHC. In year one of the demonstration project, 5,049 individuals were served. As of this date, it appears we served over 6,000 individuals in the second year of the project.
- In the year prior to CCBHC, UBHC treated 115 unique individuals with primary Substance Use Disorder. In year one, 374 individuals were served and 448 individuals were served in the second year of the demonstration.
- UBHC provided MAT to 300 individuals during year two of the demonstration grant through maintenance and induction within the Ambulatory Management Program which is a new service as a result of becoming a CCBHC.

Respectfully Submitted,

Mary-Catherine Bohan, MSW
Vice President of Outpatient and Ambulatory Services
Rutgers University Behavioral Health Care

Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Investing in America's Health Care"
June 4, 2019

Mr. Frederic Riccardi

The Honorable Debbie Dingell (D-MI)

1. Mr. Riccardi, can you explain why it is important for Congress to pass a long-term extension of these outreach programs, instead of a short-term extension?

Making these activities permanent is the best way to meet current and future needs.

From our experience assisting people with Medicare and their families, we know that health care and prescription drug affordability are ongoing challenges. Every day on our National Consumer Helpline, we hear from people who are struggling to cover their Medicare costs. For many—particularly those with low or fixed incomes—the program's premiums and cost-sharing amounts are out of reach. As the population ages and economic trends persist, we are concerned an ever-growing number of beneficiaries will experience these financial challenges.[1]

Already, half of all Medicare beneficiaries—nearly 30 million older adults and people with disabilities—live on $26,200 or less per year, while one quarter have incomes below $15,250 and less than $14,550 in savings.[2] At the same time, health care costs are taking up a larger and more disproportionate share of beneficiaries' limited budgets. In 2016, nearly 30% of Medicare households spent 20% or more of their income on health care, while only 6% of non-Medicare households did so.[3] Out-of-pocket costs for prescription drugs represent a significant share of this amount, accounting for nearly one out of every five beneficiary health care dollars.[4]

Thankfully, help is available. The Medicare Part D Extra Help/Low-Income Subsidy (Extra Help/LIS) program, for example, helps eligible beneficiaries pay their Part D premiums and reduces their costs at the pharmacy counter,[5] and Medicare Savings Programs (MSPs) can help

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[1] MedPAC. "The next generation of Medicare beneficiaries," (June 2015) available at: http://www.medpac.gov/docs/default-source/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-june-2015-report-.pdf?sfvrsn=0.

[2] Jacobson, Gretchen et al., Kaiser Family Foundation. "Income and Assets of Medicare Beneficiaries, 2016-2035," (April 21, 2017), available at: https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/.

[3] Cubanski, Juliette et al., Kaiser Family Foundation. "The Financial Burden on Health Care Spending: Larger for Medicare Households than for Non-Medicare Households," (March 1, 2018), available at: https://www.kff.org/medicare/issue-brief/the-financial-burden-of-health-care-spending-larger-for-medicare-households-than-for-non-medicare-households/.

[4] Kaiser Family Foundation. "10 Essential Facts about Medicare and Prescription Drug Spending," (January 29, 2019), available at: https://www.kff.org/infographic/10-essential-facts-about-medicare-and-prescription-drug-spending/.

[5] Medicare Rights Center, Medicare Interactive. "Extra Help Basics," available at: https://www.medicareinteractive.org/get-answers/cost-saving-

beneficiaries in need pay their Part B premiums.[6]

But people don't always know about these programs or how to apply for them. As a result, they may not be getting the help—or the care—they need, which can lead to worse health outcomes and higher costs.

MIPPA seeks to change that. It provides targeted funding for community-based organizations—including State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the Benefits Enrollment Centers (BECs) supported by the National Council on Aging's (NCOA) National Center for Benefits Outreach and Enrollment—to help low-income Medicare beneficiaries apply for assistance programs that can make their health care more affordable, including Extra Help/LIS and MSPs.

However, uncertainties associated with temporary allocations can make it difficult for MIPPA grantees to meet current and growing needs. Static, short-term allocations and looming expirations not only fail to provide the assurances needed to hire and retain qualified full-time staff who can build community relationships and gain valuable experience, but also degrade the year-over-year stability necessary to conduct effective outreach.

This has contributed to far too many people who are eligible for these programs not getting the help they need:

- Almost three million Medicare beneficiaries eligible for the Extra Help/LIS are not enrolled—including over 72,000 Michiganders.[7] This program is valued by the Social Security Administration as saving beneficiaries an average of $4,900 a year.[8] Improving enrollment is a critical component of reducing out-of-pocket prescription drug costs for those who can least afford them.
- Less than half of eligible low-income beneficiaries receive help for assistance paying Medicare Part B monthly premiums ($135.50 in 2019) through an MSP.[9] These programs save beneficiaries at least $1,626 a year by putting the Part B premium back into their monthly Social Security check. Absent this assistance, many are left un- or under-insured.

MIPPA grantees uniquely work to identify low-income people with Medicare who may be missing out on these benefits. The infrastructure to successfully continue this much-needed outreach—including processes and a trained workforce—already exists. But without sufficient and reliable long-term funding, current capacity challenges will persist, and the program will remain subject to threats of suspended or unavailable resources.

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programs-for-people-with-medicare/the-extra-helplow-income-subsidy-lis-program/extra-help-basics.

[6] Medicare Rights Center, Medicare Interactive. "Medicare Savings Program basics," available at: https://www.medicareinteractive.org/get-answers/cost-saving-programs-for-people-with-medicare/medicare-savings-programs-qmb-slmb-qi/medicare-savings-program-basics.

[7] National Council on Aging 2019 internal data.

[8] Social Security Administration. "Extra Help with Medicare Prescription Drug Plan Costs," available at: https://www.ssa.gov/benefits/medicare/prescriptionhelp/.

[9] MedPAC. "Medicare Savings Program Enrollees and Eligible Non-Enrollees," (June 2017) available at: https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf.

In 2013, for example, a delay in reauthorizing MIPPA activities meant that SHIPs, AAAs, and ADRCs experienced a funding gap that led to staff layoffs, and these agencies had to halt or significantly scale back outreach efforts for these populations. Roughly 200,000 individuals[10] went unserved during this gap, without the one-on-one assistance to navigate their options. Many may not have received the help they needed to afford their Medicare expenses.

Permanent funding would prevent this from happening again. It would allow for seamless continuation of MIPPA outreach activities, enable community organizations to dedicate the resources and staff needed to accomplish their goals, and support the establishment of a BEC in every state.

This consistency is critical. Enrollment counselors often must make multiple contacts with beneficiaries in order to build trust so that the beneficiary feels comfortable applying for health savings programs. Long-term funding would enable agencies to maintain outreach across several fronts to build these relationships, especially among vulnerable communities such as rural residents, veterans, and those with disabilities who may have trouble accessing online services or traveling to local offices for assistance.

In sum, permanence would bring much-needed assurances and stability to the program, allowing community-based organizations and state agency partners to conduct maximally effective outreach that is needed to best serve the growing number of older adults and people with disabilities who need help accessing affordable health care.

At a time when the Medicare-eligible population is growing rapidly,[11] and their economic security eroding, the continued availability of this assistance is more critical than ever.[12]

2. How would Medicare beneficiaries be impacted if these programs were not reauthorized?

MIPPA funding allows community-based organizations to target outreach and enrollment to vulnerable, hard-to-reach and low-income Medicare beneficiaries. Without MIPPA funding, these organizations would have to reduce staff and outreach efforts to this population—to the detriment of low-income older adults and people with disabilities who need help paying for care.

The consequences of health care and prescription drug unaffordability are significant, both for the Medicare program and those who rely on it. Beneficiaries who cannot purchase their medications or pay for coverage may be forced to go without care—leading to worse health outcomes and quality of life, hospitalizations, or even death. And the cost to the Medicare program is also extreme, as beneficiaries who forgo needed care and experience declining health as a result may need more costly interventions later, like emergency department or inpatient

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[10] The average annual number of those helped to submit MIPPA subsidy applications in years prior to FY13.

[11] Glenn Kessler, Washington Post. "Do 10,000 baby boomers retire every day?" (July 24, 2014) available at: https://www.washingtonpost.com/news/fact-%20checker/wp/2014/07/24/do-10000-baby-boomers-retire-every-day/?utm_term=.342861b35a79.

[12] MedPAC. "The next generation of Medicare beneficiaries," (June 2015) available at: http://www.medpac.gov/docs/default-source/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-june-2015-report-.pdf?sfvrsn=0.

care.[13]

Access to affordable care is a particular concern for Medicare beneficiaries, a group at high risk of developing one or more chronic conditions: approximately 80% of older adults have at least one chronic disease and 77% have at least two.[14] This risk is greater for low-income beneficiaries, who face higher rates of many conditions—including kidney disease, congestive heart failure, heart disease, mental illness, and diabetes—than their middle- or upper-income peers.[15]

For those impacted and at-risk, the timely provision of needed care can be critical to health maintenance and improvement, as well as to controlling out-of-pocket and program costs. The Medicare Savings Programs and Extra Help/LIS in particular can help those who are eligible afford needed preventive care and medications. This increases prescription adherence, which in turn helps them better manage chronic conditions—representing a cost savings to Medicare in the long run. This is an important consideration, as these conditions are expensive to manage and treat, accounting for more than two-thirds of national health care costs.[16] Despite the benefits, research indicates that many people with Medicare are unaware of these programs—making outreach and enrollment assistance essential.[17]

Connecting those in need with programs that increase affordability and access can truly be life-changing—helping them improve their health and better meet their needs of daily living.

Consider Ms. W, a recent Medicare Rights' client. She is legally blind and lives on a limited, fixed income. When she first became eligible for Medicare, she reached out to an enrollment counselor because she was confused about her Medicare coverage and unable to afford it. Working with the counselor, she applied for and was enrolled in the Medicare Savings Program and Extra Help drug subsidy—which now save her more than $6,500 each year on health care costs.

While Ms. W was able to obtain financial and enrollment assistance relatively seamlessly, not all low-income beneficiaries share her experience—and she is far from alone in facing difficulty navigating and paying for Medicare.[18] For many such beneficiaries, it is through MIPPA's outreach and enrollment efforts that they are able to better afford and access care. Absent this help, they would likely continue to face significant barriers that could cause them to forego needed coverage or meet basic needs—risking worse health outcomes and significant out-of-pocket costs.

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[13] Lee, Shinduk et al., "Attitudes, Beliefs, and Cost-Related Medication Nonadherence Among Adults Aged 65 or Older With Chronic Diseases," (December 6, 2018) Prev Chronic Dis 2018;15:180190, available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6292137/#.

[14] NCOA Compilation of data from the Centers for Medicare & Medicaid Services. "Chronic Conditions Prevalence State/County Table: All Fee-for-Service Beneficiaries," (2015) available at: https://www.ncoa.org/blog/10-common-chronic-diseases-prevention-tips/.

[15] AARP. "Chronic Conditions Among Older Americans," available at: https://assets.aarp.org/rgcenter/health/beyond_50_hcr_conditions.pdf.

[16] NCOA. "Chronic Disease Self-Management Facts," available at:https://www.ncoa.org/news/resources-for-reporters/get-the-facts/chronic-disease-facts/.

[17] NCOA. "What the Research Says," available at: https://www.ncoa.org/centerforbenefits/outreach-toolkit/what-the-research-says/.

[18] Year after year, calls about how to enroll in and afford Medicare present as top trends on Medicare Rights' National Consumer Helpline. See: Medicare Rights Center. "Medicare Trends and Recommendations: An Analysis of 2017 Call Data from the Medicare Rights Center's National Helpline," (April 2019) available at: https://www.medicarerights.org/pdf/2017-helpline-trends-report.pdf.

3. Can you summarize the successful track record we've already seen from these four outreach and enrollment programs?

Since its inception, MIPPA funding has allowed community-based organizations to connect low-income Medicare beneficiaries with programs that make their health care and prescriptions more affordable. MIPPA grantees also provide Part D counseling to Medicare beneficiaries who live in rural areas and promote Medicare's prevention and wellness benefits.[19] Currently, grantees in 50 states and the District of Columbia are carrying out these activities, with evidenced success.[20] To date, MIPPA resources have enabled grantees to:

- Assist 2.7 million individuals in need;[21]
- Submit over 1.8 million applications on behalf of low-income seniors and persons with disabilities, worth a valued $5 billion in annual savings on health and prescription drug costs;
- Help ensure that over 9 million low-income Medicare beneficiaries are now able to better afford rising health care costs thanks to enrollment in the Medicare subsidy programs;[22]
- Target rural communities and other high-need, hard-to-reach populations to improve access to help with rising Medicare prescription drug costs.

Additionally, MIPPA-funded agencies do more than help low-income people with Medicare enroll in money-saving programs. They also help them to weigh their options to determine if the drug or health plan they are in provides the best coverage at the most affordable cost.[23] According to an August 2016 study by American Economic Review, only between 8-9% of Medicare beneficiaries chose the Part D plan that offered the best value. While 1-800-MEDICARE and the Medicare Plan Finder are valuable tools that can help some beneficiaries with their coverage choices, they are not available or helpful to everyone, especially those without reliable internet access. The combination of personalized assistance in the community, as well as online and call center resources, is essential to helping the nation's 60 million Medicare beneficiaries—as well as the 10,000 people who reach Medicare eligibility age each day—make optimal coverage choices. Through MIPPA, these organizations are able to establish initial connections with people who need assistance affording coverage—relationships that can beget future and long-term opportunities to help beneficiaries build health and economic security.

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[19] Medicare Rights Center. "Medicare-covered preventive services," available at: http://www.medicarerights.org/fliers/Original-Medicare/Medicare-Covered-Preventive-Services.pdf?nrd=1.

[20] National Council on Aging. "MIPPA at a Glance," available at: https://www.ncoa.org/wp-content/uploads/MIPPA-at-a-glance-2018.pdf.

[21] Based on 2019 grantee reports submitted to the Administration for Community Living and Centers for Medicare & Medicaid Services; obtained by the National Council on Aging.

[22] National Council on Aging. "Medicare Savings Program Enrollment Visualization," available at: https://www.ncoa.org/economic-security/benefits/visualizations/medicare-savings-program-visualization/.

[23] Jason Abaluck and Jonathan Gruber; Am. Econ Rev. "Evolving Choice Inconsistencies in Choice of Prescription Drug Insurance," (August 2016) available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5665392/.